UK Consortium on AIDS and International Development

Our response to *'Towards Zero Infections'* DFID's Position Paper on HIV and AIDS

Summary

'Towards Zero Infections', published in May 2011 in anticipation of the UN High Level Meeting on HIV and AIDS is DFID's most detailed articulation of the Coalition Government's commitment to the goals of universal access by 2015.

However, just one year on, we find the landscape of the AIDS response has changed dramatically, bringing both opportunities and threats that few anticipated.

This response from the Consortium, the result of extensive consultation with our membership, fulfils three functions: it is

1. a detailed response to *'Towards Zero Infections'*;
2. an attempt to set its findings within the very different context we face in 2012;
3. an effort to set our sights on the 2013 review of *'Towards Zero Infections'* to be conducted by DFID.

While the Consortium recognises the significance of the paper as a strong indication of the Government's response to the global HIV epidemic, it has also identified a number of areas for further consideration if an effective evidence-based HIV response is to be achieved.

In light of this, the Consortium would encourage DFID to:

1. Set more specific and measurable targets in terms of:
    - Improving the quality and quantity of HIV and TB services
    - Scaling up early infant diagnosis
    - Financial commitments of the UK Government to the Global Fund (especially in light of the replacement of Round 11 with the Transitional Funding Mechanism)
2. Explore further the gender specificities of HIV prevention, treatment and care, as well as the intersections between gender-based violence and HIV.
3. Give greater attention to the links between the HIV response and broader health and development goals.
4. Move away from representing women as a homogenous group and instead to recognise the broad spectrum of women's experiences and needs and the implications this has for prevention, treatment and care.
5. Assess the criminalisation of most at risk populations and the impacts of this on access to treatment, care and support and prevention.
6. Engage further with civil society and community-level actors, especially in their work to tackle stigma and discrimination of most at risk populations.
7. Pursue an integrated model for service delivery, rather than focussing too heavily on prevention. Given DFID's intention to scale down bilateral HIV programmes, it is particularly important that HIV interventions are well integrated into broader programmes.
8. Develop a more all-encompassing understanding of care and support.

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Introduction

1. *'Towards Zero Infections'*, published in May 2011 in anticipation of the UN High Level Meeting on HIV and AIDS, remains DFID's most detailed articulation of Coalition Government ambition on HIV and TB to-date. *Towards Zero Infections*

2. The opportunities emerging in 2011 were both political and scientific and have been well documented. At the UN High Level Meeting, the UK, alongside other countries, set an ambitious target of putting a further nine million people on treatment, care and support by 2015. Scientifically, 2011 saw great progress in the field of treatment as prevention, further reductions in costs, and the approval of important antiretrovirals. This has led us to the position, to quote from Prime Minister Cameron's March 2012 article in the Washington Post, where we can "see the beginning of the end of the AIDS pandemic".

3. And yet, at this very moment of opportunity, the attention of the international community was seen to shift focus away from HIV. Leadership is waning. Funding is decreasing. The Global Fund to Fight AIDS, TB and Malaria is in crisis, with no prospect of new grants being awarded until 2014. Targeted prevention efforts for key populations are not being fully leveraged. The number of children orphaned by HIV continues to grow. Rhetorical acknowledgement of 'the feminisation of HIV' has not resulted in vast implementation of gender transformative approaches to address the structural drivers of women's and girl's vulnerability to HIV infection. Caregivers, the backbone of the HIV response in local communities, continue to work without remuneration. Furthermore, hostile legal environments in some countries threaten to undermine responses to HIV, in their criminalisation and stigmatisation of homosexuality.

4. Not only do these facts put the fragile and incomplete successes to-date in jeopardy, but they also make it implausible that the goal of reaching an additional nine million people with treatment, care and support by 2015 will be achieved.

5. In this context, the Consortium regards *'Towards Zero Infections'* as an invaluable step forward in defining how the Government is responding to the continuing threat of the global HIV epidemic. As this paper makes clear, our membership applauds many of the commitments made. Yet we also perceive gaps and challenges that we suggest DFID address, if it is to translate its broad commitments into concrete results.

6. We also note with disappointment that one year on from the publication of *'Towards Zero Infections'*, it is still unclear how the commitments outlined in the paper will be measured and reported to the UK public, our partners and those most affected by the epidemic – the people to whom we, UK Government and civil society, made such clear promises in 2001, in 2005, and again in 2011.

7. This paper serves two functions. It provides Consortium members with an opportunity to reflect on the content of *'Towards Zero Infections'* and identify the opportunities to renew a partnership with Government that has established the UK as a leading voice in the response to HIV over the past decade. It also provides members, interested members of the public and those directly affected by the epidemic, with the opportunity to discuss how this Government is developing its response to HIV and AIDS.

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Overarching comments

8. In its broad commitments, *'Towards Zero Infections'* uses language that we can applaud, particularly with regards to key populations, TB/HIV co-infection, PMTCT, and its support for the Global Fund and UNITAID. Taken as a whole, *'Towards Zero Infections'* is welcomed by Consortium members as the most detailed articulation of UK Government ambitions on HIV and TB to-date.

9. However, the disconnection between the targets outlined in the paper and the reality of the current global context is concerning. The commitments are in many cases *too* broad. The Consortium recommends that these be supported by specific financial commitments and concrete (and measurable) targets for the number of people they hope to reach through their bilateral and multilateral engagement.

10. Overarching commitments to global goals, such as the UNAIDS and Stop TB Partnership goal to halve HIV deaths from TB by 2015, are commendable. However, DFID could give greater credibility to these commitments by outlining the interventions it sees as being integral to the achievement of these goals, and how they intend to take this forward through their multilateral and bilateral support. It would be beneficial for DFID and other stakeholders to be able to assess the UK's contribution to this end in terms of lives saved.

11. *'Towards Zero Infections'* neglects to give proper coverage to some important elements that must be considered if we are to ensure the effectiveness of the future HIV response. More attention could be given to elements of care and support beyond the provision of cash transfers and to new evidence based approaches to prevention such as treatment as prevention.

12. *'Towards Zero Infections'* appears to be pushing for prevention at the expense of other priorities at a time when the response in general is moving towards a more integrated model for delivering services, a model which reflects the complex and overlapping nature of approaches to tackling HIV and AIDS. The approach to prevention outlined in the paper focuses on many of the groups at highest risk of HIV infection, but could benefit from properly engaging with people living with HIV to ensure such an approach is effective.

13. The language used in *'Towards Zero Infections'* is not effective in positioning HIV within DFID's core priorities. For example, clear links between HIV and the four strategic areas they set out in their strategic vision for girls and women could be better established. General points of overlap between HIV and other health and development areas are not clearly acknowledged. The Consortium suggests that DFID strengthen its position by being clearer about the linkages between the HIV response and their key priority areas, particularly RMNCH and SRH, and how a strong HIV response can impact positively on these. The Consortium Policy Brief *'Girls and Women: Mainstreaming HIV and AIDS into DFID's Strategic Vision'* (link) addresses some of these gaps by highlighting the links between HIV and DFID's strategic vision for girls and women.

14. We also feel that DFID could make a stronger commitment to support the role that civil society - and especially communities - play in an effective HIV response. Although *'Towards Zero Infections'* acknowledges the role civil society plays in affecting policy change, it is less clear about the diverse roles that community-level actors play in supporting the broader effectiveness of the response and how it intends to work to build capacity in this area. Consortium members would value more clarity about how

DFID plans to engage with community based organisations (CBOs), faith based organisations (FBOs) and organisations and networks of people living with HIV and key affected population, both centrally and through DFID country offices. They look forward to more information on how DFID plans to capitalise on the important findings identified in the *Evaluation of the Community Response to HIV and AIDS* (2009-2011) undertaken by the World Bank in partnership with DFID and the Consortium.

15. *'Towards Zero Infections'* makes it clear that DFID are scaling down its bilateral HIV programmes, and there is concern that this will limit the impact DFID have on HIV and related health issues unless HIV interventions are carefully integrated into their broader programmes. If DFID are committed to achieving results for HIV and TB largely through their multilateral engagement, they must continue to play a leading role in ensuring that the multilateral bodies they work with are fit for purpose and are adequately resourced to be able to deliver these results.

16. The paper states that DFID is "working more closely with other UK Governments Departments than ever before", particularly with reference to challenging legal and political environments that increase the vulnerability of key populations, and in driving forward the issue of access to medicines. It would be useful to have greater clarity about how it plans to engage other departments, specifically the Foreign Office and the Department of Health, to deliver results. This would strengthen our understanding of the commitments contained in *'Towards Zero Infections'* Consortium members suggest that Government departments support communities at country level in responding to these political and legal challenges. The 2001 World Bank Report on HIV Epidemics among MSM shows that the effectiveness of HIV prevention is undermined by the criminalisation of homosexuality and by the lack of adequate HIV prevention for MSM. [1]

17. Finally, there is concern that *'Towards Zero Infections'* presents women's experience in a way that ignores many of its complexities. Rather than addressing women and girls as a homogenous group, it is suggested that a broad spectrum of women with different needs are recognised, including those living with and affected by HIV; lesbian, bisexual and transgendered women; adolescents and young women; female child-headed householders; women engaged in sex work; women who use drugs and female prisoners.

Analysis by theme

Prevention

18. DFID's commitment to ending paediatric AIDS through scaling up comprehensive PMTCT services is applauded. Consortium members have suggested that DFID may benefit from a focus on areas that might be neglected by other funders, including supporting the sexual and reproductive health and rights of HIV positive women (and women more generally). This does not seem to be reflected in the paper. DFID could also indicate, beyond general support, what it will explicitly contribute to the *'Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and keeping their mothers alive.'* Consortium members see DFID's pledge to scale up comprehensive PMTCT as a key opportunity to emphasise the centrality of the sexual and reproductive health and rights of all women, including those living with HIV, in

[1] *Global HIV Epidemics Among Men Who Have Sex with Men (MSM): Epidemiology, Prevention, Access to Care And Human Rights.* The World Bank, June 2001, http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/MSMReport.pdf [Accessed 10th September 2011]

reaching these goals, and believe that the language DFID uses could better reflect this. DFID's strategic vision for girls and women includes access to safe abortion care within its plans to promote women and girls' wellbeing, and enhance reproductive and maternal health. This would be worth highlighting as part of their approach to tackling the burden of HIV on girls and women, given the need to align this effectively with broader strategies.

19. A focus on key populations in the context of prevention, which was a priority for Consortium members, comes across strongly in the document. However, the only identifiable commitment is the promise to "focus on reducing HIV infections among most-at-risk populations in at least 6 countries by improving access to prevention services such as needle exchange and condoms and help maintain HIV prevalence below 1% in the general population". To build on and strengthen this, we believe DFID could outline more clearly how many men and women within key populations they hope to reach with vital services and the level of funding they intend to direct to this cause.

20. The prominence given to reducing stigma and discrimination as DFID's third strategic priority reflects the priorities of Consortium members. The Consortium welcomes the intention set out in the Position Paper to work to achieve this in partnership with civil society, communities, and networks working on HIV prevention for most at risk populations which DFID identify as having the potential "to deliver transformational change for people living with HIV, by changing policy and reducing stigma and discrimination". Given that DFID understand the crucial role they play, the next step might be identifying strategies to build the capacity of community-based organisations and networks, including faith based organisations, to address stigma and discrimination, and ensure they have the appropriate levels of funding and support. DFID could be clearer about the role stigma and discrimination play as 'key drivers' of the HIV epidemic. Addressing stigma and discrimination is an essential precondition for effective prevention efforts, and this could have been better articulated in the Position Paper. This is particularly the case for their bilateral commitments. Given that their support to development partners' national HIV strategies will focus largely on prevention, their bilateral commitments would ideally include efforts to address the stigma and discrimination that affects women and girls *and* most at risk populations.

21. The paper states that DFID will "contribute to reducing new HIV infections in at least 7 Sub-Saharan African countries, through scaling up prevention services, including TB prevention, strengthening reproductive health services, empowering women and encouraging better resource allocation " with the target of reducing infections amongst women by at least 500,000. It would be beneficial to have clear mechanisms for measuring achievement against this goal, such as the number of women DFID intend to reach through specific TB prevention services.

22. Consortium members welcome DFID's commitment to tackle gender-based violence and harmful gender norms and promote women's and girl's ability to protect themselves from both violence and HIV transmission, but believe it would benefit from a clearer articulation of the way gender-based violence and HIV intersect (for more information on this topic please see the Consortium Policy Brief *Girls and Women: Mainstreaming HIV and AIDS into DFID's Strategic Vision*) and impact on one another. There is also a need to address the different kinds of violence experience by different groups of women and how these impact on HIV vulnerability. For example, there has been a rise of specific attacks against women who have sex with women known as 'corrective/curative rape', and this form of violent, unprotected sex presents a particularly high risk of HIV transmission. Sex workers in many parts of the world experience particularly

frequent violence yet representatives of law enforcement authorities are often unwilling to address it and at times are actually complicit in this violence.. Due to their significant stigmatisation in many societies, sex workers often struggle to access condoms and HIV prevention services and are sometimes prevented from protecting their sexual health, which significantly increases their vulnerability to HIV infection. Such examples require specific strategies designed to prevent violence and HIV infection that are tailored to their specific needs.

23. *'Towards Zero Infections'* mentions that DFID will work with specific networks to target HIV prevention efforts for most at risk populations, but makes no reference to women's networks, in particular networks of women living with HIV. Although women are included in references to programming in concentrated epidemics among key populations (important given that in sub-Saharan Africa women, particularly young women, have the highest prevalence rates) further clarity on exactly how they fit into these, and whether all aspects of vulnerability beyond gender, age and reproductive capacity have been taken into account would be welcome.

24. Although *'Towards Zero Infections'* is relatively strong on women and girls, it neglects to acknowledge the role that men and boys play in driving the epidemic, particularly in Africa, and the role they play in increasing the vulnerability of women and girls to HIV infection. There would be benefit in working to identify ways to encourage behaviour change amongst men and boys, including through education and improving access to prevention and treatment services, and integrate these into their strategy for tackling HIV, particularly as it relates to women and girls.

25. Consortium members value DFID's commitment to improving access to comprehensive sexuality education for girls and women. However, more detail is required to make it clear how DFID plans to deliver on this commitment and it would be worthwhile extending it to include men and boys as well.

26. Although there is some good language on harm reduction, Consortium members feel that in general the need for an effective, evidence-based approach might be better articulated. This is in contrast to the leading role the UK played at the 2011 High Level Meeting, where it successfully pushed to secure a reference to the WHO's comprehensive harm reduction package in the outcome document. Nevertheless, there is a strong reference to the comprehensive harm reduction package and evidence for its effectiveness in the section on DFID's multilateral commitments. There is a brief mention of opioid substitution therapy (OST) when DFID talk about their programmes in Asia and methadone in the overview of their programme in Vietnam, but the paper could do more to highlight the important role that OST can play in effective approaches to harm reduction. The US have taken a back seat on this issue, with PEPFAR recently reinstating their ban on funding for needle exchange, and therefore there is real scope for the UK to lead the way in pushing for harm reduction to be a key consideration in both bilateral and multilateral HIV and related health policy and programming worldwide. This could include efforts to work towards removing legal barriers that prevent the effective implementation of harm reduction initiatives in many parts of the world.

27. To support and strengthen their commitment to women and girls, DFID may benefit from working with others to develop a better understanding of the gender dimensions of injecting drug use and harm reduction, and the links between injecting drug use, gender-based violence, sex work and HIV for women who inject drugs. DFID could also make more of the role that harm reduction plays, alongside condom

provision, ART and other interventions, in preventing HIV infection in prison populations, including female prisoners.

28. Despite the evidence for its effectiveness in preventing transmission, 'treatment as prevention' is not well covered in the paper. When it comes to discussing ARV-based prevention interventions, DFID says that they are "promising new technologies but need further research". Although Consortium members understand the rationale behind this cautious approach, they hope that DFID will play a leading role in advocating for, supporting and funding additional research to enable the international community to capitalise on the potential of treatment as prevention, as one of a crucial set of evidence-based interventions, to bring an end to AIDS within a generation. This would have the additional advantage of bringing DFID's position in line with the position taken by the UK Department of Health in its recent guidelines on treatment.

29. In addition, there is no direct mention of the new prevention technologies designed to empower women to take control over their sexual and reproductive lives, such as vaccines and microbicides; or reference to existing technologies such as the female condom. Given the strong commitment to empowering girls and women that comes across in the Position Paper, when DFID talk about HIV prevention technologies, it might be worthwhile making specific reference to these kinds of women-centred tools.

30. It would be valuable to get more detail illustrating how DFID will support WHO guidelines recommending that children and adults living with HIV, including pregnant women and those receiving antiretroviral treatment, should receive TB isoniazid prevention therapy.

Treatment

31. Consortium members consider TB/HIV co-infection a key priority. This was well referenced in the document, with TB being mentioned over 40 times. This coverage would benefit from being supported by a specific TB Position Paper, which would be welcomed by Consortium members.

32. The Position Paper commits broadly to scaling up access to HIV and TB diagnosis, treatment and care and support. However, this commitment would be strengthened by targets for how many people they hope to screen in their various bilateral programmes, and details of how TB will be integrated into their HIV and MNCH work and vice-versa. Consortium members feel it is vital that DFID ensure central level commitment and related policy is there for country-level offices to refer to in order to assist them with TB/HIV/MNCH integration (for more information on TB/HIV integration with particular reference to DFID programmes, please see the Consortium Policy Brief *'Fighting TB/HIV Co-infection: Realising Commitments Through Integrated Programming'* link). This will help bridge the gap between the worthy commitments made in this paper and DFID bilateral programmes on the ground.

33. DFID mention they will drive progress on HIV and TB in particular through their multilateral engagement. Specifically, they commit to increasing their support to the Global Fund, which they say will have an impact on both HIV and TB: the Global Fund contributes to more than two-thirds of all TB spending worldwide and in some low income countries as much as 80%. Given the recent replacement of Round 11 with a Transitional Funding Mechanism, and the UK's prominent position on the Global Fund's board, it is important that the UK Government takes a prominent and vocal role leading international efforts to rescue

the fund. Consortium members would like to see DFID announce the level of its increased funding support to the Global Fund in advance of the G20 in Mexico, June 2012, in order that such an announcement can be leveraged with other donors.

34. Access to treatment was also a key priority of Consortium members. DFID's commitment to give treatment to 268,000 people living with HIV, including 37,000 HIV-positive women in order to prevent transmission to their babies, through their support of the Global Fund is positive, but may be strengthened with decisive action to ensure the future of the Fund at this challenging time. Whilst prevention of vertical transmission is a worthwhile motivation for ensuring HIV-positive women receive on-going treatment, it should not be the only one, and the Consortium would welcome an acknowledgement by DFID of the lives of women beyond their reproductive roles.

35. However, targeting access to treatment interventions to key populations was not discussed in the Position Paper, and this is an area that might benefit from consideration, given the specific vulnerability of these groups to HIV infection.

36. Recognising the added value it brings to improving prices and access to medicines, diagnostics and treatment, DFID pledge to maintain their funding to UNITAID, which is a positive commitment. However, it would be helpful if DFID could define more clearly the planned actions that will support them in delivering on their promise to "encourage the pharmaceutical sector to engage with the Medicines Patent Pool to support availability of more appropriate and affordable ARVs." This extends beyond the Patent Pool to their commitment to encourage the pharmaceutical industry to play its role in supporting access to affordable medicines more generally.

37. In their Strategic Priorities, DFID commit to scaling up early infant diagnosis. Although this is positive, it would benefit from more concrete commitments supported by appropriate targets to ensure it is deliverable. In particular, Consortium members call on DFID to pledge support to speed up the availability of pediatric point-of-care diagnostic tools to ensure that those children who are infected can be identified and put onto treatment quickly. A research and development focus in this regard is particularly important in relation to infant diagnosis for TB as currently existing TB diagnostics for children are inadequate, carrying poor sensitivity and specificity.

38. The paper does not give any attention to the need to scale up pediatric treatment, including access to both cotrimoxazole preventative therapy and ART, to address the life-threatening problems faced by children who are already living with HIV. DFID should support research to enable ART treatment to differentiate between the treatment needs of young children and adolescents living with HIV.

39. Given the recent evidence for the effectiveness of treatment as prevention, DFID could strengthen their position by putting more emphasis on supporting treatment adherence across their programmes. The vital role that community-level actors such as caregivers, faith leaders and others play in promoting treatment adherence for both TB and HIV could be given more attention. The role that strong effective communities play in supporting the response to a whole wealth of health and development issues beyond just HIV is could be explored in much greater depth.

Care and Support

40. Social Protection was a key priority for Consortium members when it came to care and support. Although DFID's focus on the provision of cash transfers in this context is positive, it would be beneficial to acknowledge the fact that, within the context of social protection, cash transfers are not a complete solution and that other interventions, such as making services free at the point of delivery, cash incentives, subsidised family planning products, vouchers for family planning and so forth, are also important. DFID could add value to their focus on cash transfers if they could assess the impact such support has on TB and other health outcomes as well as HIV.

41. The Consortium was concerned to emphasise that there is more to care and support than just social protection (see for example, the Consortium's publication *'What do we mean by Care and Support?'*). *'Towards Zero Infections'* makes no reference to the gender dimensions of care, issues around remuneration and the role of carers (for more information on this topic please see the Consortium Policy Brief '*Past Due: Remuneration and Social Protection for Caregivers in the Context of HIV and AIDS'* link). Nor does it reference psychosocial support (especially important for those affected by MDR-TB), care and support services for key populations, the care and support needs of children, adolescents and older people (both as people living with HIV and as carers), or access to palliative care (including opioids for pain relief). These broad ranges of services are crucial to the well-being of people living with HIV and their caregivers as well as orphans and vulnerable children and yet are not covered in the Position Paper.

Coordination/health systems

42. The importance of linking the HIV and TB response comes across clearly in the paper, although without a clear programming strategy or commitments. However, acknowledgement of the linkages with SRH services is less strong. Although DFID commit to broadly "significantly reduce stigma and discrimination by working for policy change for most at risk populations and to empower women and girls, including with sexual and reproductive health and rights" in their Strategic Priorities, this is not clearly echoed throughout the rest of the paper.

43. DFID's RMNCH Framework and the *'Towards Zero Infections'* could be better coordinated. Within the RMNCH framework, MSM, female injecting drug users, sex workers, women living with HIV, prisoners, and people living with HIV are either not mentioned at all or only 1-2 times. In *'Towards Zero Infections'*, there is no clear indication about how HIV, TB and PMTCT in particular will be integrated within their RMNCH/SRH programming. This lack of a coordinated vision makes it difficult to develop and promote mechanisms to provide funding and technical support that can facilitate integration of HIV and TB specific services into broader programming for women and girls.

44. DFID could benefit from being much stronger on the role the community plays alongside formal health systems in ensuring the effectiveness of the response and commit to build and strengthen the links between them. This is particularly the case given their recent involvement in work with the World Bank assessing the value of the community's contribution. The findings of this evaluation could be used to help define and target how DFID works to build the capacity of community-based organisations to respond effectively to HIV and other health issues. This might include faith based organisations (FBOs), absent from

the Position Paper, but who play an important role in addressing many HIV-related problems, including stigma and discrimination. DFID should recognise and respond to the key role that faith plays in many communities in encouraging social cohesion and community mobilisation. A clear commitment to community systems strengthening does not come across in the paper, and DFID could do more to highlight its importance, particularly in delivering cost effectiveness and value for money.

Advocacy and tackling neglected areas

45. Consortium members felt that DFID is particularly well placed to influence other development actors and country governments around the world, due to its excellent reputation and its position on the boards of a number of key agencies. In the paper, DFID are strongest on their commitment to advocate for the health and rights of key populations, stating that "the UK will continue to be a voice for (key populations) on the international stage... we will work through the boards of multilateral organisations and with our partners in support of a public health and human rights based approach that is proven to deliver the best health outcomes". However, as the majority of their commitments to tackling HIV and TB will be delivered through multilateral engagement, it is suggested that DFID be clearer about how it plans to ensure this engagement delivers results. Given the current status of the Global Fund and the Health Systems Funding Platform this is all the more important.

46. Although Consortium members have stressed that ensuring the involvement of PLHIV in the response was a key issue that DFID could take forward, this did not come across as a strong point in the *'Towards Zero Infections'*, with the exception of a passage in the introductory section that agrees with "the principles of greater involvement of people living with HIV." This is a positive inclusion but one that requires additional commitments to support it. DFID could also do more to highlight and support the need for greater involvement of key populations in the response.

Value for Money

47. Prior to the publication of the paper, in a meeting with DFID, Consortium members highlighted the fact that an effective community response had the potential to deliver cost effectiveness and value for money. Whilst avoiding taking advantage of community-level actors by ensuring they are properly remunerated and supported for their work, Consortium members believe that working to strengthen communities should be a key strategy in the drive towards achieving better value for money. It is not clear in the paper how DFID plans to invest in local leadership and build the capacity of communities to tackle HIV and other health issues, and deliver efficiency, effectiveness and value for money.

48. DFID highlighted the value for money brought about by the work of UNITAID, and is quite strong on its commitment to support innovative initiatives to reduce the cost and increase access to medicines. However, it could be clearer about the nature of the support they will give, and how this will achieve results.

49. In terms of value for money, DFID says it will give particular focus to the delivery of quality integrated HIV, TB and reproductive health services based on national and local epidemic. Again, this needs to be supported by clear bilateral and multilateral targets and commitments, and Consortium members hope to

see a focus on quality integrated services reflected in country-level business cases, particularly those for the priority countries identified in the Position Paper.

50. Whilst Consortium members understand the need for a value for money driven approach, this should not be at the expense of quality or limit the impact of DFID's work on beneficiaries. DFID should consider strategic approaches to funding, such as the UNAIDS Investment Framework, that are designed to deliver both value for money and improved results for beneficiaries.

Targets

51. The only international HIV-related target highlighted in the *'Towards Zero Infections'* is Universal Access. The MDGs including MDG 6 are absent from the entire paper, highlighting the need for further consideration of the often-significant impact HIV has on other health and development goals. Although DFID are strong on PMTCT, there is no explicit commitment to achieving universal access to PMTCT by 2015.
52. In the past, DFID have been strong on making clear commitments to HIV and Health. In the 2008 updated Strategy, DFID committed to spending £6bn on health and health systems between 2008 and 2015. This was not restated in the Position Paper, although Consortium members strongly expressed their support for its inclusion.

53. DFID has set ambitious targets for Malaria. In its Framework for Results on Malaria in the Developing World, it has committed to spending up to £500 million each year up to 2015 to combat the disease. HIV needs similarly strong financial commitments to support the broad commitments made in *'Towards Zero Infections'*. DFID annual expenditure tracking has traditionally focused on the amount of aid delivered by sector. Given this fact, without clear financial commitments it is difficult to see how results for HIV or TB will be measured or achieved.

Accountability and Transparency

54. DFID's commitment to develop and use better metrics to assess their programmes is welcomed. However, Consortium members recommend that DFID make an effort to measure quality as well as quantity, and determine success not only through the use of metrics but also based on feedback from their beneficiaries and factors such as wellbeing and quality of life.

55. Consortium members remain concerned that the lack of specific targets and commitments in *'Towards Zero Infections'* present a real barrier to implementing effective HIV. Consortium members would like to encourage DFID to set out in more concrete terms the results they hope to achieve for HIV and TB, and be clearer about how they will integrate HIV and TB interventions into broader programmes on RMNCH and SRH.

56. Prior to its publication, Consortium members pointed out that the paper was underdeveloped in the area of accountability and transparency. *'Towards Zero Infections'* remains weak on commitments that will enable DFID, civil society and others to monitor its progress on HIV, TB and related commitments, including those for girls and women. Until *'Towards Zero Infections'* is translated into clearer financial commitments

and specific targets progress and impact will be difficult to measure. Moreover, until it is made clearer how HIV and TB services will be integrated into broader RMNCH and SRH agendas, both in international policy and more importantly at country level, it is difficult to develop a clear, coherent picture of what DFID's response to HIV and TB will look like.

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