

14 September

**ATTACHMENT 1: RESPONSE TO AFRICA APPG RECOMMENDATIONS TO THE
UK GOVERNMENT**

1. Plug the gap in funding needed to avert the worst predictions by:

(a) Setting a timetable for UK overseas development assistance to reach 0.7% of GNI within the next Parliament.

1. The Government's 2004 Spending Review delivered a good outcome for UK official development assistance (ODA). Total UK (ODA) will rise to almost £6.5 billion by 2007-08, representing a real terms increase of 140 per cent since 1997. DFID's budget will continue to grow substantially, from £3.8bn in the current financial year to more than £5.3bn by 2007/08. This means that UK official development assistance (ODA) will reach 0.47% of Gross National Income by 2007/08, up from last year's figure of 0.34%. The settlement represents an average increase of 9.2% in real terms over the 3-year period.
2. The Government wishes to maintain these rates of growth and on this basis would reach 0.7 per cent of GNI by 2013. The UK's proposal for an International Finance Facility were adopted, the objective of 0.7 per cent could be achieved earlier, by 2008-09 on best estimates.

(b) Launching the International Finance Facility in 2005.

1. The UK is committed to an early agreement to, and the successful implementation of a new IFF to secure long-term predictable funding for developing countries. Since the UK's Call for Action on HIV and AIDS we have been working hard to broaden international support for the IFF. The UK co-hosted a successful international conference with the French government in April 2004 at which emerging markets and developing countries strongly endorsed the IFF and urged donors to implement the proposal. Next steps on the IFF will be agreed at the annual meetings of the World Bank and International Monetary Fund (IMF) in October 2004.

(c) Pushing for the urgent use of unspent funds within the European Development Fund.

1. The bulk of the European Commission's (EC) aid to African, Caribbean and Pacific (ACP) countries are financed from the European Development Fund (EDF). The EDF is negotiated and financed by EU Member States separately from the core Budget of the EC. EC aid to other regions comes from the core Budget.

2. A new EDF is agreed every five years and committed over a slightly longer period, with disbursement intended to occur over a much longer period, as most commitments are multi-year to allow forward planning. This means that disbursements are made from several different EDFs at once. There is a "backlog" between commitment and disbursement built in to the design of EDFs. All development organisations have a backlog between commitment and disbursement. This is an inevitable and desirable feature of a programme of firm commitments for medium term spending.

3. EDFs 1-5 are all expended. The €38.4bn of EDFs 6,7 and 8 is all fully allocated, including to the Global Fund for AIDS, TB and malaria (GFATM), and through National Indicative Programmes. Funds are drawn down from Member States immediately before they are required. About €11bn is yet to be drawn down from Member States and disbursed to developing countries. (including €373m paid over to the GFATM – which has not been disbursed because of GFATM's own built in "backlog"). This means that there is no money lying idly in Commission accounts.

4. However, Member States, and indeed the EC, are not satisfied with the scale of backlog and the speed with which the Commission is able to re-commit funds from dormant or defunct projects. Around €1.4bn of the €11bn remaining in EDFs 6,7, and 8 is committed to projects which are dormant – this €1.4bn needs to be committed to new uses. The Commission is implementing reforms of development assistance, including addressing this problem.

5. Progress has been made. The Commission reported in 2003 that disbursement of the "backlog" is speeding up. For the EC Budget, the number of years required to spend the backlog at current expenditure rates has been reduced to 3.5 years, which compares with 4.6 years at the end of 1998. The EDF backlog would take about 4

years to clear at current expenditure rates compared to 5.5 years at the end of 2000. We continue to work with the Commission improve efficiency in EDF management and decision making to shorten the time required to make commitments and further reduce the proportion of commitments that cannot be spent.

6. Reforms have included simplification of procedures, introduction of sunset clauses on commitments (expiry date beyond which they are deemed to lapse and funds can be recommitted), and administrative decentralisation to delegations in the field. In May 2004, negotiations started on revising elements of the Cotonou Agreement, with a key goal to make EDF aid more efficient and effective. The UK would like to see more flexibility to move financial allocations around in support of need and performance.

7. As progress continues some commitments will be freed up and will be allocated to other purposes. There is inevitably much debate among Member States, and the ACP states themselves, about the use of these resources. There are many competing calls including support for better performing countries, crisis countries, social sectors, natural resource management etc. The GFATM's mandate is to mobilise additional resources, and not to recycle existing public aid of which these EDF commitments by Member States form part.

8. In the new Commission, EuropeAid, the body which implements EC programmes will come under the responsibility of Dr Benita Ferrero-Waldner the Commissioner for External Relations designate. The UK government will address these issues with both the new Development Commissioner, Louis Michel, and the commissioner responsible for EuropeAid to continue reform to further improve the effectiveness of EC aid.

(d) Increasing UK funding to the Global Fund to Fight AIDS, TB and Malaria to US\$ 216 million for the 2005 funding rounds.

1. The UK recognises that in order to be effective, the Global Fund to Fight HIV/AIDS, TB and Malaria needs predictable and long term financing. Therefore in May 2003, the UK extended its existing pledge by a further 2 years to 2008, bringing our total contribution to approximately US\$280million.

2. On 20 July 2004, the UK announced an additional **£77 million** to the Global Fund for the period 2005/06 –2007/08, contingent on the effective performance of the Global Fund. The new pledge doubles our existing contributions from 2005 to 2008 but has not been broken down on a year-by-year basis. So - the total funding has been doubled to £154m but amounts have not yet been ascribed to any particular year.
3. We are working closely with the GFATM Secretariat and partners of the Global Fund to help set in place time-bound and measurable indicators of performance to help to demonstrate the effectiveness of the Global Fund. We believe good results will increase donor - and recipients' confidence in the Fund as an instrument to tackle these diseases and encourage the wider and increased support that it needs.

(e) Pushing for better coordination of existing and new funds.

1. In April 2004 the UK, US and UNAIDS secured agreement among all major donors including the World Bank and the Global Fund to support the "Three Ones": one agreed HIV and AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority; and one agreed country-level monitoring and evaluation system. In addition, the UK government will lead efforts to take forward a proposal to establish what has been tagged a "Fourth One" for harmonization of donor funding efforts. At country level the "Fourth One" would entail the establishment of a single pooled funding mechanism, to channel all bilateral and multilateral support, and reduce the burden on recipient governments. We have begun to explore the establishment of a "Fourth One" with the Governments of Tanzania, Norway and other donors.

(f) Working with partners including the Bretton Woods institutions to ensure that HIV/AIDS funding is treated as exceptional investment and not delayed or reduced because of expenditure frameworks.

1. DFID has been in dialogue with the Bretton Woods Institutions on these issues and will continue to do so. Our view is that the IMF would be unlikely to prevent concessional resources for HIV/AIDS being spent as long as the resources were reasonably predictable and reliable. DFID would not support

calls for macro and fiscal stability to be abandoned completely in order to finance AIDS action.

2. However, there is little macroeconomic justification for a government to refuse a permanent and predictable increase in aid, as the long-term benefits should be able to offset any initial negative impact of large inflows. There is, however a good reason for caution when the anticipated increase in aid consists of large, volatile or short run pledges.
3. We believe it would be useful to shift the debate onto what donors/financers need to do for countries to have the confidence in the predictability of aid flows. Recent analysis shows that predictability and credibility of donor funding is very relevant for countries macroeconomic planning.

2. Make sure policy across all UK Government Departments on HIV/AIDS is coherent and joined up. Under the leadership of DFID, every UK government department should develop policies to support coordinated and intensified efforts to fight the global HIV/AIDS epidemic.

1. We are committed to ensuring that UK Government responds to the priorities set in the HIV & AIDS Strategy in a coherent and joined up manner. To this end we are establishing a cross Whitehall Working Group on AIDS. A key function of this group will be to monitor the implementation of the strategy across all departments. The FCO has already identified clear objectives to intensify its response to HIV and AIDS in countries where we think UK can encourage stronger political leadership.

3. Support African governments, NGOs and community organisations to put together a full scale social rescue package. Such a package should be used to address the orphan crisis and the wider threat to the social fabric posed by the AIDS crisis.

1. We are in the process of developing the details of our support to orphans and vulnerable children and will announce these in December. We recognize the need to assist countries in developing comprehensive responses to the impact of AIDS on children, families and communities. These will involve partnerships between governments, NGOs and community-based

organisations. We endorse the multi-sectoral approach developed by UNICEF and partners in the Framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS. This will assist us in supporting the development of sustainable responses at country programme level, the details of which will necessarily vary from context to context, depending on the severity of impact on children. DFID is currently exploring the implications of HIV and AIDS for social protection and assessing the impacts of key interventions in order to support a more robust multi-sectoral response to the epidemic.

4. Support African governments to provide integrated health interventions including prevention and nutrition programmes and basic treatments such as antibiotics for opportunistic infections and antiretroviral therapy (ART). To deliver these swiftly, governments will need to harness the capacity of business, NGOs and community organisations.

1. The UK Government is fully committed to the implementation of comprehensive responses to AIDS in developing countries. Responses should include efforts to prevent the spread of the disease, provision of care and treatment (including opportunistic infections, sexually transmitted infections and antiretroviral (ARV) drugs) and programmes to minimise the social and economic impacts of AIDS.
2. The recently published Government strategy on HIV and AIDS and its policy on treatment and care detail the UK's activities to support these efforts. These strategies emphasize the importance of harmonization and alignment of donor efforts to support nationally led responses. Prevention and nutrition programmes will both be supported.
3. The provision of treatment will also be supported. In the case of ARVs, provision has become increasingly feasible with significant price reductions in the last four years, and greater understanding of the effectiveness of antiretroviral therapy in poor countries. We fully support the WHO and UNAIDS '3 by 5' initiative and its target to get 3 million people on treatment by the end of 2005 – we also support the longer term goal of universal access. Working with others we will seek to provide increased, and eventually universal, access to treatment.

4. The UK Government has also done a great deal to increase access to essential medicines in developing countries, including for the treatment of HIV and AIDS. We recently published 'Increasing access to essential medicines in the developing world: UK Government policy and plans' which detailed our work in this area, including our work in relation to health systems strengthening, the pharmaceutical industry, and the 30th August TRIPS decision allowing poor countries with no, or insufficient, manufacturing capacity in their pharmaceutical sector to import copies of patented drugs.
5. The UK Government is committed to multisectoral responses to AIDS, whereby governments work with the private sector, non-governmental organisations and community organizations to ensure programmes reach the poor.

5. Support African governments and civil society in affected countries to develop policies and programs to ensure access to health interventions on the basis of equity, cost effectiveness and transparency, and in particular to ensure that women are prioritised.

We look to strengthen political leadership for these priorities. We will continue to work closely with countries to ensure that equity and rights are prioritised, including in Poverty Reduction Strategy processes and in the decision-making process around scaling up treatment and that strong links are made between PRS processes, National Health Sector Development Strategies and Medium Term Expenditure Frameworks. These are supported transparent planning and budgeting processes to ensuring that the interventions necessary for reaching the MDGs and reducing poverty are prioritised (and cost effective). However we do not support a sole focus on cost effectiveness as it may mean that some important interventions or innovations are not taken up.

Much of our new emphasis on HIV and AIDS will be directed to women, children and vulnerable groups. It will be important to ensure that this redresses imbalances in response to HIV and AIDS in many countries and that equity of access by poor people overall is not compromised as a result. DFID has supported and coordinated the work of the Equity TaskForce of the Health Metrics Network and in Southern Africa is engaged with the EquiNet Network.

EquiNet furthers approaches to equity in HIV/AIDS treatment, health systems development, human resources capacity development, and within civil society alliances. The UK government supports research on both interventions that promote equity and cost effectiveness through our health systems Knowledge Programmes.

6. Support African governments in affected countries to prepare for losses in Capacity through capacity building programmes and massively scaled up staff training programmes particularly for key public sector workers such as teachers, health workers and public service managers.

1. The UK government is supporting capacity building programmes in many of our sixteen target countries in Africa, and we shall continue to more. Strengthening country capacity is a key theme of the UK's new HIV and AIDS strategy. Examples of ongoing and planned work include:
2. Mozambique- Sustained financial and institutional support to the government's pharmaceutical department (through pooled arrangements and harmonised approaches) has substantially increased drug security, led to fewer stockouts and greater equity as funds are first spent to purchase vital medicines for peripheral health facilities. DFID has been supporting this process for five years (£25m over the five years). Procurement, supply and distribution associated with the scale-up and roll-out of anti-retroviral therapy are likely to be accommodated more easily as a result of this on-going systems strengthening
3. In addition we, with other donors and the World Bank, are supporting the Government's Public Service Reform Programme, which is a comprehensive framework spanning some 10 years in two phases. The first phase includes capacity building initiatives such as training, financial management and procurement reform, and a range of human resource management reforms.
4. Ghana - As part of our support to health systems development we and others are working with the Government to improve the effective deployment of health personnel – through decentralising human resources budgets, increasing financial and career incentives for those serving in deprived areas, and training auxiliary staff.

5. Rwanda - DFID and GoR are currently developing a new Civil Service Reform Programme to enable the Rwandan Civil Service to deliver services in an effective, efficient and economic manner through enhancements to structure, human resource capacity, results orientation and performance management. There will also be a component for managing the impact of HIV/AIDS within the public service. Since 2001 we have contributed £5.3 million to CSR in Rwanda.
6. Malawi is one of the ten poorest countries in the world and its funding for its health service is too low to provide adequate health care. It has about 29 nurses per 100,000 population, which is less than half the levels in Ghana and Tanzania, and one fifth of the level in South Africa. The UK is working with the Malawian government and other international development agencies on a plan to double the level of staffing in the Malawi health service over the next six years.
7. DFID is very aware of the impact of losses in human capacity upon the ability of countries to plan for and mount effective HIV/AIDS responses. A key priority amongst these strategies for increasing capacity is improving the pay and working conditions for key public sector workers so that staff are attracted and incentivised and remain in post. In many countries the greatest losses in capacity are caused by demotivated personnel choosing to leave their posts for alternative employment.
8. Secondly, we will seek to support country based training programmes, building up local or African based institutions as they are best placed to train staff with appropriate skills.
9. Thirdly, where capacity depletion is extreme we will consider making available international staff to work as teachers, trainers and direct service providers, but at all times will prioritise the transfer of skills and knowledge so as not to displace the creation of indigenous capacity. In these efforts we will work with the Department of Health and Department for Education and Skills. They can bring specialist expertise to the design of country based programmes, and in some cases already have strong working relationships with countries on aspects of professional education.

7. Use the UK's 2005 chairmanship of the G8 and presidency of the EU to urge all major donors to increase coordinated spending on HIV/AIDS to meet existing commitments and to prioritise the issues highlighted above.

1. Africa will be a priority for our G8 Presidency next year. As one of the major constraints to Africa's development, the Prime Minister is committed to making AIDS a centrepiece of the UK Presidencies of the G8 in 2005 and of the EU, alongside the priority being to Africa. G8 leaders will report on progress on the Africa Action Plan next year under the UK Presidency. The Africa Action Plan includes a number of commitments to combat the effects of HIV/AIDS, across a range of intervention areas from prevention, care and treatment to strengthening policy and technical capacity and systems.
2. In 2005, the Commission for Africa will produce an action-orientated report setting out what action is required both within Africa and the international community. This report will be presented to the G8 leaders. The Commission recognises that AIDS is a cross-cutting issue and as such it will address many of the areas highlighted above and be tackled in all areas of its work: including governance, the economy and human development.
3. Details of a focus during our EU Presidency are still being refined, and we are discussing with the other like minded presidencies and the Commission, how this might fit in with the Multi Annual Programme. Under their Presidency the Irish promoted the Three Ones, and currently the Netherlands are urging the EU to harmonise, and co-ordinate their political interventions on HIV at country level. It will be important for us to build on this work. We shall also use our EU Presidency to report to the General Assembly on EU action towards meeting the MDGs. During the EU Presidency there will also be a review of countries achievements against the UNGASS Declaration of Commitment on HIV/AIDS targets. We will monitor progress at the UNGASS review, ensuring that clear steps are put in place to move forward, especially if targets have not been met.

Further Recommendations to the UK Government:

- 8. Increase support for UNAIDS' *Three Ones* initiative to ensure that funding is more coordinated and therefore more effective.**

1. The UK governments strategy for tackling HIV and AIDS in the developing world, "Taking Action", emphasizes the importance of the UNAIDS "Three Ones" strategy. This is fundamental to strengthening long term and sustainable national responses to the HIV and AIDS epidemic.
2. DFID is working globally with donors and international agencies such as the Global Fund, the EC, World Bank, UNAIDS, UNFPA, WHO, UNICEF to advocate for a coordinated response to the epidemic under the banner of the "Three Ones". DFID is also working to support UNAIDS to monitor the roll-out of the Three Ones by developing indicators and a system of reporting linked to the UNGASS targets. The G8 and EU presidencies will be a prime opportunity to undertake further advocacy efforts around the UN Three Ones.
3. At country level, DFID is working with national governments and other partners including UNAIDS to strengthen their domestic planning, coordination and monitoring through various mechanisms from technical assistance programmes through to budget support. For example, DFID is planning to provide budget support to the Government of Tanzania along with technical assistance and support to civil society development.
4. DFID aims to lead efforts to establish harmonisation of donor efforts to provide a single pooled funding mechanism, to channel all bilateral and multilateral support, and reduce the burden on recipient governments. Where appropriate, DFID aims to support countries that want to reduce the number of donors, for example by setting a minimum entry level of funding.

9. Ensure that the initiatives that the UK Government has signed up to, such as the WHO 3 by 5, are met.

1. We are committed to achieving the outcomes across the range of initiatives that the UK has signed up to and outlined in the new HIV/AIDS Strategy. With the publication of "Taking Action" DFID is developing an implementation strategy which will be monitored to help ensure that the initiatives the UK Government has signed up to will be met. We shall monitor the implementation of initiatives throughout DFID's organizational structure –

- We are currently finalizing the review and strengthening of DFID internal financial management, reporting and monitoring mechanisms, in order to effectively track that levels of financing for multilateral institutions and national programmes will be appropriate to meet the UK Government spending target of £1.5 billion over the next three years (from 2005-06 to 2007-08).
- We will use the lessons learned from the National Audit Office (NAO) review of DFID's response to HIV and AIDS to improve monitoring and evaluation frameworks that will effectively measure the impact of the UK's action. DFID will evaluate the implementation of the new HIV and AIDS strategy in 2006.
- At the country level African country offices will review commitments to AIDS and cover these in Country Assistance Plans and country agreements.
- DFID produces, monitors and regularly revises Institutional Strategy Papers (ISPs) for multilateral institutions where we focus particular attention on AIDS, including the World Bank (to be revised and published in mid-2004), the World Health Organisation (to be updated in 2006) and UNAIDS (with whom our first ISP will be published in 2004). A new ISP with the EC will be developed and issued in mid-2005. Through the ISPs we are able to strengthen our strategic engagement with multilaterals and identify clear AIDS objectives. All CAPS and ISPS will be monitored on a continuing basis.
- We will focus on harmonization of donor programmes and international initiatives (3x5, The Presidents Emergency Plan for AIDS relief, The Clinton Foundation, The World Bank multi country HIV/AIDS Programme and the Global Fund) and work to support the role of WHO and UNAIDS in providing normative, clinical and technical guidance.
- We will maintain a high political focus on priority AIDS initiatives through ongoing advocacy at national and international levels including using our Presidencies of the G8 and EU in 2005.

10. The exceptional scale of the AIDS crisis poses a challenge to existing development mechanisms, an exceptional response will be required. DFID's use of direct budget support needs to be fully reconciled with the high priority rightly given to averting the worst impacts of the AIDS epidemic while also facilitating pro-poor development.

1. We agree that DFID's use of direct budget support should facilitate pro-poor development and take account of the need for a high priority response to AIDS. In DFID's bilateral programmes there continues to be a trend towards a greater share of disbursements through poverty reduction budget support (PRBS) where country conditions are appropriate. This enables governments to take long-term responsibility for their AIDS responses. It is designed to work through government in order to increase the predictability of external funding and improve its effectiveness in providing services (thus it is often supplemented by technical assistance), including those aimed at prevention and mitigation of HIV/AIDS.
2. For example, DFID's strategy in Tanzania seeks to generate an increased allocation within the government's central budget for AIDS-related activities and thus scale up the government's national multi-sectoral strategic framework. DFID will explore with the government of Tanzania and other donors the possibility of establishing an HIV fund. DFID will contribute to such a fund (£15 million in 2005-06 rising to £25 million in 2006-07) through the budget support mechanism, offering sector ministries resources for AIDS that are additional to their normal budget bid. This fund would be complemented with high-quality technical assistance, as well as funds from several donors and ourselves to support innovative, large-scale NGO initiatives.
3. However we take the view that a pluralistic approach to aid instruments for HIV/AIDS is required. The particular mix of instruments will evolve over time depending on the country context – the stage and nature of the epidemic, the national HIV/AIDS response, capacity of different actors and the broader, long-term development agenda. DFID is developing a policy paper on Service Delivery in Difficult Environments. The paper will analyse the impact and appropriateness of different instruments in these settings and advise as to the nature of our future engagement.

11. Ensure that a balanced approach to the continuum of HIV/AIDS interventions from prevention through treatment and including impact mitigation is central to DFID's HIV/AIDS policy and also integrated in other DFID policies. A balanced approach is needed in all affected countries not only those with the highest rates.

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1. As described in the HIV/AIDS Strategy, though prevention must remain the mainstay of action, DFID will provide money and advice to support the development and delivery of national AIDS strategies that are comprehensive, integrating programmes that prevent, treat, care and mitigate the impact of AIDS. Moreover, they should address the broader causes and effects of HIV and AIDS that go beyond health. This strategy will be implemented through DFID's internal business plans and strategies for working with developing country and multilateral partners.
2. It is now clear that linking care to prevention and dealing with the impact of AIDS can increase effectiveness. Therefore, the UK government will not support vertical, stand-alone interventions that neglect these links and could weaken national systems and responses. We shall continue to place our focus on strengthening the health systems and building a supportive environment.
3. We agree the need to take a balanced approach in both high and low prevalence countries. DFID is working in many high prevalence countries, such as South Africa and Lesotho. In these countries the aim is to follow the example of countries like Uganda which was successful in curbing the epidemic from prevalence of 15% in 1991 5% in 2001. We fully recognise the importance of tackling AIDS in low prevalence countries, such as Ghana, where prevalence is still below 5%. In such countries it is vital to follow the example of Senegal, where early and targeted interventions were able to keep prevalence rates low. It is acknowledged that once prevalence exceeds 5% it is much more difficult to contain the epidemic. Maintaining low prevalence rates in individual countries will also benefit regional development.

12. Recognise that preventing HIV infection among the largely young populations of most sub-Sahara African countries will reduce overall prevalence and that effective prevention efforts are the first line of defence

against the epidemic.

1. 15-24 year olds account for half of all new HIV infections worldwide. Children with HIV and AIDS are likely to be orphaned, suffering emotional and psychological trauma. They consequently have limited support to deal with their own condition. The HIV and AIDS strategy recognises this and prioritises women, young people and excluded groups. DFID prioritises approaches which combine prevention of mother to child transmission to reduce the risk of children being born with HIV and the provision of long term treatment and care for parents so as to prolong the lives of parents so as to avoid and delay orphan-hood. Children and young people with HIV and AIDS should have access to treatment and care to allow them to live productive lives. The UK has endorsed UNICEF's "Strategic Framework for the Protection, Care and Support of Orphans and Vulnerable Children living in a world with HIV and AIDS".
2. The HIV and AIDS strategy specifically commits to spending at least £150 million on programmes to meet the needs of orphans and other children, particularly those in Africa, made vulnerable by HIV and AIDS.

13. Learn from the failure to stem infection in those countries which now have very high prevalence rates to ensure the window of opportunity is used to avoid such high rates in other regions.

1. DFID works in high prevalence countries such as South Africa and Lesotho, where the aim is to follow the example of countries like Uganda that was successful in curbing the epidemic from prevalence of 15% in 1991 5% in 2001. However, DFID also works in other countries such as Ghana, where prevalence is still below 5%. In such countries it is vital to follow the example of Senegal, where early and targeted interventions were able to keep prevalence rates low.

14. Recognise that ART can extend life for HIV affected people considerably and is an essential part of an overall strategy to mitigate the impact of AIDS. Support roll out of treatments at scale, where possible with state leadership but utilising capacity in other sectors.

1. The UK Government fully supports the WHO and UNAIDS '3 by 5' initiative and its target to get three million people on antiretroviral therapy (ART) by the end of 2005. We also support the eventual goal of universal access to ART. We have committed in our recent strategy on HIV and AIDS, and in our policy on treatment and care, to support efforts to provide increased, and eventually universal access to both treatment and care. The UK will support national responses that include public and private sectors and civil society.

15. Ensure that national nutrition and food security are considered part of an effective HIV/AIDS strategy.

1. DFID will support governments to incorporate nutrition and food security issues into their national plans and AIDS strategies. The key to progress is a multi-sectoral response, assisting joint working among Ministries and collaboration with multilateral agencies to promote harmonization around the Three Ones. In particular, DFID will work with World Food Programme (WFP) and UNICEF to improve planning systems around HIV/AIDS and food security and nutrition. The roll-out of anti-retroviral drugs will have implications for the poor in terms of food and nutritional requirements and we will work to close existing knowledge gaps around specific issues, such as the efficacy of anti-retroviral treatment in malnourished populations.

16. Work with UNAIDS and the World Health Organisation to develop a 'toolkit' for health priority setting in AIDS affected countries in Africa and promotes its use by ministries of health in AIDS affected countries in Africa and by other agencies.

1. We fully support the work of UNAIDS, WHO and other UNAIDS cosponsors in developing normative guidance and toolkits for developing effective multi-sectoral HIV and AIDS responses.

17. Encourage governments of AIDS affected countries to meet their commitments to increased health spending quickly.

1. In April 2001 in Abuja, Africa governments committed to increasing their health expenditure to 15% of GDP. Though this might not be appropriate

everywhere, countries like Kenya, Malawi and South Africa spend around 8%. The Commission for Macroeconomics and Health launched in 2002 also made recommendations to increase domestic resource mobilisation. We work with governments and support them to provide appropriate budget allocations to social sectors and to improve the effectiveness of services provision. The HIV/AIDS epidemic is a long-term event, which needs sustained engagement and thus significant sustained investment.

18. Recognise that affected countries will also need to prepare for impacts on a larger scale and prioritise this within UK policy.

1. Illness and mortality caused by AIDS will have a significant socio-economic impact, on household poverty and food security as well as the capacity of public services. The UK HIV and AIDS Strategy recognizes this and commits to providing money and advice to support national AIDS strategies that address the impact of AIDS as part of a comprehensive, integrated programme. The Strategy also prioritises the needs of the most vulnerable and marginalized groups, women, young people and orphans that will be prioritized.
2. For example, in Ethiopia, food insecurity and vulnerability increase the impact of AIDS at household level. DFID Ethiopia will therefore work with the Ethiopian government and key donors to look at ways in which social protection could be used to reduce the impact of AIDS. An important part of this will be to explore ways of targeting social protection (through cash transfers) to the estimated one million orphans and vulnerable children in Ethiopia. The increasing numbers of elderly people caring for orphans will also need support.
3. Moreover, the UK Government will work to address the significant impact of AIDS on food security by working with international organisations, including the World Food Programme (WFP) and UNICEF to improve planning systems. DFID will also work with others to improve data collection and analysis and to understand better the interaction between HIV, nutrition and treatments.

19. Support education programmes to raise awareness and tackle stigma to

ensure take up of available prevention, testing and treatment services is not hindered by stigma.

1. We recognize that stigma and discrimination remain principal barriers to effective action across the spectrum of HIV and AIDS services. Accordingly, we will be working to ensure that national AIDS responses tackle these in a comprehensive way. We see a key role for the media in raising awareness. Education either school-based or in non-formal education also has an important part to play. This is necessary but insufficient. We will also promote the greater involvement of people with HIV and AIDS in planning and delivering programmes. This can contribute effectively to addressing stigma and discrimination. We are committed to supporting legislative reform to improve the human rights environment including anti-discrimination legislation.

20. Support African governments and organisations such as the World Health Organisation to calculate possible staff attrition in key sectors such as health, education and security, and in key roles within these sectors, in order to help governments plan for increased recruitment and training needs.

1. We fully recognize the need for African governments to assess the current and predict future impacts of AIDS on the ability of key sectors to perform effectively. This problem is particularly acute in the health and education systems. We have worked with WHO and development partners in country to bring about assessments. In some cases, such as in Rwanda, Zimbabwe and Botswana, we have directly support the comprehensive assessment of the impact of AIDS in education. We have learned from these interventions and work closely with Ministries of Education to help develop policies and programmes to mitigate the impact of AIDS on the demand for and supply of education in relation to the achievement of universal primary education. We are increasingly mainstreaming HIV and AIDS perspectives, including tackling impact, into all of our sectoral programming.

21. Scale up government capacity building programmes and tailor them to build capacity in both in those areas identified as under most threat from AIDS and where capacity is needed in order to coordinate the battle against

the epidemic.

See recommendation 6.

22. Support African governments to mitigate the impact of losses in human capacity through massively scaled up staff training programmes particularly for teaching and medical staff but also for key public service managers. The Department for Education and Skills should work with DFID to also fund distance learning courses for key professionals such as teachers and nurses.

1. See response to Recommendation 6 and 21.
2. On the specific issue of funding distance learning we acknowledge that this is an effective means of delivering skills training that African governments need to consider alongside other more traditional training providers. There are no immediate plans for DFID and DfES to fund distance-learning courses. Such programmes would need to be implemented through African education institutions as these are best placed to customise the training to the demands of national context.

23. Reduce UK use of health professionals trained in AIDS affected countries by reducing incentives to come time allowed to remain and by compensating Ministries of Health who paid for those professionals' training.

1. Following extensive discussion at the May 2004 World Health Assembly at the a proposal to compensate African Ministries of health for the loss of professional capacity due to international recruitment was not taken forward was not tabled due to difficulties in gaining agreement among developing countries themselves. Instead a resolution was tabled and agreed which calls for the creation of an International Code of Practice on health worker migration, and examination by WHO of the feasibility of other international instruments. Another welcome feature of the Resolution is the call for WHO to improve data on mobility of health care workers. The resolution, which was supported by the UK places emphasis on the need for better human resource management and general health system strengthening. It also promotes

bilateral agreements as a mechanism for managing migration. The UK already uses this mechanism in our relations with South Africa, the Philippines, Indonesia and India.

2. DFID and DOH have a good working relationship on this. The UK government has a voluntary code of practice that covers the UK recruitment to the NHS. DFID and DOH are working together on the 2nd Edition of the Code of Practice and to strengthen it to cover the private independent sector agencies and employers as well as NHS sector.

24. Establish a unit within the DTI in partnership with experienced companies (and coalitions of companies) to advise other companies with operations in Africa on developing fully comprehensive HIV/AIDS programmes for both their workers, their families and the communities in which they work and where migrant labour is used also in the communities from which there workers come and return to.

1. DFID supports the objective of this recommendation, but would suggest that the DTI is not necessarily best placed to offer this service. DTI agree. While some British companies have developed expertise in supporting their staff and in addressing the impact of HIV and AIDS amongst their Africa workforce and families – the real expertise lies with local companies and NGOs working in practical and culturally sensitive ways at grassroots level to support AIDS affected families. The Government, through DFID country offices, support such organisations and will continue to do so.
2. AIDS workplace policies are an important source of treatment, care and prevention advice and support for employees - and increasingly for their partners, dependents and communities.
3. DFID is working with business groups, including, the Global Business Coalition on AIDS and the Business Exchange on AIDS and infectious Disease, individual companies, NGOs, the International Labour Organisation, and the International Confederation of Free Trade Unions who advise companies and operations in Africa on developing fully comprehensive AIDS programmes and support the development of these policies.

4. The Global Business Coalition could be said to be coordinating things from the business perspective, whilst ICFTU (Global Unions) is doing from some from the union perspective. WHO and UNAIDS '3 by 5' and UNAIDS "Three Ones" are taking an holistic view. DFID and DTI can play an important role in encouraging policy responses that are consistent with principles of pro poor, equity, focused on the needs of women and children, health systems strengthening, and linking to prevention and impact mitigation.
5. DTI leads on Corporate Social Responsibility (CSR) something to which commitment is clearly demonstrated by companies as they work with others to tackle HIV and AIDS. Recent initiatives from DTI on the Operating and Financial Review and the recent discussion paper on corporate social responsibility provide context to our work, and we will ensure that we work with them as appropriate to ensure coherence on this issue across Whitehall.

25. Continue to support programmes that empower women and support local and national initiatives to look at gender relations.

1. We fully recognise the importance of addressing gender power relations in national and local AIDS responses. Increasing rates of HIV among women highlight the importance of addressing the needs and rights of women and young people, especially girls. We have learned that responses need to be comprehensive. Piecemeal activities to address gender inequalities are unlikely to be effective. Accordingly, we will be prioritising the needs of women and young people - girls in particular - in our support for the development and implementation of national AIDS strategies.
2. We will support efforts to promote girls' education and work to support programmes tackling gender violence. We will work closely with countries to ensure that equity and rights are prioritised.
3. At the international level, we will support the UNAIDS Global Coalition on Women and AIDS.

26. Support interventions to mitigate the impacts of AIDS on women, in particular to financially and otherwise support care of the sick and of orphans and vulnerable children, in their communities.

1. We are committed to funding action that prioritises women, young people and vulnerable groups. We recognize the social impacts of AIDS on women. In developing our support to OVCs, we will be working with development partners to ensure that national responses provide appropriate support to building the capacity of families including caregivers. The details of this support will be announced in December.

27. Support African governments to ensure policy coherence on HIV/AIDS including on orphans and vulnerable children, across ministries, with leadership at the highest level and direct responsibility for the welfare of children at senior rather than junior ministerial level.

1. We see this as a key challenge. The implementation of the Three Ones principles offers an opportunity to assist governments in developing greater coherence at policy and programme levels on HIV and AIDS. We will be working with governments and development partners such as UNICEF to support the development and implementation of comprehensive OVC responses guided by the strategies laid out in the Framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS. This agenda includes creating a supportive environment and the mobilization of influential leaders.

28. Take on a role of leadership and coordination in helping countries and other stakeholders to best address the needs of orphans and vulnerable children.

1. We will be working closely with key international partners such as UNICEF at all levels to best address the needs of orphans and vulnerable children. In developing our support for country OVC responses, we will work to strengthen national leadership and coordination of these programmes.
2. UNICEF, UNAIDS USAID and WFP are already engaged with 17 African countries in a rapid appraisal process that will establish baseline data for planning and monitoring, identify critical gaps and constraints as well as

actions and resources required. We will play our part in ensuring this process leads to implementation of comprehensive responses at country level.

3. We will be participating in the African-European Parliamentary Consultation on Children Orphaned by AID in Africa to be held in Cape Town in September. This is expected to develop agreement on a Parliamentary Action Plan on OVCs and the introduction of the OVC agenda into various national and international processes such as NEPAD, PRSPS, ACP-EU Joint Parliamentary Assembly.

29. Support research and interventions that address the links between HIV/AIDS and food insecurity at the household level.

1. HIV and AIDS compound existing problems of food security at household and national levels. Affected individuals and households will often go hungry and patterns of food insecurity are changing. However, food security is multifaceted and includes issues of access, availability and effective utilization of food. The key to progress is understanding the interaction of HIV/AIDS with other factors, such as poverty, governance and conflict.
2. DFID will continue to support efforts to tackle the underlying development issues which exacerbate food insecurity and are intensified by AIDS. We will work with others to improve monitoring systems that feed accurate information into policy and programming. We will also work with others to address identified research gaps. One priority area is the impact of improved nutrition on HIV-positive people for whom access to ART will be very limited.

30. Scale up government capacity building programmes and tailor them to build capacity in both in those areas identified as under most threat from AIDS and in those areas where capacity is needed in order to coordinate the battle against the epidemic. (see response to Rec 6, 21 and 22)

31. Encourage non-state actors with valued capacity skills and resources to take part in national programmes, led by national governments, as well as those for their own workers and their communities.

1. Evidence from Uganda has shown the effectiveness of combining community-based response by non-governmental organisations with political leadership and government commitment. Moreover, given the way in which the epidemic simultaneously impacts on the need for and availability of capacity to deliver services to those affected, governments and non-state actors need to work together to combine efforts.
2. Therefore, DFID supports institutions such as National AIDS Committees, which bring together different actors in the field of AIDS prevention, treatment and impact mitigation to work within the context of a coordinated national HIV & AIDS response. For example, in South Africa DFID are establishing the management arrangements for the £30m HIV/AIDS Multisectoral Support Framework. The aim of this programme is to strengthen the capacity of a range of South African partners to achieve the objectives of the national HIV/AIDS and STD Strategic Plan.
3. The private, for-profit sector also has a vital role to play. DFID, for example in South Africa, will support lesson learning between companies, both large and small, and encourage employers in countries affected by AIDS to provide treatment and care.

32. Support African governments to address HIV/AIDS amongst their security services

1. Some military leaders have identified HIV/AIDS as a huge threat, as it has been suggested that once prevalence thresholds exceed 10%, it is difficult to maintain military discipline. As such, the driver for the successful Ugandan response to HIV/AIDS was Museveni's discovery of high HIV prevalence in the military. However, a lot of secrecy surrounds the impact of AIDS on the military because it has direct implications for future national security arrangements.
2. Given the importance of national leadership in this area, DFID supports national governments to mainstream the HIV/AIDS response and address the impact of AIDS on the public service, which includes the security forces and security sector reform programmes.

33. Support programmes to address HIV/AIDS in Multilateral and British forces operating in AIDS affected countries.

1. For UK troops on deployment, the UK Ministry of Defence provides a powerful pre-deployment HIV/AIDS briefing, free condoms and sexually transmitted disease (STD) services, including voluntary testing and counselling, at location.
2. The Whitehall Africa Conflict Prevention Pool is supporting work with the African Union to develop coherent standards on HIV/AIDS for AU peace support operations, and to assist with the implementation of such guidance. Moreover, the Africa Pool is considering other work in this area, such as ensuring that HIV/AIDS forms part of standard peace support training (e.g. at the Kofi Annan International Peacekeeping Training Centre in Ghana or the British Peace Support Team in Kenya).

34. Support research to identify key impact areas within the security services to help governments plan for and mitigate these impacts, for example through support to the UNAIDS office on AIDS Security and Humanitarian Response.

1. DFID does not directly support the UNAIDS office on AIDS Security and Humanitarian Response, however, we provide significant core funding to UNAIDS as part of a strategic partnership with the organisation.
2. Last year DFID commissioned the collection of evidence and experience concerning HIV/AIDS and conflict in Africa. The work dealt with two major issues, namely (a) how the HIV/AIDS epidemic could contribute to conflict, and measures that can be taken to minimise this threat, and (b) the impact of conflict on HIV/AIDS. This work is being used for the design of HIV/AIDS programmes in conflict and post conflict countries.

35. Support further research into the impacts of AIDS on security, in particular the potential impact of large numbers of AIDS orphans.

1. According to UNAIDS, by 2010 there will be an estimated 25 million children who have lost at least one parent to AIDS. This is clearly a humanitarian disaster with long-term implications as these children risk being even more susceptible to HIV and vulnerable to the impact of AIDS. According to UNICEF, approximately 1 in 10 African orphans have no family to care for them.
2. However, there is little evidence to cast the problem as a security problem. Though orphans will be an additional difficulty for societies affected by HIV/AIDS, AIDS orphans will not necessarily be inadequately socialised when they lose one or both parents. Countries like Uganda have illustrated the amazing strength of communities coping with increased orphanhood, for example, through networks of extended families.
3. Therefore, the response should not lie in the area of security, policing and criminal justice system, but rather in tackling HIV/AIDS and poverty and directly supporting orphans and vulnerable children as a group. The UK government is committed to spending at least £150 million on programmes that meet the needs of orphans and other children, particularly in Africa, made vulnerable by HIV and AIDS. Moreover, UK government provides a substantial share of total donor funding to UNICEF, the multilateral that addresses the needs of children through a major new strategy for the prevention, care and support of orphans and vulnerable children.