**BASHH/BHIVA**

**Joint Response to IDC request for evidence regarding DFID's work on HIV/AIDS**

This response is from the British Association for Sexual Health and HIV (BASHH) and the British HIV Association (BHIVA) which are the leading organisations in the UK representing and educating healthcare professionals who deliver HIV and STI care, prevention and research, and work closely with Public Health England, as well as with patient and advocacy groups in the sector. The organisations have strong international links. Members represent the UK in an organisational or personal capacity through board membership on international HIV/STI organisations, and advise governments of the UK and abroad. They deliver national and international courses/conferences on HIV, sexually transmitted infections, and co-infection with TB and hepatitis B/C. They participate in exchange programmes with countries served by DFID and members are involved with MRC and international research on HIV epidemiology, prevention and treatment.

We believe that DFID has a vital role to play in HIV/AIDS prevention, improving healthcare, and reducing healthcare inequalities and stigma, through supporting and collaborating with policy makers, healthcare professionals, community groups and adults and children with, at risk of, or affected by HIV. We welcome the opportunity to help improve and strengthen DFID's position, and we would argue strongly against any reduction in DFID involvement in this ongoing devastating global epidemic.

Integration of HIV and sexual and reproductive health care are essential and unequal. Whilst not within the scope of this consultation this should be considered in any future strategy.

**Strategy Coherence**

There is currently no clear, comprehensive, or coherent strategy with demonstrable effectiveness that is visible to our organisations. There appears to be limited consideration to links between DFID and those in the UK that have expertise in this area. We feel DFID has been poorly perceived nationally and internationally in terms of its HIV/AIDS response. There

is no named contact or lead for HIV strategy, and little engagement with UK stakeholders that BASHH and BHIVA are aware of. DFID has not been well represented at major international HIV conferences, as stated. This has resulted in a lack of clarity in terms of international standing for the UK in the response to HIV/AIDS, a missed opportunity for the UK government, and a disconnect between the work of DFID with UK HIV professionals.

**Monitoring Effectiveness**

The effectiveness of DFID's contribution to HIV/AIDS control and care is difficult to assess or comment on in the absence of a clear strategy, goals, objectives or achievements in the public arena.

**Suggestions for Improvement**

In the current political climate with DFID funding as a proportion of GDP hotly debated, but where there is an ongoing burden of HIV, with huge potential of new innovations to reduce incidence and increase life-expectancy of those infected, but where and ongoing stigma and criminalisation of vulnerable groups deter from testing and diagnosis, it is essential that DFID has a clear, collaborative, over-arching strategy on HIV/AIDS, developed with partners in the UK as well as overseas, capitalising on opportunities for mutual learning and benefit. The UK has one of the best 'treatment cascades' in terms of achieving the UNAIDS targets of 90:90:90. DFID strategy should include prevention, treatment, education and research, as well as addressing health inequalities and stigma/criminalisation of certain groups, and how to ensure equity of access to prevention and treatment innovations, in order to support all countries improving their own treatment cascade. The strategy needs clear aims with a monitoring strategy. Collaboration of DFID with established scientific national bodes such as BASHH/BHIVA would lend more weight to continued spend on HIV/AIDS, in particular through advice on high-impact interventions and cost-effectiveness. There is a high level of interest within our organisations to increase dialogue and support DFID, and we see the opportunity to respond to this consultation as a first step in this conversation.

We welcome the continued commitment to the Global Fund, noting the huge impact that this will have had on the economic as well as physical health of those countries affected, but do

feel that the UK should adopt its own clear policy, based on sharing our expertise and successes to help improve economies and health of countries within the remit of DFID. Benefits achieved overseas may benefit the UK, such as by reducing the risk of HIV for travellers, improving the economies and health of our trading partners, or by reducing potential for 'health tourism'. International research, training and collaboration may also benefit our own healthcare professionals leading to better UK delivered care. There is an opportunity to show genuine global leadership and be recognised for that a time of change. For example, it is unclear what the change in US administration will mean for PEPFAR spending.

In order to achieve a coherent strategy around HIV/AIDS, DFID should take into account the wider health inequalities and cultural and structural factors that contribute to the burden of HIV/AIDS in vulnerable populations and in particular, in gay, bisexual, and other MSM (GBMSM). Whilst we acknowledge that challenging moral and legal structures in other countries can be challenging, this population remains at disproportionate risk of HIV. Punitive laws enforced at varying levels in 75 countries worldwide render gay men at increased risk of arrest, convictions and violence[1]. Decriminalisation and anti-discrimination legislation remain first steps toward improving health and wellbeing globally. Any funding for biomedical HIV prevention strategies must take into account these structural factors and DFID should highlight the need for the UK government to use its influence to highlight the health inequality and economic consequences of continuing to criminalise the sexual behaviour of GBMSM, as well as other 'at risk' and vulnerable populations. DFID should consider funding projects that attempt to improve societal attitudes and tackle abuse and bullying of GBMSM, as well as those that provide sex and relationship education that is more inclusive of same sex relationships.

We would welcome a DFID strategy that focuses on five main areas:

**1. Education**

- We believe that DFID should take a world-leading stance on improving HIV

care globally, utilising the skills of UK clinicians, as well as relevant national stakeholders, developing better models of support and skills exchange

- Whilst financial aid can be useful, UK skilled staff can also be better supported to work overseas, for instance with protected pension and National Insurance contributions during periods of voluntary overseas work
- Flexible working patterns should be more readily available to facilitate skilled staff pending periods of time overseas in addition to their UK activities, giving security to NHS employers and to people with families, whilst encouraging and supporting periods of voluntary placement in environments requiring skills transfer and support

**2. Prevention**

The focus should include all interventions with priority on those most cost-effective and/or reduce health inequalities and include the most recent interventions, such as:

- PrEP (Pre-Exposure Prophylaxis)
- Testing linked to treatment as prevention for sexual and vertical transmission

**3. Access to treatment**

- This should include a stronger focus on generic drugs
- In the UK there is heightened interest in approvals for generic products and manufacturers and it is essential that those infected with HIV wherever in the world they are, and in particular for DFID funded Global Fund initiatives, have access to best-value, reliable generic antiretrovirals

**4. Technical and other health innovations**

- The MRC is strong in clinical trials science and links with the MRC, DFID, and professional links organisations such as BASHH/BHIVA could help deliver innovations in DFID focussed areas

**5. Tackling underlying causes of HIV persistence in societies**

- Particular focus on key populations – adolescents, girls and women, men who have sex with men, sex workers, injecting drug users, transgender groups and prisoners
- Strengthening health systems to improve access to quality healthcare, and tackling the broader drivers of the epidemics, such as stigma, discrimination and gender inequality, which influence behaviour and limit people's ability to make healthy choices

**Summary**

We believe that DFID has a vital role to play and should take a world-leading stance on improving HIV prevention, care, research and education of professionals globally. In order to achieve this it should utilise the expertise and skills of UK clinicians, and national bodies including BASHH and BHIVA, who would welcome the opportunity to be involved and can provide important international links through their existing networks.

The UK should play an increased leadership role both at home and abroad, and with some humility, as we may well have things we can learn in our own response from the community empowered and integrated approach in many developing countries

We would welcome the opportunity to discuss these issues further, and to have representation at future meetings regarding DFID's stance on HIV/AIDS.

Yours sincerely


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**Reference**

1. Carroll A, Itaborahy L. State-sponsored homophobia: A world survey of laws: criminalisation, protection and recognition of same-sex love, Geneva: International Lesbian, Gay, Bisexual. Geneva: ILGA, 2015