Introduction to STOPAIDS and our reason for submitting evidence

STOPAIDS is a network of 70 UK agencies fighting to secure an effective response to HIV and AIDS since 1986.

The effectiveness of UK Aid and the infrastructure that supports it are of huge importance to STOPAIDS, as we monitor and influence the quality and quantity of UK commitments to the global HIV response and global health.

The global HIV response is in a precarious position. Despite decades of progress, many donors, including the UK, are showing signs of taking their eye off the ball at a time when the gains that have been made could be easily lost. The COVID-19 pandemic puts these gains at even greater risk, where UNAIDS modelling shows that a total interruption of HIV services for 6 months would lead to an additional 500,000 lives lost in Africa this year alone and set us back to 2008 HIV mortality rates.[1] Given the shortfalls in financing available to meet the targets of the Sustainable Development Goals (SDGs) even before the economic recession brought on by the COVID-19 crisis, STOPAIDS has a strong interest in ensuring that donor governments, like the UK are allocating and spending aid effectively to close these gaps and help ensure no one is left behind.

STOPAIDS also focuses on other elements of aid effectiveness, including the impact of donor transition and changing aid relationships on people living with HIV, the impact of partnerships between the private sector and governments in global health efforts and the role of international public finance in the future of international development.

The definition and administration of UK aid – who should be responsible, and accountable, for targeting and spending aid?

The UK's development approach since 2010 and the changing landscape

1. At the start of 2010 it was clear that DFID's overseas development assistance (ODA) investment approach had changed significantly and would increasingly be driven by a core determination of eligibility based on gross national income (GNI) per capita. If a country that DFID was working in was a middle income country (MIC), particularly an upper middle income country (UMIC), DFID would no longer continue to support programmes there and would pull out funding and a DFID country presence as quickly as possible. For example, STOPAIDS tracked DFID's bilateral investments in HIV programmes and found that between 2010 and 2015 DFID rapidly (within 6 months) pulled out of 15 MICs[2].

[1] UNAIDS (2020)*The cost of inaction: COVID-19-related service disruptions could cause hundreds of thousands of extra deaths from HIV.* Available online: https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2020/may/20200511_PR_HIV_modelling (Accessed 14.05.20)

[2] RESULTS UK and STOPAIDS (2019) *Laying the foundations: Principles of a sustainable, successful*

2. This approach, still common among most bilateral donors at the time and many still now, was built on two incorrect assumptions about development:
    a. The first assumption was that countries can be plotted along a linear 'development continuum' - that once you get to a certain national economic threshold (see next assumption) the only direction for all national development indicators is one of improvement. In fact, progress is along what we might better understand as multiple development continuums and it is neither steady or in one direction.
    b. The second assumption is that economic growth and its measurement using GNI per capita (GNIpc) can act as a meaningful proxy and the sole determinant (or even sole economic determinant) of where to direct ODA. GNIpc is one of the few economic indicators that is reliably collected for all countries and does give some indication of total economic capacity writ large. It is useful for identifying low income countries that need considerable external financial support but, used on its own, it is woefully inadequate and misleading as a tool to direct ODA for MICs. It does not tell us whether a country has sufficient tax revenue or fiscal space to invest more in social services. Often MICs have neither. It does not tell us whether a government has the technical capacity to deliver effective programmes for the poorest and most marginalised nor whether they have social contracting systems in place to fund civil society to do so. Often MICs have neither. It does not tell us, even if all these features are actually in place, whether the government has the political willingness to direct funding to the poorest and most marginalised and to reduce inequality within a country. Often they are not willing and the exit of donor funding does not change that.
    c. Ultimately both of the assumptions above led to the (often rapid) withdrawal and exit of bilateral and multilateral aid in UMICs over the last decade. This has led to the rapid closure of programmes that have often not been picked up by domestic governments and this has adversely affected the poor and marginalised populations in these countries and undermined or lost the development gains that ODA had made possible. More can be read about this in our 'Laying the Foundations' paper[3].
3. In addition to these two incorrect assumptions, there have been shifting global realities ('shifting geographies' as Jonathan Glennie writes[4]) that demanded recognition and further challenge traditional beliefs regarding ODA:
    a. Wealth is shifting towards the BRICS and a second tier of MICs.
    b. The poorest and most marginalised people, who are the focus of our development work, increasingly reside in what are now termed MICs.

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transition from external donor funding. Available online: https://stopaids.org.uk/resources/laying-the-foundations-principles-of-a-sustainable-successful-transition-from-external-donor-funding/ (Accessed 22.04.2020)

[3] Ibid (1)

[4] Glennie, J (2019) *Global Public Investment: Five paradigm shifts for a new era of aid.* Joep Lange Institute. Available online: https://www.joeplangeinstitute.org/wp-content/uploads/2019/10/Global-Public-Investment-FULL-REPORT-Sept2019.pdf (Accessed 07.04.2020)

    c. With economic shifts come changes in geopolitical power and knowledge, more countries (and indeed other key non-state stakeholders) are demanding a seat at the table and in decision-making and this requires shifts in global governance. This leads to less western-centric and more heterogeneous approach to aid spending.
4. All of these global changes coincided (and were contributory to) the paradigm shift in development thinking and ambition embodied in the SDGs agreed by UN member states in 2015. The 17 goals agreed were game-changing in several ways - 1) they applied to all countries and not just low and middle income countries - this recognised that all countries are aiming for and would be accountable to the same goals for the first time 2) they combined development and climate goals together under a common umbrella of sustainability 3) there was a broader focus on eliminating poverty (not just extreme poverty) and, for the first time, reducing inequality. All of these shifts fundamentally alter our understanding of what we are trying to achieve and the particular need and role that ODA has/should have in achieving it.
5. With these ambitious goals came a hefty price tag. The significant gaps in financing needed to deliver the SDGs must be noted in all policy discussions around aid. The United Nations Conference on Trade and Development estimates that achieving the SDGs will cost between $3.3 trillion and $4.5 trillion per year in developing countries alone, with an investment gap of about $2.5 trillion.[5] Aid is one small but critical financial tool required to fill this void, alongside other public and private financial contributions. Given the scale of the gap, increasing global aid and spending it effectively is critical.

How the UK's development approach has changed since 2015

6. Since 2016 DFID appears to have (quietly) responded to the changing realities described above. Since 2015 our understanding is that DFID has not undertaken any more total exits of ODA (often euphemistically called 'transitions' globally) from (usually upper) MICs. Instead the UK Government has undertaken a *shift* in aid relationships in 3 important ways: 1) ODA has been channeled increasingly through different types of interventions, including an expansion of focus on innovative financing and the private sector 2) ODA has been channeled more through other government departments, and 3) ODA has increasingly needed to answer whether it also meets the 'national interest'.
7. DFID have described that they adhere to an allocation model that accounts for: a country's need (measured by extreme poverty), aid effectiveness (the degree to which aid can be translated into poverty reduction), future need, and ability to self-finance[6].
8. Broadly this approach makes some very important steps in the right direction by recognising the ongoing critical role of ODA and the need for increased flexibility and

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[5] UNCTAD (2014) World Investment Report 2014, p. xi, Available online http://unctad.org/en/PublicationsLibrary/wir2014_en.pdf (Accessed 27.04.20)

[6] DFID (2016), Rising to the challenge of ending poverty: the Bilateral Development Review 2016. Available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573889/Bilateral-Development-Review-2016.pdf (Accessed 27.04.20)

nuance in how ODA can be applied effectively at varying levels and in different ways to achieve development aims. However, key problems also remain or emerge as new.

Challenges to be addressed

9. The UK's ongoing focus on only eliminating extreme poverty fails to recognise the broader focus of the SDGs. While poverty reduction is currently enshrined in the International Development Act 2002 as the main purpose of UK Aid, the SDG's additional focus on reducing inequality is not addressed. **Recommendation: UK Aid should have dual objectives of both reducing poverty and inequality in order to meet the targets set out in the SDGs.**
10. The UK still has a stated approach that unduly focuses on economic indicators, particularly GNIpc, in assessing eligibility for ODA. STOPAIDS supports the UK Sustainability and Transitions Working Group Submission which **recommends that DFID should look to adopt a multidimensional and rights-based approach to reducing poverty and inequality**.
11. UK Aid must be targeted towards supporting the poorest and most marginalised, wherever they are (including adolescent girls and young women, people from lesbian, gay, bisexual and transgender communities, sex workers, people who use drugs and people living with HIV) ensuring their dignity and human rights are respected and protected. To do so, DFID must strengthen the eligibility and allocation criteria in its assessments so that support and resources can be allocated according to need. **Recommendation: DFID country eligibility criteria should include a range of financial indicators including GNIpc, a country's debt burden, fiscal space, level of economic inequality, and a range of social and political measures - levels of poverty, prevalence of health conditions, levels of education, etc**.
12. The current DFID approach to aid allocation detailed in the 2016 Bilateral Development Review did not publicly articulate what indicators they use to define 'aid effectiveness' or 'future need'[7]. Without a clearer set of indicators that guides the eligibility or allocation of ODA, the UK government is not being transparent to the taxpayer to facilitate them to understand the basis of deciding where their money is being spent to achieve SDG targets. **Recommendation: DFID should publish a clear eligibility and allocation approach for their bilateral and multilateral spending.**
13. A further concerning reality is the increasing dilution of the amount of UK Aid spent by the most experienced and effective government Department created to deliver development progress and the rumours and speculation of its independence being at risk. The ONE Campaign's Real Aid Index[8] allocates DFID a 'strong' rating across poverty reduction, effectiveness and transparency, the only Department spending over £100 million of ODA which receives these ratings. **Recommendation: The Department for International Development (DFID) should remain an independent Department**

[7] DFID (2016), Bilateral Development Review: technical note. Available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573890/Bilateral-Development_Review-technical-note-2016.pdf (Accessed 27.04.20)
[8] ONE Campaign (2019), Real Aid Index: Summary. Available online: https://s3.amazonaws.com/one.org/pdfs/ONE_Real_Aid_Index_Summary.pdf (Accessed 27.04.20)

with a Cabinet level Secretary of State. DFID should be spending the majority of the UK's Aid portfolio and have overarching authority for the Aid budget across all government Departments spending UK Aid.

14. However, despite DFID delivering the highest level of aid effectiveness amongst UK Aid spending Departments, it has room for improvement. A worrying trend is its increasing investments of aid in CDC Group. There is very little evidence to suggest that CDC's investments are making an impact when it comes to reducing poverty and inequality. This is because:
    a. The CDC does not provide information on how it assesses the development impact of its investments, and monitoring and evaluation are still poor.
    b. The CDC invests heavily in private equity funds which removes accountability for how funding is spent.
    c. **Recommendation: DFID should be responsible for the running of the CDC to ensure that investments prioritise reducing poverty**
15. As highlighted above, the UK's international development agenda has failed to fully adapt to the new SDG landscape and this could be down to a lack of political leadership for the diverse SDG portfolio. **Recommendation: In order to guarantee all UK government activities are in line with the universal ambition of the SDGs, the Government should appoint a Cabinet level representative responsible for SDG coordination who has a close working relationship with DFID but also high level oversight across other government departments.**
16. Accountability mechanisms for effective aid spending are essential. **Recommendation: Institutional bodies with the mandate and remit to scrutinise and interrogate UK Aid, including the Independent Commission for Aid Impact and the International Development Committee must continue to be adequately resourced and respected.**
17. Currently there is an inconsistent approach by the UK government regarding consultation with the UK public and key stakeholders in the countries where ODA is spent. There is no document that describes the UK Government's approach to consultation. **Recommendation: In order to ensure diverse and quality scrutiny, UK civil society should be recognised as a key development partner by the Government and engaged regularly and systematically for feedback. Additionally, UK Aid must be accountable to communities that it serves and create opportunities for feedback through country programmes and spending where these do not already exist.** Any government department spending UK Aid should include information on citizen needs and preferences as a systematic requirement for portfolio and programme design and management.

How effective and transparent is the UK aid spent by the Department for International Development (DFID) compared to aid allocated to other Government departments and to the cross-Government funds?

18. Transparency and effectiveness of UK Aid spent by DFID via CDC Group is limited[9].

a. The CDC provides very little public information on its investments. This means there is no information on what CDC expects the development impact to be, and how this will be measured and evaluated.
b. CDC does not report on whether its investments are additional to those that the private sector would have made anyway nor the proportion of its investments that are spent on new activities compared to buying companies that already exist.
c. **Recommendation: The CDC should have an independent evaluation body which reports to the International Development Committee on how the CDC is meeting a reformed, broader definition of development impact, as described by Global Justice Now[10].**

19. It is welcome that the UK is the second-largest government funder of medical research and development (R&D)[11], with funding for global health R&D now exceeding 0.01% of GNI as was advised by the WHO Consultative Expert Working Group on R&D[12]. However there are a clear lack of safeguards across departments to ensure that the final products that derive from publicly funded R&D are accessible to those that need them.
20. Public funding for health R&D is predominantly managed by four government departments: the Department of Health; the Department for Business, Energy and Industrial Strategy; the Department for Education; and the Department for International Development. Though there are some guidelines on public funding in these departments, they are usually vague and fall far short of concrete guarantees that products developed with public funding will be made available at an affordable price to patients in the UK and beyond.
21. Compared to other UK Government departments, DFID has one of the most detailed 'value for money' approaches, which aims to maximise "the impact of each pound spent to improve poor people's lives"[13]. DFID is involved in a number of different R&D initiatives that are taking positive steps to secure affordable and accessible medicines.
22. For example, DFID is a significant donor to the Drugs for Neglected Diseases initiative (DNDi). DNDi is a Product Development Partnership (PDP) that builds in accessibility from the very start of the R&D process. DNDi relies on public (50%) and private (50%) contributions to pay for R&D upfront. This allows them to keep their research agenda focused on priority public health needs, promote greater sharing of research data and

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[9] Global Justice Now (2020) Doing More Harm than Good: Why CDC must reform for People and Planet. Available online: https://www.globaljustice.org.uk/sites/default/files/files/resources/web_gjn_-_doing_more_harm_than_good_cdc_-_feb_2020_2.pdf (Accessed 09.04.2020)

[10] Ibid (8)

[11] Viergever, R.F. and Hendriks, T.C.C (2016) The 10 largest public and philanthropic funders of health research in the world: Qhat they fund and how they distribute their funds Health Research Policy and Systems 2016 14:12. DOI: 10.1186/s12961-015-0074 Available online: https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-015-0074-z (Accessed 27.04.20)

[12] WHO (2012) Research and Development to Meet Health Needs in Developing Countries: Strengthening Global Financing and Coordination. Available online: https://www.who.int/phi/CEWG_Report_5_April_2012.pdf (Accessed 27.04.20)

[13] Department for International Development (2011) DFID's Approach to Value for Money. Available online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67479/DFID-approach-value-money.pdf (Accessed 27.04.20)

costs and price products affordably and transparently. However, not all UK funded R&D initiatives disclose their R&D costs or commit to ensuring that their products will be affordable to those that need them[14].

23. The UK government has been particularly resistant to ensuring greater transparency of R&D costs; as highlighted by the decision to disassociate themselves from the resolution on 'Improving the transparency of markets for drugs, vaccines and other health-related technologies' that was adopted at the 72nd World Health Assembly.
24. **Recommendation: The UK should attach conditions to ensure that there is a public return on public R&D investments. These conditions should guarantee that the final products will be accessible and affordable to patients and ensure transparency of knowledge, costs and prices. . For global equitable access to COVID-19 health technologies, receiving public funding should be conditional upon mandatory sharing of COVID-19 related data, knowledge and technologies in a WHO-led global pool of rights.**
25. **Recommendation: DFID should outline how the UK government will work across departments to 'Improve availability, affordability and efficiency of health products by increasing transparency of prices of medicines, vaccines, medical devices, diagnostics, assistive products, cell- and gene-based therapies, and other health technologies across the value chain' as outlined in the Political Declaration of the High Level Meeting on Universal Health Coverage, which the UK Government supported.**

How should the national interest be defined, and what weight should it be given, in relation to targeting UK aid?

26. STOPAIDS supports an adapted version of the Overseas Development Institute principled approach to the national interest where countries target aid to populations that need it most, support global cooperation and adopt a public spirited focus on development impact rather than a short-sighted domestic return.[15]
27. Research shows that the UK public are more supportive of the moral case for Aid than the rhetoric that Aid protects them[16].This suggests that 'the national interest' is currently given too much weight in the delivery and communication surrounding UK Aid.
28. **Recommendation: Efforts to address global inequality and global health security in the national interest should be reframed to articulate how strong and stable health systems and investments in global public goods (including health R&D) positively influence global health and prosperity everywhere.**
29. **Recommendation: The national interest can be pursued within the bounds of SDG-driven need but should not be a primary objective or consideration of UK Aid**

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[14] STOPAIDS, Global Justice Now (2017) Pills and Profits - How drug companies make a killing out of public research. Available online: https://www.globaljustice.org.uk/sites/default/files/files/news_article/pills-and-profits-report-web.pdf (Accessed 27.04.20)

[15] Overseas Development Institute (2019) Principled Aid Index. Available Online: https://www.odi.org/opinion/10502-principled-aid-index (Accessed 27.04.20)

[16] DevCommsLab (2018) Messaging using moral frames: what works. Available online: https://devcommslab.org/blog/messaging-using-moral-frames-what-works/ (Accessed 27.04.20)

spending. Additionally, communications framed around the national interest should be scaled down in favour of messaging which describes the impact and progress driven by UK Aid.

How is official development assistance defined, administered and targeted elsewhere in the world?

30. Other ODA stakeholders are beginning to review how they define, administer and target ODA. For example, regarding the use of GNIpc, the EU recently developed the 'Neighbourhood, Development and International Cooperation' instrument that creates the possibility to cooperate with all global south countries regardless of their income level and there is no longer graduation "by law". Thus cooperation remains possible regardless of the development status of the country.
31. **Recommendation: The UK should partner with other large bilateral donors and multilaterals to convene discussions on how to make the best use of ODA to achieve the SDGs and ensure the sustainability of development gains.**
32. As is noted in the first section regarding outdated assumptions driving many bilateral donor eligibility policies, the same outdated assumptions were also driving many multilaterals up to 2015 because of the substantial influence exerted by donors on their Boards. By 2015, it was becoming increasingly clear that these policies were having considerable negative effects. For example, bilateral donors such as the UK looked to (and publicly spoke of) multilaterals such as the Global Fund as the funder of last resort - when UK funding left a country, it would be the Global Fund that would continue funding. The reality however, was that due to similar eligibility policies, the Global Fund was actually exiting funding very soon afterward bilateral donors had left and there was no funding left for critical services for the poorest and most marginalised. For example, Romania was one example of where the Global Fund left and HIV infections and deaths spiked.
33. In 2015, the growing realisation that something was wrong led to the launch of the Equitable Access Initiative (EAI) by the heads of multilateral organizations engaged in global health: GAVI, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, the World Bank and WHO. The aim of the initiative was to explore what criteria should be used to determine eligibility and specifically whether using GNIpc was sufficient on its own. The analyses found that "*policymaking should not rely on a single variable to inform complex health financing polices on the eligibility for and the prioritization of investments. It is proposed that policymakers consider a more comprehensive framework for decision making that accounts for countries' position on a health development continuum, based on the analysis of countries' needs, fiscal capacity and policies. For instance, eligibility policies should not only consider the level of wealth in a society, as measured by GNI per capita, but account for health need relative to income as well as mitigate the effects of discrete thresholds that render a country ineligible for support once it passes a certain GNI per capita level. Further, in order to prioritize investments, a government's resources and policies to meet this health need should be taken into account. Finally, the analyses highlight the need to account for equity considerations, particularly within country inequity, suggesting that*

context-specific analyses are relevant when assessing the level and type of support to be provided."[17]

34. Unfortunately the majority of donors (bilateral and multilateral) have either ignored or misquoted the findings of the EAI. The only significant change at the time was the recognition of the need to mitigate the worst impacts of these eligibility policies by improving transition (donor exit) policies. One of the leaders in this was the Global Fund which developed the first public policy to deal with this in 2015 - the Sustainability, Co-financing and Transition Policy. It would appear that DFID may have informally changed some of its eligibility criteria at around the same time but nothing was ever said publicly.
35. Despite attempts to manage donor transitions better, many health multilaterals we work with still maintain eligibility methodologies that are mired in outdated assumptions and criteria. Most health multilaterals have so far retained limited eligibility approaches based around GNIpc. The previous review of the Global Fund's eligibility criteria in 2018 led to a few important changes but there was absolutely no change to the use of GNIpc as the primary eligibility criteria with disease burden as the only other secondary criteria. **Recommendation: The UK should utilise their position on the board of the World Bank, Gavi and the Global Fund to a) review whether the eligibility and allocations policies of these key multilaterals are still fit for delivering their mandates and, in the meantime, b) ensure synergy and coordination amongst leading multilaterals to mitigate the risk of simultaneous transition, c) push for global health multilaterals to modify their transition policies to prioritise sustainability and protect development gains, particularly health outcomes.**
36. There is a growing clamour of voices from MICs, global institutions and civil society for ODA to be made fit for the 21st century. When considering how ODA is defined, administered and targeted, it is important to recognise that ODA is one element of concessional international public finance that contributes towards sustainable development. This broader financial umbrella is described by Jonathan Glennie (2019) as Global Public Investment (GPI). **Recommendation: The UK should review and explain how they are addressing the paradigm shifts proposed by Glennie (2019) for how GPI is defined, administered, targeted as well as governed and managed.**
37. STOPAIDS contributes to ongoing international discussions on the paradigm shifts described by Glennie. The following principles are particularly relevant for how ODA is defined, administered and targeted:
    a. As conveyed in point 6 above, amending the ambition of ODA to include both reducing inequality and poverty is required. **ODA must also promote sustainability and the importance of developing global public goods or 'public value**'. STOPAIDS details the definition of 'public value' and its relevance for health innovation in our report 'The People's Prescription'[18].

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[17] World Bank (2016) The equitable access initiative: final report. Available online: http://documents.worldbank.org/curated/en/358571481297620038/The-equitable-access-initiative-final-report-June-30-2016 (Accessed 27.04.20)

[18] UCL Institute for Innovation and Public Purpose, Global Justice Now, Just Treatment, STOPAIDS. (2018) *The people's prescription: Re-imagining health innovation to deliver public value*, IIPP Policy Report. London: IIPP. Available online: https://stopaids.org.uk/wp/wp-content/uploads/2018/10/report.pdf (Accessed 07.04.20)

b. **Recognising that it is not only the amount of ODA that matters, but it's unique set of characteristics that cannot be replaced by other types of finance.** ODA is not a temporary stop-gap but a permanent component of the global financing ecosystem that shifts in line with internationally agreed goals.
c. **Recognising that shifting geographies (outlined in point 3) mean that the concept of 'north-south' is shifting to one of universality.** The number of and size of contributions from non-DAC providers to 'development' are increasing. There is also a shift to understanding that developing countries should be considered as partners, rather than donor recipients. In addition, as conveyed in point 5, countries should not graduate from ODA but be assessed according to specific needs.
d. **Evolving governance processes and structures to ones that are better able to respond to today's geopolitics and give civil society a central role**. STOPAIDS, Aidsfonds, Civil society Sustainability Network and Frontline AIDS propose key principles to guide the evolution of the global health architecture[19]. Multilateral organisations and global mechanisms that receive and administer ODA need to be fit for purpose in the SDG era. To do so:
    i. greater coordination among multilaterals, donors, implementer countries and communities is needed,
    ii. the processes by which financing is mobilized and targets are set need to be recalibrated for impact, with more input from end-users,
    iii. representation and power in global health governance should be balanced,
    iv. And; civil society and communities must be meaningful engaged and have real power in governance structures; DFID should strengthen its recognition of the role that communities play in the health system, particularly as it moves forward with its Ending Preventable Deaths Strategy and its long awaited Strategy on Health Systems Strengthening. Through formalising and recognizing that community-led responses and systems are essential parts of health care systems and the role of community-led responses in reaching the most marginalised people, donors and governments can fill critical gaps in public health systems.
e. These principles, as well as the paradigm shifts proposed by Glennie, are important considerations for current discussions on how to develop new governance and financing structures or evolve existing global institutions to fund, plan, implement and monitor the global response to Covid-19.
f. The principle regarding the meaningful engagement of civil society in global health governance is relevant now in the context of the governance mechanisms being developed/used to drive the Covid-19 response as national, regional and global level - including through the ACT Accelerator. **Recommendation: At global level this means there should be civil society involvement as**

[19] Aidsfonds, Civil Society Sustainability Network, Frontline AIDS and STOPAIDS (2020) *HIV, Universal Health Coverage and the future of the global health architecture*. Available online: https://stopaids.org.uk/resources/global-health-architecture/ (Accessed 07.04.2020)

partners in each of the 3 pillars of the ACT-Accelerator. First with a seat at the table for interim civil society representatives followed by establishment of an open selection process that can identify standing representatives. A similar process should be followed at national and local levels where civil society and community representatives should be involved in the governance and accountability of all covid-responses.

g. This principle is also relevant for current discussions surrounding the WHO and it's relations with Non-State Actors. **Recommendation: DFID, working with DHSC, should encourage the WHO to engage in a consultation with non-State actors to identify the most appropriate mechanisms to support their meaningful engagement in the governance processes of WHO.**
h.

Accountability of the 'Government systems and structures' recommended by the Integrated Review (including arrangements for parliamentary scrutiny)

38. We have covered accountability arrangements in the above.