11. Lessons Learned – Managing Tensions between Central AIDS Targets and Country-Led Approaches

In Brief

Question: How are the potential tensions between top-down AIDS targets and a flexible country-led approach being managed? What are the lessons (a) for future UK AIDS strategy (b) for other UK development strategies?

The AIDS spending target is a central feature of *Taking Action* as a strategy. However, the method used to determine the level of this is not clearly documented. A new method to track progress towards this was agreed in early 2007. There are a number of tensions between this spending target and other centrally-determined strategies, on the one hand, and country-led approaches, on the other. These have been effectively managed to date as UK spending and activities on HIV and AIDS are broadly in line with countries' priorities and burdens of disease. However, these tensions may become more evident as pressure mounts to raise spending on HIV and AIDS by 30% per year in order to meet the spending target.

The main value of spending targets is to ensure that adequate levels of funds are available for a particular issue. They also serve to raise the profile of a particular issue and give a strategy traction within a government bureaucracy. Drawbacks of spending targets are both conceptual and practical. They may be seen as contrary to the UK's commitment to country-led approaches to development and risk seeing the UK's financial contribution to national responses to HIV and AIDS in isolation from other donors.

Based on experience from country case studies conducted for this evaluation, most tensions appear to have occurred in countries with well-developed country-led approaches, e.g. Ethiopia and Zambia. These appear to have been well-managed to date, but it is likely that these will become more marked if levels of spending are to rise in the next two years in line with the requirements of the spending target.

There is no evidence yet that limitations in absorptive capacity have affected the UK's ability to meet this spending target. However, there are concerns in countries visited about different aspects of absorptive capacity, e.g. inadequate human resources in Zambia and the ability of UN agencies to handle increases in funding in Zimbabwe. These concerns are particularly significant when considering increased levels of international funding for AIDS overall and not the UK's contribution in isolation.

UK Spending Target on HIV and AIDS

11.1 As part of its commitment to 'closing the funding gap' *Taking Action* committed the UK government to spending £1.5 billion on HIV and AIDS over three years[241], of which £150 million would be spent on programmes to meet the

[241] From 2005/6 to 2007/8

needs of orphans and other children, particularly in Africa, made vulnerable by HIV and AIDS[242] (DFID, 2004a).

11.2 The principles underlying *Taking Action* and its spending target were described in a memo to DFID's Development Committee in May 2004 (Schultz, 2004). This stated that the spending target would be set at a level which continued the annual rate of increase of bilateral spending on HIV and AIDS from 1999/2000, which was cited as 30-50%. However, although the memo contained figures for HIV/AIDS spending for the period from 1997/8 to 2003/4[243,244], it did not use these to derive figures for the spending target. It appears that this was done later. The evaluation team has been unable to obtain documented evidence of these calculations. This absence of a clearly documented basis for calculating the level of the spending target is a major weakness, and has hampered efforts to monitor progress towards achieving the target. The methods that DFID used to track HIV/AIDS spending at the time of adopting *Taking Action* have since been challenged (Janjua, 2003; NAO, 2004; Daly, 2005; ActionAid, 2005; International Development Committee, 2005; DFID, 2005b; Benn, 2005) and recently revised (Benn, 2007).

11.3 There have been many attempts to define how the AIDS spending target is to be tracked. These have recently been concluded (see section 3.5 and Table 2, p10). Challenges faced are not unique to the UK Government but also affect others seeking to track spending on HIV and AIDS. They include how to deal with:

- Poverty reduction budget support (PRBS)
- Activities that have a significant but not principal focus on HIV and AIDS
- Spending on activities with a principal or significant focus on sexual and reproductive health
- Programme partnership agreements (PPAs) which provide strategic funding to NGOs
- Core funding to multilateral organisations whose work is not exclusively focused on HIV and AIDS
- The need for a system to provide accurate information whilst being simple to administer
- Spending by government departments other than DFID (see Table 2, p10)

[242] There were a number of other financial commitments to particular agencies, including the Global Fund, UNAIDS and UNFPA (SSS, 2006a, section 3.1)

[243] Calculations contained in this memo (p11) show that spending on HIV and AIDS was being identified through the use of PIMS markers for HIV and reproductive health on DFID's information system, PRISM. Bilateral spending was taken as 100% of all spending with such a marker, regardless of whether it was a P (principal) or S (significant) marker. Budget and sectoral support and PPAs were treated the same way as other projects/programmes, although separate totals were shown with and without general budget support. This approach was consistent with the method being used at that time, but is no longer consistent with the method being used (seeTable 2, p10). This means that the spending target was set using one method but is now being tracked with a different method. The new method, in general, gives lower figures for the UK's spending on HIV and AIDS than the old method (see Figure 2, p11).

[244] Provisional figures for 2003/4

Tensions between Top-Down AIDS Targets and Flexible Country-Led Approaches

11.4 There is a potential tension between central spending targets[245] and a commitment to country-led approaches[246]. This is perhaps most clearly seen in financial decision making where commitment to central spending targets might require funds to be spent in one way while a country-based needs assessment might draw different conclusions. However, as the analysis in other parts of this report shows (see sections 4.17 to 4.20, from p35 and section 5.12, p44), UK bilateral spending on HIV and AIDS is largely consistent with the burden of disease in countries, and decisions about resource allocation have been consistent with country plans and needs.

11.5 This tension is not unique to spending targets. It is seen in terms of any central policy or strategy. For example, DFID's Corporate Performance Framework faces the same tensions (OECD DAC, 2006). Table 20 (p144) seeks to outline in more detail the tensions that can arise between central targets and country-led approaches.

11.6 Nor are these tensions unique to the UK. Similar tensions are also faced by the Global Fund and have been extensively documented (Radelet, 2004; Caines, 2005). Other institutions and initiatives facing these tensions include: CIDA (Lavergne and Alba, 2003); the World Bank's Comprehensive Development Framework[247] (World Bank, 2003); and the 3 by 5 initiative[248] (DFID, 2005g).

[245] Particularly as they multiply

[246] See section 6.2, p56 for more discussion of country-led approaches

[247] These issues are quite extensively explored in this document because the comprehensive development framework was based on four principles – long-term and holistic vision; country ownership; results orientation; and country-led partnerships. The evaluation explored complementarity and tensions between these principles.

[248] Criticisms of the central global target in '3 by 5' were influential in the current push for 'universal access' not having any central global target rather emphasising the need for country-led approaches.

Table 20. Tensions between Central Targets and Country-Led Approaches[249]

Issue	Central Targets	County-Led Approach
Time Frame	Short; emphasis on urgent delivery; sees AIDS as an emergency situation	Long-term view with strong focus on systems for sustained delivery of services
Capacity Development	Secondary emphasis; means to deliver results	Central focus
Ends or Means	Ends, i.e. results matter. How they are achieved is of less importance	Means, i.e. processes matter as much as results. Strong emphasis on using country systems and harmonising with other donors
Accountability	Largely financial, i.e. to providers of funds, e.g. tax payers in donor countries	Strong value of country ownership, i.e. accountable to people of the country through elected government
Reporting	Probably heavy and donor-specific	Lighter, integrated into national systems and harmonised with other donors
Quality Standards	Derived from international best practice, e.g. through technical assistance	Derived from participation of and consultation with national stakeholders

Pros and Cons of Spending Targets

11.7 The question of pros and cons of spending targets can be considered in two ways. First, it can be considered specifically in relation to a spending target on HIV and AIDS[250]. Second, it can be broadened to spending targets more generally. Table 21 (p145) summarises the possible pros and cons of central spending targets.

11.8 The main imperative for the spending target in *Taking Action* was the high public and political priority placed on HIV and AIDS in international development. Reasons for this include the scale and impact of the epidemic[251], the need for the international response to be urgently and significantly expanded, and the track record of many national governments in failing to respond promptly and adequately[252].

[249] Based on work relating specifically to the Global Fund

[250] This approach may also touch on the pros and cons of *Taking Action* as an overall strategy.

[251] Particularly in parts of Sub-Saharan Africa

[252] This has occurred in both countries with generalised epidemics and those with concentrated epidemics. A particular problem in concentrated epidemics is that those disproportionately affected are the most marginalised groups, such as injecting drug users, sex workers and men who have sex with men. In many countries, responding to an epidemic mainly affecting these sub-populations is not a public or political priority because of widespread stigmatising attitudes towards members of these groups.

Table 21. Possible Pros and Cons of Central Spending Targets

Pros	Cons
Mechanism for giving a priority issue higher public and political profile Potential to strengthen political and public financial accountability of UK Government departments, in general, and DFID, in particular AIDS spending target has resulted in a higher profile for HIV and AIDS within government departments, in general, and within DFID, in particular As part of the overall strategy can act as a 'yardstick' for assessing priority given to HIV and AIDS by parts of the UK Government, e.g. DFID country offices Having a spending target has the potential to give 'bite' to efforts to mainstream a priority issue into projects/programmes in other sectors, i.e. in the case of HIV and AIDS, beyond the health sector A spending target may be a counter-weight to other policies. For example, it has been possible to fund activities on HIV and AIDS in parts of Europe, Middle East and the Americas because of the spending target, in spite of DFID's '90/10 rule'[253] Having a spending target to report against has raised the profile of information systems, in general, within DFID, and specifically the Policy Information Marker System (PIMS[190(p115)])	Seen as a supply driven, one-size fits all approach Promoting 'AIDS exceptionalism' which may have adverse effects on attention given to other issues Central spending targets run counter to DFID's way of working which prioritises country-led approaches. They risk promoting 'vertical' programmes and undermining use of aid instruments such as PRBS and sectoral support. There are concerns that spending targets are unduly focused on identifying UK contributions[254] Availability of funds for HIV and AIDS may drive programme development rather than need Risk of considering UK funding in isolation without consideration of international and country context Concerns over process for adopting the spending target (see section 11.2, p142), i.e. it was done quickly with less consultation than desired by some DFID staff. There are also concerns over the way it is being used and additional work involved in reporting against the target Level at which target is set may be problematic. If it is too high, it may be unrealistic. If it is too low, it risks encouraging a minimalist approach The breadth or narrowness of a spending target may affect spending patterns, e.g. there are concerns that having an AIDS spending target may have diverted resources away from a broader focus on SRHR For the AIDS spending target, there was no clearly agreed and documented method for tracking it at the time it was introduced although this has now been addressed (see section 3.5, p10). DFID's information systems, e.g. PRISM and PIMS were not intended for this purpose and may not be up to the task

11.9 Having a spending target is one mechanism by which the UK Government can show that it is prioritising this issue[255]. It also seeks to quantify the Government's commitment financially and potentially provides an

[253] This is derived from target 6 in DFID's Public Service Agreement which states that 'the proportion of DFID's bilateral programme going to low-income countries is at least 90%' (DFID, undated).

[254] Sometimes referred to as 'flag-planting' and/or 'branding'

[255] Although this will be less the case as the number of other spending targets increases

accountability mechanism for this[256]. The spending target has raised the profile of HIV and AIDS within the UK Government, as a whole, and particularly within DFID. As part of the strategy, it provides a mechanism by which the relative priority given to HIV and AIDS by different parts of the UK Government, including DFID, can be assessed[257]. A spending target gives some 'bite' to a strategy that it would otherwise lack. This could potentially drive mainstreaming of HIV and AIDS issues into sectors beyond health and allow specific support to be provided on this issue in lower middle income countries[258]. Finally, having a spending target has raised the profile of information systems within DFID. Tracking progress against a spending target requires a good information system and for it to be used competently and consistently.

11.10 However, there are both conceptual and practical problems with spending targets. Conceptually, central spending targets run counter to the UK's commitment to country-led approaches, do not fit into DFID's current business model (CSG, 2004)[259], risk viewing UK contributions in isolation from those of other donors and diverting funds from other areas of development. In practice, the latter does not appear to have occurred, possibly due to the increase in DFID's overall budget[260].

11.11 Practical problems with spending targets can be grouped into four main categories:

- *Process* – concerns over the rapid introduction of the AIDS spending target and the limited consultation process with DFID staff (see section 11.2, p142).
- *Level* – if the spending target is set too high, it risks being unrealistic and/or creating significant spending distortions in efforts to meet it. If set too low, it risks changing nothing because it can be met through 'business as usual'.
- *Method* – the method to be used to track progress towards a spending target needs to be agreed and documented before the target is set. If this is not done, there is a risk that any proposed method will be evaluated in terms of the results it gives in relation to the spending target[261].

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[256] Although currently, there are considerable limitations on this which are discussed in the section on 'cons'

[257] Although it would be easier to do this if *Taking Action* had a monitoring and evaluation framework. This approach is also not universally welcomed within DFID as it runs counter to the current business model and the principles of country-led approaches to development.

[258] When other policies might suggest that such activities should not be supported

[259] This model is illustrated in Figure 23, p42. Under this model, DFID staff work towards the MDGs through their own Personal Development Plan/Performance Measurement Framework. This contributes, in turn to team/departmental objectives, which contribute to country assistance plans or institutional strategy papers. These then contribute towards Directors' plans for delivery and the Public Service Agreement. The AIDS spending target does not appear to fit into this scheme although it can be argued that *Taking Action* has influenced this model at different levels.

[260] There is a risk that this may happen as DFID strives to continue to increase AIDS spending by 30% per year to meet the spending target (see section 3.5, p10).

[261] This has certainly been problematic in terms of the AIDS spending target and may have contributed to the delay in finalizing the method for tracking this target (see section 3.5, p10)

- *Information systems* – DFID's current information systems were not designed for monitoring progress towards spending targets and are not really suited for this purpose. If spending targets become a regular part of DFID's work, information systems need to be established and utilised to make it possible to accurately track progress towards these targets.

Experience of Managing these Tensions

11.12 These tensions have not been experienced yet because the strategy is in its early stages and the method for tracking AIDS spending has recently been agreed (see section 3.5, p10). Before this, it appeared that the spending target was on track. Under the new method, the UK will need to increase HIV and AIDS spending by 30% per year if the target is to be met. Tensions between meeting this challenging rate of increase and maintaining the UK's commitment to country-led approaches are likely to increase as the deadline for reaching the target nears.

11.13 Nevertheless, there is some early experience of managing the tensions in country offices and in other parts of DFID. Table 22 presents experience of these tensions for each of the countries visited for the purpose of this evaluation. It appears that tensions are most keenly felt where there are well-developed country-led approaches, e.g. Zambia and Ethiopia and least keenly felt where these are not well-developed, e.g. DRC and Zimbabwe.

Table 22. Managing Tensions between Central AIDS Targets and Country-Led Approaches: Experience from Country Case Studies

Country	Comment
China	No specific tensions were identified. DFID selected elements from *Taking Action* which fitted an understanding of priorities shared with the Chinese Government. This allowed the provision of critical support to innovative approaches among those most vulnerable to HIV infection in China, particularly injecting drug users.
DRC	No specific tensions were identified. This is largely because of extremely limited government capacity in DRC. As a result, it is not really appropriate to think of a country-led approach in such a fragile state. Major donors agree that HIV and AIDS are one of the main priorities in the country.
Ethiopia	Tensions have been keenly felt by DFID Ethiopia and relate both to the targets themselves and the methods to calculate them. Based on country context (including epidemiological situation, availability of other sources of HIV funding and national absorptive capacity), DFID Ethiopia decided not to provide specific AIDS funding but to focus support on other areas, such as building coordination capacity and health systems strengthening. There is a fear that pressure to meet the central spending target could undermine that decision although this has not yet happened. There are also tensions because of the method used to track both AIDS and OVC spending target[262].

[262] Previously, UK supported Ethiopia through PRBS but now funds Protection of Basic Services (PBS). In 2005/6, DFID Ethiopia estimated that its spending on HIV and AIDS was around £3m, based on allocating 5% of PRBS to AIDS spending. This rose to around £30m in 2006/7 because of counting 50% of funding through PBS. This gives the impression of a ten-fold increase in AIDS funding although the content of the programme had changed relatively little. This risks creating perverse incentives for using particular aid instruments (for more detail see summary of Ethiopia country case study, pA23). Although PSNP appeared in *Taking Action* as a way of supporting OVC, funding for this does not count towards that spending target as it has no PIMS marker for HIV/AIDS nor a sector code for OVC. Allocating it a PIMS marker for HIV/AIDS would mean that 50% of its spending would count towards the overall AIDS spending target.

Country	Comment
India	There is a tension between DFID's approach in India and the spending target on OVC because the latter is seen as a sub-set of HIV spend. This is not appropriate for India where very few of the many orphans and vulnerable children are as a result of HIV and AIDS.
Russia	No specific tensions were identified related to the AIDS spending target. However, there have been acute tensions between country priorities on HIV and AIDS, e.g. focused prevention among vulnerable populations and reducing UK aid for Russia in preparation for closure of DFID's country office in 2007.
Zambia	There are concerns that central spending targets undermine the UK's commitment to country-led approaches particularly as targets multiply. Because of the very high HIV prevalence, all DFID-funded activities have significant AIDS impact. However, staff were reluctant to give all activities an S PIMS marker for HIV[263]. 5% of Zambia's PRBS funding counts towards the AIDS target, even though UK does not fund AIDS in this way. If the UK's AIDS funding went through PRBS, the current method would report a reduction in AIDS spending even if spending levels remain unchanged. Support for OVC initiatives, e.g. through the STARZ programme do not contribute to the OVC spending target because levels of financing are neither fixed nor known, so the allocation of a weighted sector code for OVC is not possible.
Zimbabwe	No specific tensions were identified. Indeed, *Taking Action* fits well with UK commitment to provide humanitarian assistance to the Zimbabwean population and priorities identified within the country's strategic plan on HIV and AIDS.

11.14 Some of the tensions have been handled by regional directorates without passing these on to country offices. This has involved different approaches in different directorates. For example, within DFID's Africa Directorate, to date it has been largely possible to meet the regional spending target without changing funding decisions. This was because DFID was already supporting a large number of activities with a principal or significant focus on HIV and AIDS. The tension has, therefore, been managed by using country-level considerations for decision-making purposes and the central targets simply for reporting back and accountability. It seems unlikely that this would be possible in the remaining years of the strategy if the spending target is to be met.

11.15 On the other hand, in Europe, Middle East and the Americas, new projects/programmes have been funded that have a focus on HIV and AIDS. It appears that it was only possible to fund these activities because of these spending targets. To date, these decisions have fitted well with national/regional priorities and the main tension has been between the AIDS spending target and the '90/10 rule' (see Box 2, p41).

Absorptive Capacity[264]

11.16 Although there were some concerns expressed about absorptive capacity in countries visited for this evaluation (see Box 34 p148), there is no evidence that these factors have yet affected the UK's ability to disburse or use the funds that are needed to meet the AIDS spending target in *Taking Action.*

[263] Because under the old method this would have resulted in 100% of spend being counted to the AIDS target. This would only be 50% under the new method (see section 3.5, p10).

[264] The term absorptive capacity is used to cover a wide range of areas including macroeconomic effects of increased external aid flows (ODI, 2005); suppression of national capacities because of increasing dependency; and inability to spend effectively the funds provided.

Box 34 Issues Affecting Absorptive Capacity: Examples from Case Study Countries

In **Zambia** the severe human resources for health crises (see Box 27, p129) is likely to adversely affect the country's ability to use additional resources for the national response to HIV and AIDS.

In **Zimbabwe** donors are increasingly channelling funds through UN agencies because of constraints on providing money to the Zimbabwean Government. It is unclear if all these agencies have the capacity to absorb this level of resources.

In **Ethiopia** there has been a massive influx of financial resources for the national response to HIV and AIDS, particularly from PEPFAR and the Global Fund. Utilisation of these resources by EMSAP and HAPCO has been slower than planned.

11.17 However, UK funding can not be considered in isolation. There are widespread concerns that recent massive increases in funding for national responses to HIV and AIDS, particularly from the World Bank, the Global Fund and PEPFAR, will not be able to be fully utilised because of problems with absorptive capacity.

11.18 It is concerns about the ability to use funds received that is the focus of much discussion of absorptive capacity. It can result in slow disbursement and/or misuse of funds. Causes include an inadequate institutional and policy environment, and limited technical and management capacity, e.g. due to inadequate human resources (ODI, 2005). However, although there are many anecdotes, there is little systematic evidence of a problem with new AIDS financing. Neither the World Bank MAP nor PEPFAR publish figures of disbursement rates so that what evidence there is is largely drawn from experience of the Global Fund (Bernstein and Sessions, 2007). Analysis of use of their funds showed that disbursement rates were higher:

- In politically stable countries
- In low income countries
- In countries with poor health systems
- Where the Principal Recipient was from the private sector (both for-profit and not-for-profit) or a multilateral agency (Lu et al., 2006)

11.19 A recent study (Bernstein and Sessions, 2007) examined Global Fund experience in two countries, Ethiopia and Uganda[265]. In both, disbursement of funds was slower than expected. In Ethiopia, this appears to have been a temporary problem which has now been addressed[266]. In Uganda, there were not only severe implementation delays but there was also reported to be 'serious mismanagement' of funds resulting in suspension of the grant[267].

[265] These are interim findings and further results are expected, also from Mozambique and Zambia.

[266] HAPCO had planned to spend $21.3 million within six months of the grant starting but only managed to spend $6 million in the first nine months. However, at 18 months, they had spent $34.4 million of a planned $40.4 million.

[267] Although the grant has now resumed

11.20 Although this might seem to be evidence of limited absorptive capacity in developing countries, there are those who believe this to be a 'myth' (Moghalu and Mbikusilu-Lewanika, 2003) promoted by donor agencies. 'International organisations like to use the absorptive capacity excuse, but in truth many of them are misinterpreting the term…" (Utan, 2005). They argue that the problems arise largely because of ways in which aid is provided in a fragmented and unpredictable way including with different disbursement procedures and financial years; with bureaucratic procurement requirements; with requirements for the establishment of new structures; and with highly centralised ways of working. All these factors contribute to high transaction costs.

11.21 A range of solutions have been proposed to the problems of absorptive capacity. These fall into two main groups. First, there are those, e.g. PEPFAR and the Global Fund who argue that the limitations are largely due to an excessive and exclusive focus on government capacity. They advocate greater use of non-state actors, e.g. outsourcing procurement through UNICEF in Ethiopia and M&E through a consultancy in Uganda (Bernstein and Sessions, 2007). Although PEPFAR has not produced evidence to support this approach, evidence from Global Fund experience suggests that non-state actors acting as Principal Recipients are able to disburse funds more rapidly than government agencies (Lu et al., 2006). However, there are also concerns about the absorptive capacity of civil society organisations (Chesnais et al., 2005).

11.22 Second there are those, including DFID, who argue that a key way to reduce problems due to absorptive capacity would be to increase aid effectiveness by implementing the principles of the Paris Declaration. These include greater harmonisation of donor efforts and increasing alignment with national priorities.

Lessons Learned

11.23 The following lessons have been learned from the experience of the AIDS spending target. These apply not only to future AIDS strategies and spending targets but also to other areas of development:

- Any spending targets should be introduced in a coherent way as part of DFID's overall planning process, including a detailed process of consultation with staff and other stakeholders. There needs to be clarity as to how the spending targets relate to each other.
- Any spending targets that are agreed need to be institutionalised into DFID's business model, in particular the Public Service Agreement, Directors' Delivery Plans and Country Assistance Plans[268].
- The method for measuring progress towards the spending target needs to be agreed before it is introduced and the target level set. Decisions over methods should take into account good practice internationally, and, in complex areas, such as HIV and AIDS, would benefit from consultation with key players[269].

[268] This also applies to Regional Assistance Plans and Institutional Strategies where appropriate.

[269] Such as NAO, UNAIDS and major NGOs working in this field

- Information systems need to be in place, and used consistently, to allow progress to spending targets to be accurately tracked.