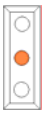
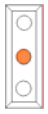
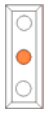
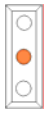
3. *Taking Action* Implementation - Progress on Priority Actions

In Brief

Question: What progress has been made on *Taking Action's* six priority actions? What are the lessons from these?

Priority Action	Grade[18]	Comment
Closing the funding gap		UK financial support to the international response to HIV and AIDS rose 30% from £298m in 2004/5 to £385m in 2005/6. This rate of increase will need to be maintained to meet the spending target in *Taking Action.*
Strengthening political leadership		The UK demonstrated strong international leadership on AIDS while president of the EU and G8. In country, DFID and FCO have exerted influence, e.g. to focus responses on those most vulnerable to infection.
Improving the international response		The UK has spearheaded efforts to implement the Paris Declaration on Aid Effectiveness, championing the need for greater donor harmonisation and increased resource flows through country-led approaches.
Supporting better national programmes		The UK is valued as a responsive and flexible funder. However, the approach to funding and limitations of information systems make it difficult to assess progress on specific commitments related to this priority action.
Taking action in the longer term		The UK has supported vaccine and microbicide research, and has championed initiatives for long-term, predictable funding, e.g. IFF and UNITAID. The need for other research is difficult to define. The commitment to longer-term funding is not well reflected in CAPs.
Translating strategy into action		The cross-Whitehall coherence group is seen as useful. However, roles and responsibilities of other government departments are poorly defined and, in practice, *Taking Action* is mainly a DFID strategy.

[18] Traffic lights in this section indicate the team's assessment of the degree to which the UK is meeting the commitments in *Taking Action's* 6 priority areas. Green indicates that the commitments are largely being or will be met; Amber means that the team has some concerns about areas where commitments may not be met or there is insufficient evidence to judge; Red means that the team concludes that the commitments are largely not being met

Progress on Six Priority Actions

3.1 This section provides an overview of progress, focusing on major successes and challenges, in the six priority areas in *Taking Action*:

- Closing the funding gap
- Strengthening political leadership
- Improving the international response
- Supporting better national programmes
- Taking action in the longer term
- Translating strategy into action

3.2 Since *Taking Action* was launched in July 2004, there has been some progress towards the commitments under each of the priority actions outlined in the strategy. There has been most overall progress on strengthening political leadership and on improving the international response. More detailed information about progress on the six priority actions and a selection of the more than 130 commitments in *Taking Action*, identified for the purposes of this interim evaluation, together with country case study examples and data sources, is included in Annex 4 (pA33) and in Annex 5 (pA74). Commitments that have seen least progress include:

- Improving the EC's allocation of and reporting on spend on HIV and AIDS
- Identifying the comparative advantage of the EC and ensuring a better division of labour between the EC and other multilateral and bilateral donors
- Accelerating progress towards joint UN action at country level
- Supporting national governments to analyse, and develop plans to address, constraints to scaling up
- Ensuring that responses to HIV and AIDS are sustainable in the long term
- Securing longer-term, predictable funding for HIV and AIDS
- Ensuring that all relevant government departments implement *Taking Action*
- Ensuring that implementation and progress towards targets are monitored across government and throughout DFID's organisational structure

3.3 The interim evaluation did not highlight any areas of UK activity or intervention that have been inappropriate. Table 1 (p9) highlights factors which have contributed to or limited progress.

Table 1. Factors Contributing to or Limiting Progress Towards Achieving the Six Priority Actions

Factors that have Contributed to Progress	Factors that have Limited Progress
• High-level political leadership and commitment on the part of the Prime Minister, Secretary of State and Under-Secretary of State and other interested parliamentarians • Effective inter-departmental collaboration, in particular between DFID and the FCO, in the lead up to and during the UK's Presidencies of the G8 and EU in 2005 • Strong support, through funding and policy dialogue for GTT process, UN reform, donor harmonisation and country-led approaches • Role played by UK in championing sexual and reproductive health rights as part of responses to HIV and AIDS • Emphasis on strengthening national systems and processes • Willingness to tackle controversial issues • DFID flexibility and responsiveness as a donor • Policy and technical skills and competence of DFID staff	• National leadership on HIV and AIDS that is inconsistent with epidemiological priorities in some countries • Weak integration of HIV and AIDS in national plans in some countries • Limited evidence of effectiveness of using multilaterals to address HIV and AIDS in middle-income countries and countries where the UK does not have a bilateral presence • Limited coherence between ISPs and CAPs • Provision of significant off-budget support for HIV and AIDS by some donor agencies and funding mechanisms has weakened harmonisation efforts • Reductions in staffing in parallel with increases in spend and in scope of work • Methodological challenges in calculating DFID spend on HIV and AIDS, including spend on women, OVC and vulnerable groups, and in tracking financial contributions of other government departments

Priority Action 1: Closing the Funding Gap

3.4 The UK has made progress on this priority action, both through its own financial commitments and through advocating for increased commitments from other donor governments. The UK is the second largest bilateral donor for HIV and AIDS, accounting for 20.5% of bilateral commitments in 2004 (Kates, 2005, see 3.4). Significant additional resources have been made available internationally for HIV and AIDS in recent years through the Global Fund, World Bank and the US Government President's Emergency Plan for AIDS Relief (PEPFAR) among others. Despite this, UNAIDS reports that the funding gap for HIV and AIDS will grow from $8.1 billion in 2007 to $15.9 billion in 2008 (UNAIDS, 2005a).

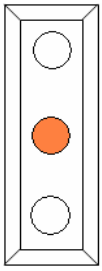
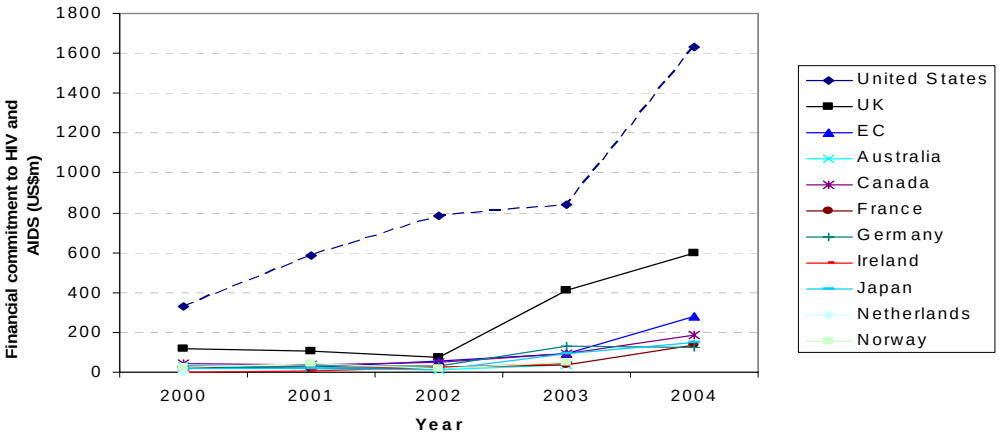


Figure 1. International Context of Spending on HIV and AIDS[19]



3.5 Figures have recently been released (Benn, 2007) on the UK's spend on HIV and AIDS for 2004/5 and 2005/6. These show that the UK spent £298 million on HIV and AIDS in 2004/5 and that this rose by almost 30% to £385 million in 2005/6 (see Figure 2, p11). Spend in 2004/5 shows an apparent reduction from spend in 2003/4. This is not due to an actual reduction in spending but to a change in method[20]. The main changes in method are summarised in Table 2. The UK remains committed to meeting the spending target in *Taking Action* (see section 11.1, p141). In order to do this, spending would need to continue to increase annually by 30% in 2006/7 and 2007/8.

Table 2. Main Differences in Old and New Methods used for Tracking UK Spending on HIV and AIDS

Issue	Old Method	New Method
General Budget Support	Included only if had PIMS[190(p115)] marker for HIV and AIDS or reproductive health; counted 100% of spending	All included; counted 5% towards HIV and AIDS spending
Debt Relief	Not included	Treated in the same way as General Budget Support
Multilateral spend	Included only if had PIMS marker for HIV and AIDS or reproductive health; proportion of spend as advised by agency	Method unchanged. Proportion of EC spend counted to HIV and AIDS has increased[21]
PPAs	Included only if had PIMS marker for HIV and AIDS or reproductive health; counted 100% of spending	All included; proportion of spend as advised by agency

[19] Figures are from SSS, 2006a – see table 1, p29

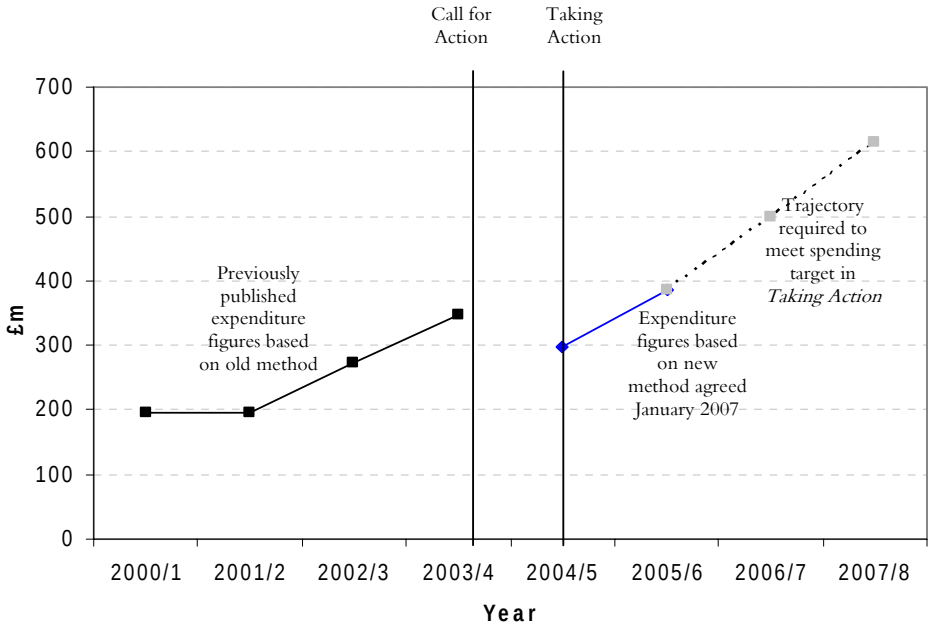
[20] For this reason, figures prior to 2003/4 and those after 2004/5 are not directly comparable.

[21] The expenditure figures are based on the UK providing the EC with £10 million for spending on HIV and AIDS in 2004/5 and £15 million in 2005/6. These figures draw on unpublished and published information from the EC on the amount of money spent on HIV and AIDS in four areas – HIV and AIDS projects; reproductive health; Global Fund contribution and research. The figure contributed by the UK is then derived by applying a percentage figure for the proportion of EC funding provided by the UK – 17.8% in 2004/5 and 17.1% in 2005/6 (DFID, 2007b)

Issue	Old Method	New Method
Projects/programmes making a 'principal' contribution to HIV and AIDS	Counted 100% of spending	Counted 100% of spending
Projects/programmes making a 'significant' contribution to HIV and AIDS	Counted 100% of spending	Counted 50% of spending
Projects/programmes making a 'principal' contribution to reproductive health	Counted 100% of spending	Counted 100% of spending
Projects/programmes making a 'significant' contribution to reproductive health	Counted 100% of spending	Many reclassified and excluded. Those remaining counted 50% of spending

3.6 In both 2004/5 and 2005/6, the majority of the UK's funding for HIV and AIDS (81%) was provided as bilateral aid. Multilateral aid accounted for 19% of funding in each of those years[63(p28)]. These figures are for DFID spending only. Although DFID includes spending from other government departments when reporting on official development assistance, in general, it does not do this for HIV and AIDS spending as other government departments cannot currently say what they spend on this issue in relation to the developing world.

Figure 2. Reported UK Government Spending on HIV and AIDS



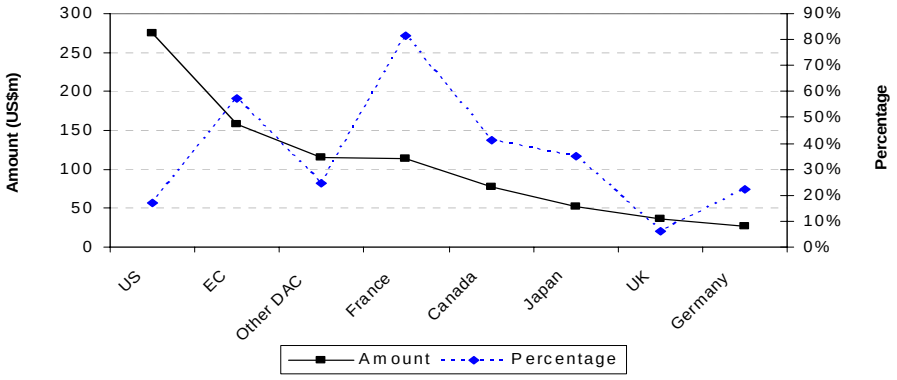
3.7 It is difficult to judge progress on the extent to which spend reflects the priority given to women, children and vulnerable groups in *Taking Action* because of the way the UK provides funding to HIV/AIDS responses and because DFID information systems do not routinely collect this information. Nevertheless, analysis conducted for this evaluation shows that expenditure on HIV/AIDS-related programmes and projects focusing on young people, OVC and other vulnerable groups increased between 2003/4 and 2005/6 although there was an apparent reduction in those with a focus on women. This appears to be related to a reduction in expenditure on specific reproductive health programmes. This is most likely because activities have either been captured within AIDS-marked

programmes/projects or absorbed into health sectoral funding. Over the same period the number of gender-marked programmes rose steadily (SSS, 2006a)[22].

3.8 DFID is proposing to track progress towards the OVC spending target by using a system of sector codes to identify a sub-set of AIDS spending of relevance to OVC. However, this system is not yet fully operational. Work carried out for this evaluation (SSS, 2006a) indicated that the UK was making good progress towards the OVC spending target. DFID reports that over £44 million has been committed to UNICEF's programmes for children affected by AIDS in response to *Taking Action.* Examples of activities for OVC supported by DFID are presented in Annex 5 (see Example 1, pA74).

3.9 The UK has either met or exceeded the targets in *Taking Action* for support to the Global Fund, UNAIDS and UNFPA. Financing for the Global Fund constituted only a small proportion (6%) of the UK's total HIV and AIDS funding in 2004, prior to the adoption of *Taking Action* (Figure 3 and Kates, 2005). In *Taking Action* the UK committed to double its funding for the Global Fund, contributing £77 million over three years. In 2005, the UK provided £51 million and has pledged an additional £100 million in each of the years 2006 and 2007 (Thomas, 2006). This will exceed the commitment in *Taking Action*.

Figure 3. Amount and Percentage of Selected Countries' HIV and AIDS Funding Distributed through the Global Fund in 2004 (figures from Kates, 2005)



3.10 A recent external review of Global Fund financing (RESULTS International et al., 2006) rated the UK's pledged support for 2006 and 2007 as average[23] in terms of its 'fair share'[24]. However, detailed figures are not provided in the

[22] For more detailed discussion of this topic, see section 7.32-7.33.

[23] Grade C, which means that the amount pledged by the country, as reported on the Global Fund website, was between 61-80% of the 'fair share' target for that country

[24] 'Fair share' is a way of seeking to decide how much donor countries should contribute to the Global Fund for 2006 and 2007. Different methods proposed include pro-rata methods based on previous contributions and comparisons to other major funds. The most widely-used is based on weighted GNI. Using these figures and assuming the Fund's resource needs for 2006 and 2007 are $7.1b, the UK's fair share would be $324m (Global Fund, 2005). The recent review used weighted GNI to calculate fair share but based on a total resource need of $8b.

publication so it is not possible to verify these calculations. The UK has committed to meet its 'fair share' of Global Fund contributions[25] and believes it will do so in 2006 and 2007 with the £100 million pledged for both 2006 and 2007 (Thomas, 2006). Indeed, if these figures are used, the UK's rating would be A+ for both 2006 and 2007[26,27].

3.11 The UK is on track to honour its commitment to provide £36 million over four years as core, predictable funding to UNAIDS to support its global leadership[28]. In addition, the UK has indicated willingness to provide additional core funding to implement the recommendations of the Global Task Team. A further £8 million was provided for this purpose in 2005/6 but the release of further additional funding for this purpose has been delayed until 2007/8 pending the results of the GTT review, because of concerns over progress in implementing these recommendations[29]. In addition to its support to UNAIDS' core budget, the UK provides earmarked, extra-budgetary support to UNAIDS, particularly through DFID country offices. Examples of UK support to UNAIDS in-country are provided in Annex 5 (see Example 9, pA80). According to UNAIDS figures (UNAIDS, 2007)[30], the UK's overall contribution rose from around $5 million from 1997 to 2003, to $16.1 million in 2004, $40.2 million in 2005 and $28.9 million in 2006[31]. In 2006, UNAIDS received a total of $231 million. Of this, 69% came from five major donors – the Netherlands, Norway, Sweden, the UK[32] and the US. Of these 'big five' funders, the UK provides the lowest proportion of its funding within UNAIDS unified budget. In 2006, this was 65% for the UK, 75% for Sweden, 88% for Norway, 91% for the US and 100% for the Netherlands.

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[25] Based on GNI calculations. However, not all other donors accept the concept of 'fair share' pointing out that their contributions to the Global Fund are voluntary in nature.

[26] The exact figure depends on exchange rate used. If a rate of 1.87 is used for 2006 and 1.94 for 2007, this would equate to $187m in 2006 (115% of fair share) and $194m in 2007 (120%).

[27] These figures differ from the figures on the Global Fund website, on which the RESULTS International calculations are said to be based. These give the UK contributions/pledges as $159m for 2005, $116m for 2006 and $194m for 2007 (Global Fund, 2007). These tally with the UK's figures overall for those three years of £251m (converts to $470m at average exchange rate of 1.87) but the spread differs because part of the 2006 contribution was released early in 2005 to ensure that all funding decisions made in round 5 could be approved by the Global Fund's Board (DFID, 2007a). However, even if the figures from the Global Fund website were used, this would mean the UK contributed 72% of its 'fair share' in 2006 (but much more in 2005) and 120% of its 'fair share' in 2007. This would equate with a grade C rating in 2006 but a grade A+ in 2007. It is unclear why the RESULTS International figures differ from this.

[28] The UK provided £8 million in each of 2004/5 and 2005/6. This rose to £10 million in 2006/7 and is due to be a further £10 million in 2007/8

[29] In particular, there were concerns about slow implementation in country; limited progress in implementing recommendations on the comparative advantages of WHO, the World Bank and the Global Fund; and concerns about the way the GIST mechanism was being implemented.

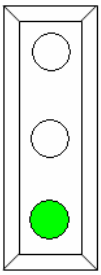
[30] There are some difficulties in comparing DFID and UNAIDS figures because UNAIDS reports for calendar years in US$ and DFID reports for its Apr-Mar financial year in sterling.

[31] The decline between 2005 and 2006 is due to the holding back of funding for implementation of Global Task Team recommendations.

[32] The UK's contribution of $28.9 million in 2006 accounted for 12% of UNAIDS' income that year.

3.12 UK support to UNFPA of £20 million in both 2004/5 and 2005/6 is in line with the commitment to provide £80 million over the next four years. Trends in, and the distribution of, UK funding are discussed in more detail in Chapter 4 of this report (p22).

Priority Action 2: Strengthening Political Leadership



3.13 The UK Government has also made a significant contribution to strengthening political leadership. The number of AIDS-related projects/programmes supported by DFID which contain an element of policy dialogue has been steadily increasing (Figure 16, p32). In addition, the UK ensured that development issues, including HIV and AIDS, were high on the agenda during its Presidencies of the G8 and EU in 2005 and played a significant role in securing G8 and EU commitments to double aid and support 'universal access' by 2010 (G8, 2005; EU, 2006). UK action contributed to ensuring that these also became UN commitments and to the establishment of the Africa Progress Panel, headed by the UN Secretary General, to monitor G8 and EU commitments (Blair, 2006). The UK was also influential in gaining support for integrating reproductive health into the Millennium Development Goals (UN General Assembly, 2005).

3.14 The UK has provided international leadership on HIV prevention, contributing to the development of the EU Statement on HIV for an AIDS Free Generation, and on contentious issues, working with the EU to ensure that the declaration from the UNGASS meeting in June 2006 had a strong emphasis on vulnerable and marginalised groups, sexual and reproductive health and rights, and harm reduction.

3.15 Considerable efforts have been made to strengthen the leadership of developing countries through long-term support for the African Union and NEPAD and, in 2004, through the establishment of the Commission for Africa. The UK helped to ensure that African perspectives informed Gleneagles discussions and that most of the Commission for Africa's recommendations were agreed by the G8. The priority given to country-led development is also reflected in UK endorsement for UN General Assembly instructions that 'universal access' be country driven. DFID has been an important supporter of the Africa Partnership Forum, which involves African and donor governments and evaluates actions against NEPAD commitments. Country examples of UK support to build national leadership are provided in Annex 5 (see Example 3, pA76).

3.16 While the importance of strong national leadership has been reflected in DFID support for the Three Ones, country-led plans and use of aid instruments such as budget support, progress has been limited by the weakness of many country plans[33]. In some countries the UK needs to find more effective ways to challenge national plans that are not evidence based, e.g. the emphasis on abstinence-only

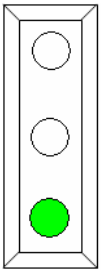
[33] In particular, there is evidence that poverty reduction strategies in many countries fail to include HIV and AIDS adequately (see section 6.9, p58). Similarly, there is evidence that national AIDS strategies in many countries do not provide an adequate basis for prioritising elements of the response to HIV (see section 6.27, p65).

prevention for youth in Zimbabwe and Zambia (see Box 30, p132), or the lack of emphasis on tackling HIV in marginalised groups such as IDU in Russia.

3.17 The FCO has played an important role both in keeping HIV and AIDS high on the diplomatic agenda and in strengthening national leadership, especially in countries most severely affected by the epidemic, e.g. Zambia. However, the degree to which the FCO and DFID work together varies from country to country.

3.18 DFID published a progressive HIV and AIDS workplace policy in 2002, which was adopted by the FCO and the British Council. Country case studies conducted for this evaluation indicate that there may be differences in the way in which the policy is interpreted and implemented in different countries (see Annex 5, Example 4, pA78). There has been no systematic follow up to ensure that the workplace policy is being implemented consistently or to assess the effectiveness of different approaches to implementation (see Annex 5, Example 5, pA78).

Priority Action 3: Improving the International Response



3.19 There has been good progress on commitments to improving the international response[34]. DFID has taken measures to ensure that Institutional Strategies with multilateral partners place greater emphasis on HIV and AIDS. Analysis conducted for this evaluation (SSS, 2006a) found that all Institutional Strategies (ISs) developed since *Taking Action* refer to HIV and AIDS. ISs with UNAIDS, UNFPA and the World Bank set out clear roles, objectives and arrangements for measuring progress.

3.20 The UNICEF Joint Institutional Approach (JIA) does not mention UNICEF's leadership role on orphans and vulnerable children (DFID et al., 2006), which was a specific commitment in *Taking Action*. The EC IS does not specify how the Commission will address HIV and AIDS in middle-income countries and is not explicit about the respective comparative advantages of the EC and of UN agencies, which also have a mandate to work with women and OVC (DFID, 2005i).

3.21 The new EC Programme for Action on AIDS, TB and Malaria covers 2007-11. It is difficult to judge the extent to which the UK has succeeded in encouraging the Commission to address under-funding of HIV and AIDS, as central funding is not tracked by sector. It is reported that the proportion of EDF funds allocated to HIV and AIDS has increased, although it has not been possible to verify these figures. Information about the proportion of other EC funding modalities spent on HIV and AIDS is not generally available[35]. However, there are encouraging signs. In December 2006, the European Council approved The EU and Africa:

[34] There are some concerns that the UK is too focused on the contribution of others, particularly multilaterals, and not enough on steps it needs to take within its own systems, incentives and communications to promote alignment and harmonisation (see section 10.8, p130, 2nd bullet)

[35] On the basis of unpublished and published information from the European Commission, DFID has calculated the amount it thinks the EC is spending on HIV and AIDS, and the UK's contribution to this – see footnote 21.

Towards a Strategic Partnership (EU, 2005), which states that the EU will provide robust financial and technical support to African countries in their efforts to confront HIV, AIDS, malaria and tuberculosis and notes that EU countries are likely to provide more than 65% in 2007 of the Global Fund's total contributions.

3.22 There has been good progress on efforts to improve monitoring of multilateral effectiveness. More recent ISs have also had a stronger focus on performance benchmarks, monitoring and evaluation (DFID, 2005b). DFID assesses multilateral performance, together with other donors, through Multilateral Organisation Performance Network (MOPAN) surveys and through its own Multilateral Effectiveness Framework (MEFF). In addition, to provide information about outcomes, DFID is conducting a series of separate multilateral effectiveness reviews. None of these approaches, however, assess performance in specific sectors or in areas such as HIV and AIDS[36]. Sector performance is monitored through DFID representation on the Executive Boards of multilaterals. DFID has also initiated a series of thematic case studies, although the HIV and AIDS 'sector' has not yet been covered by these studies (DFID, 2006w). More details of work looking at relative comparative advantage of the Global Fund and the World Bank is presented in Annex 5 (see Example 6, pA79).

3.23 UK support for multilateral and bilateral harmonisation, the Paris Declaration on Aid Effectiveness and the Three Ones has contributed to progress on improving the international response to HIV and AIDS. Specific support has been provided to enable UNAIDS to monitor roll out of the Three Ones and to develop indicators and systems of reporting linked to UNGASS targets. UNAIDS, in its 2006 report on the global epidemic, states that '90% of reporting countries now have a national AIDS strategy, 85% have a single national body to coordinate AIDS efforts, and 50% have a national monitoring and evaluation framework and plan' (UNAIDS, 2006). Other examples of activities in country to promote harmonisation are provided in Annex 5 (see Example 2, pA74).

3.24 The UK played a key role in support for the Global Task Team, established to strengthen coordination and harmonisation around HIV and AIDS (GTT, 2005) and has taken the lead among bilateral donors in advocating for funding harmonised UN country programmes, based on an agreed division of labour. The UK is also a strong supporter of longer-term UN reform and DFID's UNCD works closely with HMT on the UN Secretary General's Panel on System Wide Coherence. Proposals for UN reform will be considered by the UN General Assembly and taken forward in eight pilot countries in 2007.

3.25 DFID country offices have received a strong steer that only unified UN programmes that respond to a country's needs should be funded. However, there are practical barriers to more joint UN working[37] and this evaluation found that, while some DFID country offices are funding or planning to fund joint UN programmes, there has been an increase in support to individual UN agencies as

[36] Except in the case of UNAIDS because all its work is focused on HIV and AIDS

[37] Including incompatible financial systems and unstandardised overhead costs

implementing partners in recent years (SSS, 2006a; see Annex 5, Example 7, pA79).

3.26 There has also been good progress towards the Fourth One[38]. DFID has been instrumental in leading the move towards pooled funding for HIV and AIDS. Examples highlighted by country case studies include pooled funding for the national HIV and AIDS plan in India and for social marketing in Ethiopia. Other examples include the development, together with other donors, of a pooled funding arrangement for civil society organisations in Uganda, and DFID support for the multi-donor pooled fund for the joint programme for HIV and AIDS in Burma.

3.27 Commitments to increase funding for UN agencies to coordinate the response to HIV and AIDS in middle-income countries and to fund low-income countries where the UK does not or will not have a bilateral presence have been taken forward. The UK has, for example, increased funding for UNAIDS in Russia and China (see Annex 5, Example 8, pA79) and, in Sudan, is funding a recently established joint donor office.

3.28 DFID has been a strong advocate of increasing support for fragile states[39] (DFID, 2006e) and has also taken forward the commitment in *Taking Action* to fund UNAIDS to coordinate a strengthened national response, build national capacity and monitor the response in post-conflict countries, strengthening UNAIDS' capacity in Angola, DRC, Ethiopia, Somalia and Sudan.

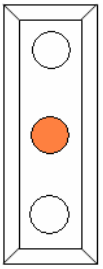
3.29 Another important commitment in *Taking Action* was to take steps at international level to improve access to medicines. There was considerable action in 2004 and 2005, including publication of a Cross-Whitehall paper (DFID et al., 2005), setting out UK support for differential pricing and a commitment to innovative incentives in the form of research tax credits and to work with the EU and WTO member states to ensure developing countries were given the necessary flexibilities in the TRIPS agreement. The UK has also been active in seeking to ensure access to reproductive health supplies (see section 5.19, p47). The issue of access to medicines had a lower profile in the first half of 2006,

[38] This refers to the Three Ones principles for effective national AIDS responses. The Three Ones are one national coordinating authority for HIV and AIDS, one national strategic action framework for HIV and AIDS and one national HIV and AIDS M&E system. The fourth one would be along the lines of one harmonised/pooled funding mechanism for HIV and AIDS. However, it is unclear how this would fit with other harmonisation agendas, e.g. pooled funding mechanisms for the health sector. In addition, there may be different understandings of how a fourth one might be implied in practice. For example, very different aid instruments, e.g. PRBS, sectoral budget support and pooled funding to a NAC could all be seen as applications of the fourth one principle. In addition, some people may see the fourth one as broader than HIV and AIDS. For example, one DFID staff member used this term to refer to pooled funding for all UN activities in a particular country. This may reflect confusion with the Four Ones of UN reform, which are one UN country team led by a Resident Coordinator, one UN country plan, one UN office sharing common services and one pooled consolidated UN budget.

[39] DFID defines fragile states as those 'where the government cannot or will not deliver core functions to the majority of its people, including the poor' (DFID, 2005j). Core functions include territorial control, safety and security, management of public resources, delivery of basic services and the ability to protect and support the ways in which the poorest people sustain themselves. DFID's list of fragile states includes three of the countries included as case studies in this evaluation – DRC, Ethiopia and Zimbabwe.

following the shift in responsibility within DFID from a dedicated Access to Medicines team to the Global Health Partnerships team and the departure of key staff. This also resulted in the Cross-Whitehall access to medicines group being less active. DFID staff have taken steps to address this including the establishment of an Access to Medicines hub in mid-2006. The Cross-Whitehall group on access to medicines has met twice in recent months to discuss issues related to research and development, innovative financing, medicines pricing transparency, intellectual property, and the work of the Intergovernmental Working Group set up to take forward the recommendations of the 2006 report of the Commission on Intellectual Property, Innovation and Public Health (CIPIH, 2006).

Priority Action 4: Supporting Better National Programmes



3.30 *Taking Action* states that the UK will prioritise comprehensive, integrated programmes that prevent, treat, care and mitigate the impact of AIDS; address the needs and rights of women, young people, including orphans, marginalised and vulnerable groups; strengthen health systems in the face of 'vertical' treatment programmes; support marginalised communities, human rights and address stigma and discrimination; fill funding gaps; and strengthen national planning. For examples of these, see Annex 5 (for the health sector, see Example 10, pA81; the education sector, see Example 11, pA81; and food security, see Example 12, pA81).

3.31 Although DFID has been a strong supporter of comprehensive national responses to HIV and AIDS and is viewed in country as a flexible and responsive donor, it is difficult to assess the level of support for specific activities outlined above (see 3.30), due to the way in which DFID provides funding, e.g. through budget support, and manages information. Consequently, there is insufficient evidence to determine whether or not progress is being made towards many of the specific commitments under this priority action.

3.32 There has been progress in strengthening national planning. Support for national planning, coordination and monitoring is a key element of DFID Country Assistance Plans (CAPs). DFID has spearheaded budget support and efforts to strengthen national planning and resource allocation processes. DFID offices, e.g. in Malawi and Zambia, have played an active role in mainstreaming HIV and AIDS into Poverty Reduction Strategies (PRSs) and building the capacity of National AIDS Councils (NACs). Analysis conducted for this evaluation (SSS, 2006) shows that DFID financial support for NACs increased threefold from 2003/4 to 2005/6 (Figure 13, p30)[40]. DFID's emphasis on building long-term national capacity and on funding through budget support does, however, result in a perception that the UK is less focused on immediate HIV and AIDS needs than some other donors.

3.33 On the commitment to support effective national treatment and care activities, DFID country offices have played an important role in promoting access to treatment, especially for vulnerable groups. In China, DFID has funded innovative projects to improve access for hard-to-reach populations and has

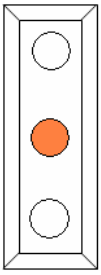
[40] Figures for 2005/6 only to February

successfully advocated for access to treatment for these populations through policy dialogue with government (see Annex 5, Example 13, pA82). Both *Taking Action* and the HIV Treatment and Care Policy (DFID, 2004b) are reported to have increased DFID country office focus on treatment issues. Wider constraints include cost of drugs and diagnostics, inadequate health systems[41] and weak logistical and supply systems. The UK is a donor for UNITAID[42] and has taken a strong stance on drug pricing issues. The UK has also given high priority to strengthening health systems and human resources for health[43]. There is less evidence of UK support for initiatives to strengthen supply chain management[44].

3.34 Until recently, international advocacy around scaling up has largely concentrated on access to treatment. The 'universal access' agenda also means scaling up prevention and care[45]. The UK co-chaired with UNAIDS the Global Steering Committee on scaling up towards 'universal access' and provided funding for regional and national consultations to develop national plans for achieving this. However, it is too early to judge the extent to which DFID has assisted individual governments to identify and tackle constraints to prevention and care access.

3.35 The UK has taken a number of important steps to tackle human resource shortages in developing countries including through its Code of Practice on the international recruitment of healthcare workers (DH, 2004) and, more recently, the establishment of the Inter Ministerial Group on Health Capacity in Developing Countries. DFID is also assisting national governments to develop short-term solutions to address current shortage of health personnel and to strengthen long-term human resource planning and management, for example in Malawi and Zambia (see Annex 5, Example 15, pA84).

Priority Action 5: Taking Action in the Long-Term



3.36 The UK, led by HMT, has championed long-term, predicable financing and the International Finance Facility (IFF). DFID and the FCO have played a critical role in advocating for the IFF with other donors and governments. The UK has made a commitment to contribute $1.4 billion over the next 20 years to the pilot IFF for childhood immunisation (IFFm), launched at the G8 in September 2005.

3.37 Overall progress with the IFF has been slower than anticipated and efforts to take forward this commitment appear to have been superseded by subsequent developments, including the increase in G8 aid commitments. However, while increased aid commitments will provide extra resources, these may not necessarily improve long-term, predictable financing. To address this, the UK

[41] In particular shortages of health care workers, see section 3.35

[42] See section 3.38

[43] See section 3.35

[44] This may be considered an example of good prioritisation as supply chain management is not considered an area in which the UK has a comparative advantage

[45] Country examples of successes and challenges in scaling up are presented in Annex 5, Example 14, pA84.

has made a commitment in the 2006 DFID White Paper (DFID, 2006e) to provide long-term predictable funding to developing countries through ten-year Development Partnership Agreements (DPAs). DFID expects to put in place a significant number of DPAs over the next 12 months.

3.38 The UK recently announced a 20-year commitment to UNITAID (DFID, 2006x), starting with £15 million in 2007 and, subject to performance, rising to £40 million a year by 2010. This international drug purchase facility, established in September 2006 and also supported by France, Norway, Brazil and Chile, aims to distribute essential HIV/AIDS, TB and malaria medicines at low prices to the poorest countries. Initially, UNITAID will fund antiretroviral drugs for paediatric treatment and for second-line treatment of adults. Effective coordination between existing financing mechanisms, UNITAID and other long-term financing mechanisms will be critical.

3.39 The UK has also supported long-term action on HIV and AIDS through research, funded by DFID, centrally and at country level, and by the Department of Health[46]. Although DFID's spending figures are not disaggregated to show spending on research, DFID's Central Research Department (CRD) reported spending on HIV/AIDS-related research[47] in 2005/6 of just over £20 million, of which £8 million was for HIV vaccine research and £7.1 million for microbicides research. Early UK support for vaccine and microbicide research helped to leverage additional funding from other sources. In 2006, CRD commissioned two HIV/AIDS research programme consortia to conduct research on HIV and AIDS treatment and care services and the social context of HIV and AIDS respectively. Total funding for these is £7.5 million over 5 years. In addition, DFID supports a number of other research programme consortia which include elements of HIV and AIDS in their work, for example on sexual and reproductive health rights and sexually transmitted infections. There is currently no mechanism to track funding for research through DIFD country offices. Respondents to this evaluation also commented that more could be done to strengthen links between research and policy, ensure research reflects country priorities, and communicate and disseminate research findings more effectively.

3.40 DFID figures on UK spending on HIV and AIDS do not include money spent by other UK Government departments on AIDS research. The Department of Health reports that it allocates £1 million a year to the Medical Research Council (MRC) for a joint research programme on sexual health and HIV. Additionally the MRC commissions its own research on sexual health and HIV worth approximately £12 million a year.

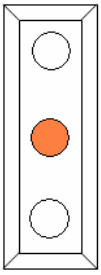
3.41 Challenges to progress overall on AIDS research include the funding gap for vaccine and microbicides research, despite the increase in global investment (HIV Vaccines and Microbicides Resource Tracking Working Group, 2006), and the lack of comprehensive information about funding for other HIV/AIDS-

[46] Commitments to the types of research to be supported through *Taking Action* are briefly summarised in Annex 5 (Example 16, p85).

[47] Health and education projects only

related research. Currently UNAIDS only tracks funding for vaccine and microbicides research.

Priority Action 6: Translating Strategy into Action



3.42 Commitments under this priority action relate to implementation and monitoring of *Taking Action* by the UK Government. *Taking Action* has resulted in a higher profile for HIV and AIDS across the UK Government and within DFID. Officials in other government departments view the Cross-Whitehall coherence group (see section 12.20, p157), which meets twice a year, as a useful forum for sharing information and promoting joint action. It is, however, difficult to comment on progress in implementing the strategy across the UK Government, because the roles and responsibilities of other government departments in delivering the strategy are not clearly specified in *Taking Action.* In addition, their HIV and AIDS activities are not tracked or do not lend themselves to measurement.

3.43 A major challenge in assessing progress towards commitments in *Taking Action* is the absence of an agreed monitoring and evaluation framework. The evaluation found no evidence to indicate that the Cross-Whitehall coherence group has taken steps to monitor implementation of *Taking Action* across all departments. Monitoring is seen as DFID's role, as the lead department. However, there is no evidence of a DFID-wide approach to overall monitoring of progress with *Taking Action.* A monitoring and evaluation framework is proposed in in Chapter 9 of this report (see p119).

3.44 DFID has given financial support to international efforts, under the leadership of UNAIDS, to harmonise and strengthen monitoring and evaluation activities. Policy dialogue on this issue has been limited to participation in meetings of the UNAIDS MERG, although the UK played a key role in the Global Steering Committee that identified core and recommended indicators for measuring progress towards 'universal access'. It is not clear where responsibility for this area resides within DFID. Currently the GAP team is taking the lead, although whether this will continue to be the case is uncertain. International Division and Evaluation Department staff have also been involved previously.

3.45 DFID has stepped up efforts to support countries to improve national systems for monitoring and evaluation (M&E) of the response to HIV and AIDS, one of the commitments in *Taking Action* and an essential component of the Three Ones. This evaluation found that DFID is increasingly supporting projects/programmes which strengthen national M&E capacity in three areas – poverty reduction, health and HIV/AIDS (Figure 17, p33). However, M&E spend remains relatively low, accounting for around 1% of UK expenditure on HIV and AIDS in 2005/6 (see section 4.15, p34).