report

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March 2007

INTERIM EVALUATION OF TAKING ACTION: THE UK GOVERNMENT'S STRATEGY FOR TACKLING HIV AND AIDS IN THE DEVELOPING WORLD

Measuring Success: Indicators and Approaches

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Preface

The UK Government's new AIDS strategy ('*Taking Action: the UK Government's strategy for Tackling HIV and AIDS in the Developing World'*)was launched by the Prime Minister in July 2004. The Department for International Development (DFID) is the lead government department for implementing *Taking Action*, working together with the Foreign and Commonwealth Office, the Department of Health and others. The Government has also committed significant funding for HIV and AIDS: at least £1.5 billion over 3 years, up from £270 million in 2002/3. The Secretary of State and Permanent Under Secretary of State for International Development are concerned to ensure systems are in place to measure the impact of the additional resources allocated.

DFID's Evaluation Department (EvD) commissioned an interim evaluation of Taking Action in 2006 to respond to these concerns, and to generate lessons which will enable the UK government to improve its effectiveness. The evaluation is being carried out by independent consultants, and is managed by Julia Compton, John Murray and Jane Gardner in EvD. Further information and publications on the evaluation, including the specific evaluation questions being addressed, the composition of the steering group and frequently asked questions, can be found at: www.dfid.gov.uk/aboutdfid/performance/evaluation-news.asp

I am happy to introduce this working paper on 'Measuring Success: Indicators and Approaches', which is the second of three working papers to be produced for the evaluation. The paper sets out a monitoring and evaluation framework for *Taking Action*, based on the public commitments made in the strategy. This lays the groundwork for a more systematic and detailed evaluation of *Taking Action*, planned for 2008/9. Roger Drew, the lead author, has done an excellent job in reviewing the many national and international indicators on AIDS and as well as proposing a practical group of these for the UK to track, has also highlighted the need for more international work on M&E to improve harmonisation and reduce duplication of effort (see Annex 6). DFID is currently considering the proposed framework with a view to adopting it for regular monitoring of progress against the strategy as well as for the final evaluation. This is part of a wider drive for increased accountability for central policy commitments.

We are grateful for the inputs provided to this paper by many people (see Acknowledgements), in particular the working group of DFID statisticians: Phil Cockerill, Elaine Drennan, Kerstin Hinds and Julia Bunting.

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The team was greatly assisted in preparing the first draft of this working paper by a number of DFID staff, including Julia Compton, John Murray, Jane Gardner, Phil Cockerill, Elaine Drennan, Kerstin Hinds, Julia Bunting, Robin Gorna, Clare Shakya, Daniel Davis, Delna Ghandhi, and Michael Borowitz.

A number of DFID staff provided initial feedback on an early draft at meetings of the Evaluation Steering Group held on 23rd and 31st August 2006 including Louisiana Lush, Julia Compton, Jane Gardner, Janet McDonald, Mike Battcock, Phil Cockerill, Andrew Rogerson, Jane Pepperall, Jenny Amery, Malcolm McNeil and Rachel Albone. Tamsin Rees of the Foreign and Commonwealth Office also attended this meeting and Sue Kinn provided written feedback. A meeting was also held on 23rd August 2006 to coordinate the development of indicators with other strategies, eg on health. This was attended by Julia Compton, Phil Cockerill, Delna Ghandhi, Julia Bunting and Tanya Cross.

A wide range of people provided comments on the draft document. These included DFID staff, including particularly Sandra MacDonagh of the Sexual and Reproductive Health Team; Katja Jobes of the Country Led Approaches and Results Team (CLEAR); and Kenny Osborne of Statistical Reporting and Support Group (SRSG). In addition, a number of DFID staff attended a working group meeting on 20th October 2006 to discuss possible tools for tracking qualitative elements of national AIDS responses and UK support to them. These included Rachel Albone, Kenny Osborne, Phil Cockerill, Ben David, Emma Fraser, Carolyn Sunners and Sandra MacDonagh. Jenny Amery provided comments on issues discussed later by telephone. Thanks are especially due to Paul de Lay, Jose Antonio Izazola-Licea and Lisa Regis of UNAIDS for their input on issues, in general, and resource tracking and research, in particular. The team are grateful to NGOs that provided written comments on the draft. These included International Planned Parenthood Federation, Marie Stopes International, Plan International, Target Tuberculosis and World Vision UK. The London School of Hygiene and Tropical Medicine provided joint comments with Marie Stopes International. All comments are included in annex 11 of this document. Thanks are also due to the members of the Orphans and Vulnerable Children (OVC) working group who provided comments on the draft report at their meeting held on 21st November 2006.

However, full responsibility for the text of this working paper rests with the authors.

In common with all evaluation reports commissioned by DFID's Evaluation Department, the views contained in this working paper do not necessarily represent those of DFID or of the people consulted.

Contents

Appendix

List of Figures and Tables

Glossary[1]

AIDS	Acquired Immunodeficiency Syndrome
APPG	All Party Parliamentary Group
ART	Antiretroviral Therapy
CHAT	Country Harmonisation and Alignment Tool
CLEAR	Country Led Approaches and Results
CSG	Corporate Strategy Group
DANIDA	Danish International Development Agency
DFID	Department for International Development
DOH	Department of Health
DRC	Democratic Republic of Congo
DTI	Department of Trade and Industry
EU	European Union
EVD	Evaluation Department
FCO	Foreign and Commonwealth Office
G8	Group of Eight
GAPT	Global AIDS Policy Team
GTZ	German Development Agency
HIV	Human Immunodeficiency Virus
HR	Human Resources
IFF	International Finance Facility
IPPF	International Planned Parenthood Federation
MOPAN	Multilateral Organisations Performance Assessment Network
NAO	National Audit Office
NGO	Non-Governmental Organisations
NHS	National Health Service
OECD	Organisation for Economic Cooperation and Development
OVC	Orphans and Vulnerable Children
PSA	Public Service Agreement
SRSG	Statistical Reporting and Support Group
SSS	Social and Scientific Systems
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint UN Programme on HIV and AIDS
UNFPA	UN Population Fund
UNGASS	UN General Assembly Special Session
UNICEF	UN Children's Fund
UNIFEM	UN Development Fund for Women
USAID	United States Agency for International Development
WHO	World Health Organisation

[1] This is a glossary of terms in the main report – a full glossary is provided as annex 9

Executive Summary

S1 Introduction

S1 This document is the third of three technical working papers for "The Interim Evaluation of '*Taking Action*: The UK Strategy for Tackling HIV and AIDS in the Developing World.'" More details of this evaluation are available from http://www.dfid.gov.uk/aboutdfid/performance/evaluation-news.asp. The aim of this paper is to contribute to the second part of the evaluation's objective which is to make recommendations on how best to measure the success of the strategy, looking forward to the final evaluation of *Taking Action* in 2008/9. In particular, the paper seeks to identify indicators and approaches for the final evaluation.

S2 Indicators identified in Taking Action

S2 The paper starts with a discussion of explicit and implicit indicators in *Taking Action*. This draws heavily on work conducted in preparing for this interim evaluation, including the preparation of a table of questions and approaches and supporting tables.

S3-S4 Evaluation framework

S3 It then introduces an evaluation framework (see figure 1, px) structured around the six priority areas specified in *Taking Action* and four levels:

- International – indicators at this level are existing indicators which are already being monitored, for example, by UNAIDS. They provide information on the overall context within which the UK operates and give some indication of overall impact of the global response to HIV and AIDS, to which the UK is a significant contributor.

- National – indicators at this level will be measured as part of a national monitoring and evaluation system for HIV and AIDS. They track the epidemic and response at country level. It is proposed that DFID collate information on these indicators for PSA countries only.[2]

- UK government – these indicators track specific contributions made by the UK. As lead agency responsible for the implementation of *Taking Action*, DFID would be responsible for monitoring these.

- Milestones - a number of time-bound processes are identified in *Taking Action*, many of them are one-off in nature. These have

[2] These are the countries specified in DFID's public service agreement (DFID, undated) which is the document used to account to the Treasury for funds received.

been grouped together under the heading of milestones (see table 2, p12)

S4 This framework was used during the development of this working paper to identify and categorise indicators implied within *Taking Action.* Under this framework, the UK government, in general, and DFID in particular would be accountable for the indicators relating specifically to UK Government contribution and the milestones (see figure 1, px).

S5 Identifying indicators

S5 The paper identifies a number of indicators to be tracked at each of these levels (see tables 1 and 2, pxi and p12). It also describes each of these in detail and explains how these could be tracked (see annex 2). It also identifies who within the UK Government, in general and DFID, in particular, would be responsible for tracking each indicator (see annex 8).

S6 Baseline data

S6 Available baseline data for each indicator is presented in detail in annex 3.

Figure 1: Proposed Evaluation Framework

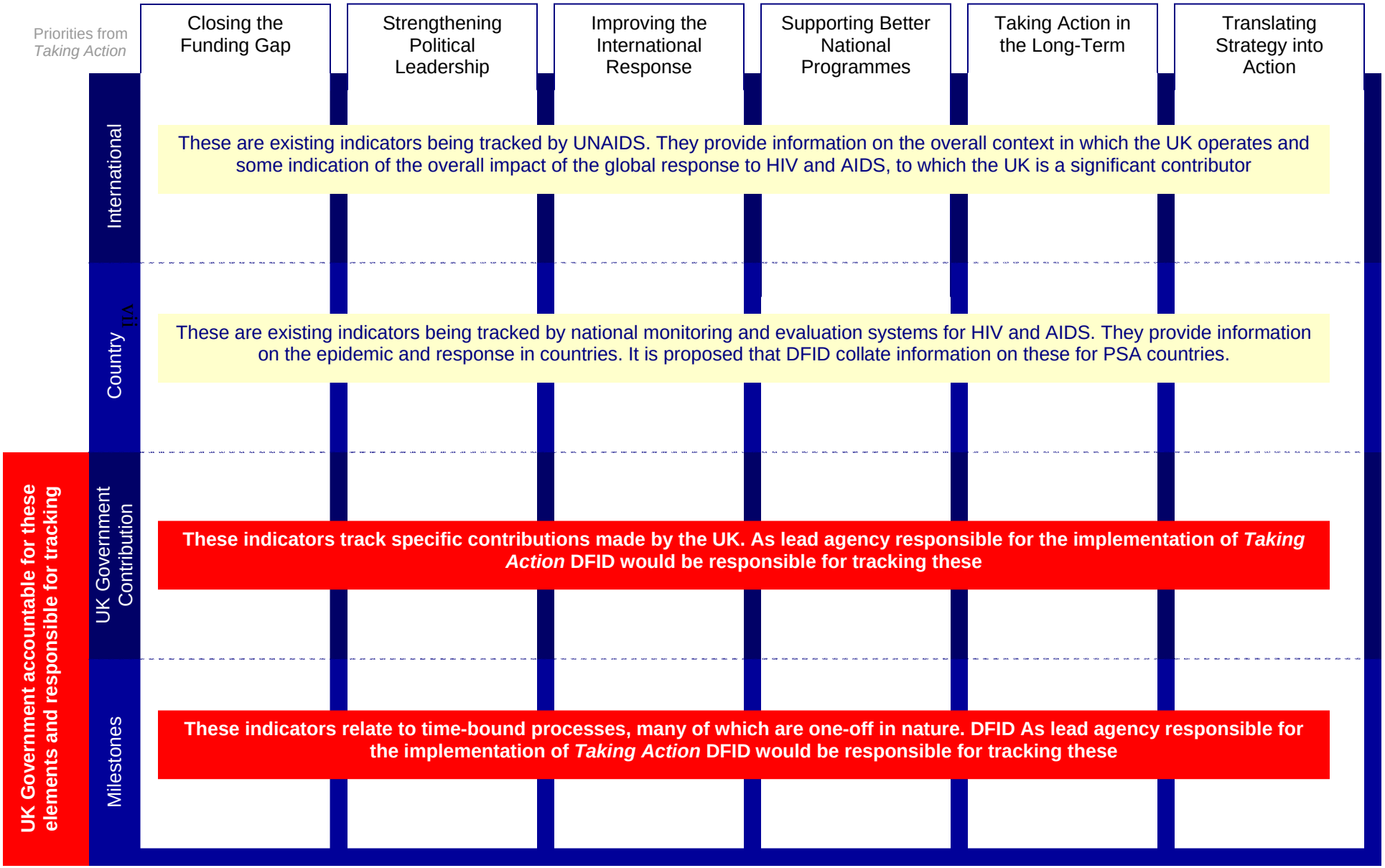

Table 1: Indicators for Tracking Implementation of Taking Action

Indicator No.	Indicator Title
1.TO BE TRACKED PRIMARILY THROUGH ROUTINE MONITORING[3]	
A. Already tracked by UNAIDS, to be collated by DFID	
I1[4]	AIDS funding requirements for low- and middle-income countries
I2	Amount of financial flows for HIV and AIDS for the benefit of low- and middle-income countries
I3	Percentage of young women and men aged 15-24 who are HIV infected
I4	Number and percentage of men, women and children with advanced HIV infection receiving combination antiretroviral therapy
I5	Annual global investment in microbicide and vaccine research
N1	Core UNGASS indicators
N2	Number of countries reporting each/all of Three Ones in place (including number of countries with functioning national monitoring and evaluation system for HIV and AIDS)
B. Already tracked by UNFPA, to be collated by DFID	
I6	Unmet need for contraception
C. To be measured by DFID	
I7	Organisational effectiveness summaries for multilateral agencies[5]
U1	UK funding for AIDS-related work (including disaggregated figures for support to work with OVC; amount and percentage of UK AIDS funding through multilaterals; amount of UK bilateral funding provided to each PSA country for HIV and AIDS; length and predictability of UK AIDS financing; UK annual investment in HIV and AIDS research; and AIDS financing provided through programme partnership agreements with NGOs)
U2	Qualitative review of UK support to AIDS response
U3	Qualitative review of UK support to HIV and AIDS research
2.TO BE REVIEWED AT THE FINAL EVALUATION OF *TAKING ACTION*	
I8	Length and predictability of international financing for HIV and AIDS
I9	Harmonised international system for monitoring and evaluation of HIV and AIDS
N3	AIDS funding requirements for individual PSA countries
N4	Number of PSA countries with harmonised funding for HIV and AIDS
N5	Qualitative review of national AIDS response (including length and predictability of financing to national AIDS response)
U4	UK influence a) at international events/with global institutions; b) in-country through both DFID and FCO; with key regional political institutions
U5	Support to multilaterals as reflected in institutional strategy papers
U6	Support to increase access to medicines
U7	Influence to strengthen monitoring and evaluation of HIV and AIDS

[3] Although data collected through monitoring will be reviewed as part of the final evaluation

[4] The letter denotes to which level of the evaluation framework (see figure 1, px) the indicator belongs – I for international, N for national, U for UK contribution and M for milestone

[5] This indicator is an exception to the rule that international indicators should be tracked by an international agency. Ultimately, this indicator might be tracked as a joint effort of bilateral donors but as DFID is currently pioneering this approach, it is noted here as a DFID responsibility

1 Introduction

1.1 This working paper has been prepared in consultation with DFID staff and other stakeholders. It is divided into the following sections:

- Brief review of explicit and implicit indicators and performance targets in *Taking Action*, subdivided into six priority areas and for the strategy as a whole
- Proposed evaluation framework
- Suggested indicator set including detailed indicator descriptions[6] and baseline data

1.2 Inputs were received during the development of the working paper from a number of NGOs. These are presented in annex 11.

[6] Also see annex 2

2 Explicit/Implicit Indicators and Performance Targets in *Taking Action*

2.1 Basis for this section

2.1 This section is based on a review of Taking Action and the design document for this evaluation[7], including tables A and B[8] attached to the Table of Questions and Approaches. It first looks at overall international targets and then considers the six priority areas of the strategy.

2.2-2.5 Global targets on HIV and AIDS

2.2 These are listed on p.1 Taking Action (DFID, 2004a)

- Twenty five per cent fewer young people in Africa infected with HIV by 2005 and globally by 2010[9]
- Increased access to sexual and reproductive health services for women and girls by 2005[10]
- Three million people, including two million in Africa, receiving treatment by the end of 2005, at least half of whom should be women and children[11]
- National plans in place to meet the needs of orphans and children made vulnerable by HIV and AIDS by 2005[12]
- Rapid implementation of the Three Ones, linking donor help to national priorities
- Increased global investment in HIV and AIDS research, addressing the needs of the poor, women and children[13]
- On track to slow the progress of HIV and AIDS by 2015[14]

2.3 These targets are drawn from a number of international agreements which relate to HIV and AIDS. These include:

- The Millennium Development Goals, - in particular, goal 6 is to combat HIV/AIDS, malaria and other diseases, and target 7 is to have halted and begun to reverse the spread of HIV and AIDS by 2015 (DFID, 2005; OECD, undated)
- The Three by Five Initiative (WHO, 2006)

[7] See http://www.dfid.gov.uk/aboutdfid/performance/evaluation-news.asp
[8] An annotated version of tables A and B has been produced which shows how particular parts of those tables relate to indicators presented in this paper.
[9] Based on Millennium Development Goal 6, target 7, indicator 18
[10] Based on Millennium Development Goal 6, target 7, indicator 19
[11] This target became known as 'Three by Five' initiative
[12] Implied in Framework for the protection, care and support of orphans and vulnerable children living in a world of HIV and AIDS (UNICEF, 2004) and specifically mentioned in UNGASS declaration of commitment
[13] Implied in UNGASS declaration of commitment
[14] Target 7 for Millennium Development Goal 6

- The framework for the protection, care and support of orphans and vulnerable children (OVC) living in a world with HIV and AIDS (UNICEF, 2004; Thomas, 2005)
- The Three Ones (UNAIDS, 2006a/b[15])
- The UNGASS declaration of commitment 2001(UNGASS,2001)

2.4 There are challenges in using these targets as indicators for tracking the effects of implementation of *Taking Action*. First, some of them are fairly general in nature and are not specific, measurable indicators. Secondly, three of them have a time frame of 2005 which has already passed and was very early in the implementation of *Taking Action*. Therefore, they may need to be updated and may also need to reflect new international initiatives, such as commitments to achieve universal access to HIV prevention, care and treatment by 2010 (G8, 2005; UNAIDS, 2006c/e, h).

2.5 Proposed indicators for these targets are presented in tables 1 and 2 (pix and p12)[16]. More details of indicators are given in section 4.2 (p11) of this document.

2.6 Closing the funding gap

2.6 At the centre of *Taking Action* are a number of spending targets, related to HIV and AIDS overall and specific support to orphans and other children made vulnerable by HIV and AIDS. These need to be reflected in the indicators to be used to monitor implementation of the strategy. However, these targets focus on the UK contribution in isolation. If the funding gap is to be closed, there will be need to consider this contribution in the broader context of other sources, both globally and in individual countries.

2.7 Political leadership

2.7 Many of the targets in *Taking Action* on political leadership relate to particular time-bound processes, such as the UK's presidency of the EU and G8. These may be considered as 'milestones' in the implementation of *Taking Action.* They have been treated this way in the proposed evaluation framework (see section 3, p7 and table 2, p12). These may have been selected because of difficulties in identifying and defining measurable indicators of political leadership at global and national level. UNAIDS has proposed indicators of national and global political commitment as part of the process of monitoring implementation of the UNGASS declaration of commitment (UNAIDS, 2005a). These focus on provision of funding and setting of appropriate policy[17]. This interim evaluation has been trying to

[15] See chapter 11 of UNAIDS report to high level meeting in June 2006
[16] See indicators I3-6; N2 and M4.1
[17] The measures of policy proposed by UNAIDS may be more appropriate at national level than globally because the global indicator is largely focused on workplace policy in international organisations

assess this area qualitatively through retrospective review and analysis of key political events and important international/regional institutions.

2.8-2.11 International response

2.8 *Taking Action* is concerned about having a more effective overall international response to HIV and AIDS. This needs to be understood in the context of effectiveness of development aid overall, which was the main focus of the Paris Declaration on aid effectiveness, which was made after *Taking Action* had been introduced (OECD, 2005). A key element in the response to HIV and AIDS is the effectiveness and interaction of multilateral organisations working in this field. At the global level, this was a strong focus of the work of the Global Task Team (GTT, 2005; UNAIDS, 2006g) which has taken this issue forward since the time *Taking Action* was adopted. However, there is still little information on how to track progress in this area, apart from the work conducted by the Multilateral Organisations Performance Assessment Network (MOPAN, 2006) and DFID, through the development of the Multilateral Effectiveness Framework (Scott, 2005). DFID is currently exploring the possibility of expanding this work through the introduction of organisational effectiveness summaries.

2.9 Many problems occur at country level when aid is delivered in an uncoordinated manner (Kates and Lief, 2006). Harmonisation may take various forms. Some elements have been captured in the 'Three Ones' although *Taking Action* takes this further by promoting pooled funding for HIV and AIDS in country[18]. In addition, international multilateral organisations may take on more direct roles in certain countries including those:

- That lack the political infrastructure to manage country-led aid instruments, eg post-conflict and fragile states[19]
- Where bilateral agencies have no direct presence[20]

2.10 The UK government's contribution to the multilateral, international response may be measured qualitatively through review and assessment of the institutional strategy papers, which describe how DFID works with individual agencies (NAO, 2004; SSS, 2006). It may also be measured quantitatively through the amount and percentage of UK funding going to the international response to HIV and AIDS through multilaterals.

[18] Perhaps the first step towards a harmonised approach to funding a national HIV and AIDS response is for all donors to unite around funding the national strategic action framework. Then various forms of pooled funding might be considered including pooled funding to the National AIDS Coordinating Authority, pooled funding to NGO umbrella bodies, pooled funding to the AIDS 'sector' (sometimes termed sub-sectoral budget support), support to the health sector and/or general budget support. All of these mechanisms include an element of pooled funding for the response to HIV and AIDS but each mechanism has quite distinctive features from the others. Pooling may also occur internationally, eg the Global Fund can be considered an internationally-pooled financing mechanism for the response to HIV and AIDS.

[19] Angola, DRC, Somalia and Sudan are mentioned explicitly in *Taking Action* in this context

[20] It is likely that multilateral organisations would play quite different roles in these two scenarios

2.11 UNAIDS is currently piloting a Country Harmonisation and Alignment Tool (CHAT) which is intended for use as part of a joint review of national AIDS programmes (Gillies, 2006). It has two key elements, namely performance assessments of national and international partners. The national partners' performance assessment covers four areas, participation in the National AIDS Coordinating Authority and the National Strategic Framework; participation in monitoring and evaluation; ownership and equitable access to financial resources; and transparency of administration and communications processes. The international partners' performance assessment covers six areas, of which three are focused on alignment[21] and three on harmonisation[22].

2.12-2.14 National programmes

2.12 There are a number of international documents which seek to identify common, standardised indicators for monitoring a national response to HIV and AIDS. These include:

- Proposed indicators for tracking progress towards UNGASS declaration of commitment (UNAIDS, 2005a)
- Top 10 output and outcome indicators for reporting to Global Fund in multi-agency toolkit (WHO et al., 2006)
- Proposed core, recommended and interim indicators for tracking universal access initiative (UN General Assembly, 2006b; UNAIDS, 2006h/i)

Differences between these indicator sets are briefly reviewed in annex 6. Some individual donors also have their own documents on key indicators (USAID, 2006).

2.13 Overall, the 'UNGASS indicators' are very useful for tracking national responses, particularly because there are different indicator sets for different epidemic types and data has been collected for these following the declaration of commitment (UNAIDS, 2006a and annex 7). However, five years after the Declaration of Commitment was made, many countries are still not reporting on some of the core indicators, the quality of the reports is variable and many countries lack specific resources for tracking these indicators.

2.14 The quality of national responses to HIV and AIDS and the UK's support to these could be reviewed and evaluated by comparing against criteria specified in *Taking Action*. Ideally, this should be measured by review of

[21] They are alignment with National AIDS Coordinating Authority and National Strategic Framework; alignment for monitoring and evaluation; and alignment of finances to national HIV response

[22] They are harmonisation of procurement and technical assistance; harmonisation of management and administration requirements and procedures; and harmonisation of communications, coordination and networking

existing reports, eg Joint Annual Programme Reviews, rather than the UK conducting new bilateral assessments.

2.15 Long-term

2.15 *Taking Action* focuses on two main aspects of long-term action. The first is more long-term and predictable funding, and the second is research. *Taking Action* specifies a number of particular kinds of research that the UK would like to support, including research into vaccines and microbicides.

2.16 Strategy into action

2.16 *Taking Action* highlights a number of milestones which need to be reached during implementation. It also emphasises the need for all relevant government departments introducing appropriate policies and procedures, and the importance of monitoring and evaluation systems in tracking the translation of strategy into action.

3 Proposed Evaluation Framework

3.1-3.2 Levels of the evaluation framework

3.1 The proposed evaluation framework is illustrated diagrammatically in figure 1 (pviii).

3.2 Within each of the six priority areas of *Taking Action* four levels of indicators have been identified. These are:

- *International* – these indicators track overall progress internationally, recognising that this is influenced by non-UK contributions. These indicators provide important contextual information about the environment in which the UK provides support. These indicators already exist and are being tracked by international agencies, particularly UNAIDS.

- *Country* – these indicators track progress in responding to HIV and AIDS at national level. They are measured as part of a national monitoring and evaluation systems for HIV and AIDS, and are reported to and aggregated by UNAIDS. It is proposed that DFID will collate information for those countries covered by DFID's Public Service Agreement, namely Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, South Africa, Sudan, Tanzania, Uganda, Zambia, Zimbabwe, Bangladesh, Cambodia, China, India, Indonesia, Nepal, Pakistan and Vietnam.

- *UK Government Contribution* – this aims to track the nature of the inputs provided by the UK, principally through DFID. As lead agency responsible for the implementation of *Taking Action*, DFID would be responsible for monitoring these.

- *Milestones* – these reflect a number of time-bound processes to be completed as part of implementing *Taking Action* (see table 2, p12).

3.3-3.10 Challenges faced in developing the framework

3.3 A number of challenges were faced in developing the framework. Attempts were made to address and resolve these. They are briefly summarised here.

3.4 Concerns were expressed that the proposed framework and indicator set focused more on processes and not on impact of implementation of *Taking Action*. Although it is acknowledged that the indicators for which DFID will

be directly responsible[23] largely track what is being done[24], the national - and international-level indicators[25] will give information about the effects to which the UK is contributing[26]. They will not however be able to ascribe causality, ie this UK contribution led to this particular effect. This is not something which is seen as appropriate, given the UK's commitment to country ownership and country-led development or the way funds are increasingly being supplied, eg through pooled mechanisms, including sectoral and general budget support.

3.5 A tension emerged during consultation about the draft document with some respondents wanting to add more indicators while others stressed the need for the number of indicators to be kept to a manageable level, if they were to be monitored regularly. An effort has been made to try to balance this tension, so that most of the commitments made in *Taking Action* will be tracked. However, priority has been given to using existing indicators and a few indicators which it was considered not feasible to measure were dropped.

3.6 A related challenge to this is the desire to have disaggregated data. In some cases[27], some disaggregation is already being carried out. Although, further disaggregation might be desirable, it was not considered feasible to include this for international or national level indicators, because these are not the direct responsibility of the UK Government to set or track.

3.7 Many of the comments received came from NGOs who understandably were concerned about tracking the amount of funding going to civil society. Although this was not a direct commitment in *Taking Action*, it has been accommodated in the indicator set by including a disaggregated figure for funding for HIV and AIDS through Programme Partnership Agreements with NGOs.

3.8 Although efforts were made in developing this working paper, it proved very difficult to establish indicators for the role to be played by government departments other than DFID. This is because:

- Some of the activities they conduct are hard to quantify, eg the role of FCO in policy dialogue or the role of DTI on access to medicines.

- *Taking Action* is not very specific on the roles and responsibilities of other government departments.

[23] Milestones and measures of UK contribution
[24] Which might be variously characterised as inputs, outputs or processes depending on definitions used
[25] For example, I3, I4, I6 and N1
[26] Which might be termed outcomes and/or impact depending on definitions used
[27] For example, I3 and I4

- Some indicators implied by commitments in *Taking Action* are no longer considered relevant, eg the need of government departments to develop their own policies on HIV and AIDS, the role of the cross-Whitehall coherence group in monitoring the implementation of *Taking Action*, and the need for a stronger code of practice to prevent the use by the NHS of agencies that recruit health care staff directly from developing countries.

- Indicators proposed by others have not been agreed by the government, eg APPG (2004).

- Systems are not in place within the departments. For example, FCO finds it difficult to determine what part of their expenditure constitutes official development assistance. Although figures are provided for this, they are not broken down as to how much of that is for the response to HIV and AIDS. DOH does not have systems in place to disaggregate money spent on health research to provide a figure for research on HIV and AIDS.

3.9 A number of specific issues were highlighted as requiring further attention. These were:

- Tuberculosis –there are important links between AIDS and TB. However, these are not explicitly referred to in *Taking Action*. Indeed, the only mention of TB in *Taking Action* is in relation to the work of the European Union and the Global Fund. Consequently, as the framework is intended to track implementation of the strategy as agreed, it does not seem reasonable to add an indicator on TB at this stage.

- Orphans and Vulnerable Children – a number of the indicators included are child-focused or have such elements. These include the number of children on ART (I4), organisational effectiveness summary and institutional strategy for UNICEF (I7 and U5), core UNGASS indicators (N1)[28], the qualitative review of the national AIDS response (N5), the amount of UK funding for OVC activities (U1), qualitative review of UK support to national AIDS response (U3) and UK influence globally, regionally and in-country (U4) [29,30]. It is also proposed to include elements related to paediatric ART in indicators relating to research supported by the UK (U3) and access to medicines (U6).

- Sexual and Reproductive Health – a number of the proposed indicators contain elements related to sexual and reproductive health embedded

[28] Including particularly indicators on prevention of mother to child transmission, support for children affected by AIDS and orphan's school attendance
[29] With a particular focus on the international strategic framework for work with OVC (UNICEF, 2004)
[30] There are also a number of child-focused milestones, namely M1.3, M3.4, M3.5 and M4.1 (see table 2, p12)

within them, which reflects well the UK's approach to linkages between sexual and reproductive health, HIV and AIDS. These include organisational effectiveness summaries and institutional strategies for UNIFEM and UNFPA (I7 and U5), unmet need for contraception (U6), qualitative review of national AIDS response (N5), UK funding for AIDS-related work[31] (U1), qualitative review of UK support to AIDS response (U2), UK influence globally, regionally and in-country (U4), and support to increase access to contraceptives and condoms (U6). Global funding for sexual and reproductive health in low - and middle-income countries is currently tracked by UNFPA but is not included in figures for AIDS compiled by UNAIDS (I2).

3.10 Despite this provision for sexual and reproductive health within the indicator set, a number of other indicators related to sexual and reproductive health have been suggested. However, as none of these relate specifically to linkages between sexual and reproductive health, HIV and AIDS, these have not been included[32]. Although there is a growing literature on these linkages (Druce et al., 2006; WHO et al., 2005a/b), including strategies of other bilaterals with a strong focus on linkages between sexual and reproductive health, HIV and AIDS (DANIDA, 2005), and examples of countries where linkages have been established (GTZ and IPPF, 2005a), there is relatively little on how these linkages themselves can be monitored and evaluated. IPPF (IPPF, 2002) have developed a checklist for assessing the integration of STI treatment and HIV services at facility level[33], and it is possible that something like this could be adapted for use at national level. However, as no method/indicator seems to be available at this time to monitor linkages between sexual and reproductive health, HIV and AIDS, no indicator for this issue has been included within the framework.

[31] Which includes projects/programmes with a principal or significant impact on sexual and reproductive health

[32] It might be more appropriate for these to be tracked under DFID's maternal health strategy (DFID, 2004c; DFID, 2005b) which currently has no formal monitoring and evaluation framework but is being tracked in terms of commitments made in four priority areas

[33] This covers a number of items – HIV strategy; protocol, norms and guidelines for screening and care; sensitization and training; services; documenting information; directory of organisations; follow-through on referrals and counter-referrals; advocacy and IEC materials; legal issues; local technical assistance; and organisational integration/sustainability

4 Suggested Indicator Set

4.1 Indicators

4.1 A proposed indicator set is presented in tables 1 and 2 (pix and p12). This is based on the explicit and implicit indicators and targets in *Taking Action* and listed in Tables A and B of the Table of Questions and Approaches. Attempts have been made to select a manageable number of indicators which can be accurately and realistically tracked during the time remaining to implement *Taking Action.* Details about each indicator are presented in the next section.

4.2 Indicators in detail

4.2 Each indicator is described in detail in annex 2. Elements described include:

- Indicator number
- Indicator name
- Overall description
- Data source
- Frequency
- Responsibility within DFID for tracking

4.3 Availability of baseline data

4.3 Available baseline data for each selected indicator is presented in annex 3. In cases of indicators with considerable baseline data, this has been separately annexed:

- Annex 4 – HIV prevalence among young people aged 15-24
- Annex 5 – HIV prevalence among most-at-risk populations
- Annex 7 – core UNGASS indicators

4.4 Adequacy of baseline data

4.4 An assessment of the adequacy of baseline data for each indicator is made in annex 10. This annex also suggests a format for reporting on these indicators with preliminary assessment of early trends where data is available.

4.5 Dates of baseline data

4.5 Wherever available, baseline data has been taken for the period prior to the commencement of *Taking Action*, ie 2004 or earlier. In the absence of such data, more recent figures have been used.

Table 2: Milestones for Implementation of Taking Action

Milestones by Priority Area	Time Frame	Review Period	Responsible
Closing the Funding Gap			
M1.1 UK funding levels for Global Fund, UNAIDS and UNFPA	Next 3/4 years	Annually at end of FY	International Division/SRSG
M1.2 Agreement to new International Finance Facility[34]	Not specified	March 2008	HMT
M1.3 UK funding levels to UNICEF's work with orphans[35]	Not specified	Annually at end of FY	International Division /SRSG
Strengthening Political Leadership			
M2.1 AIDS as a centrepiece of UK Presidency of G8 and EU	2005	Interim Evaluation	Evaluation Team
M2.2 UK focus on AIDS at high-level UN General Assembly events	June 2006[36]	Interim Evaluation	Evaluation Team
M2.3 Establish cross-Whitehall working group on HIV and AIDS	End 2005[37]	Interim Evaluation	Evaluation Team
M2.4 Table AIDS work as a case study at the discussion on harmonisation	Not specified	Interim Evaluation	Evaluation Team
M2.5 Follow up our call for the UN Security Council to develop a clear evidence base on the links between peace and security and AIDS	Not specified	Not known	Not specified
M2.6 FCO identified clear objectives on HIV and AIDS for Ambassadors and High Commissioners	Not specified[38]	Not known	CSG

[34] It appears that the IFF is only one of several mechanisms being proposed to make funding for HIV and AIDS responses more predictable. Others include promoting advance market commitments, championed by the US and an airline tax, championed by France (Lief and Izazola-Licea, 2006)
[35] It is reported by UNCD that following the release of *Taking* Action, it was stated that £44m of the £150m for OVC would go through UNICEF. Clarity is needed as to whether this relates to all UNICEF's work or only part of it, and whether it includes both multilateral and bilateral funds. If it is only part of it, clarity is needed as to whether this is for orphans only or for orphans and other vulnerable children, and whether it is a sub-set of their AIDS spending or not. In working paper 1 (SSS, 2006), it was assumed that all funding provided by DFID to UNICEF benefits orphans and vulnerable children.
[36] Time frame was not specified in *Taking Action* but review now following recent UNGASS high level meeting seems reasonable
[37] No deadline given but this action had been completed at the time this evaluation began in February 2006
[38] Although it is perhaps implied that this was done prior to adoption of *Taking Action*

Milestones by Priority Area	Time Frame	Review Period	Responsible
M2.7 UK Government staff in the UK and overseas are fully aware of HIV and AIDS and receive due care and treatment.	Not specified	Not known	GAPT/ FCO/ DFID HR[39]
M2.8 Adopt a progressive workplace policy on AIDS has across Whitehall.	Not specified	Not known	GAPT/FCO/DFID HR
Improving the International Response			
M3.1 UK/US taskforce reports on coordination.	Twice per year	Interim Evaluation	GAPT
M3.2 Ensure better division of labour between World Bank and Global Fund[40]	Not specified	Interim Evaluation	Global Health Partnerships Team
M3.3 Support UNAIDS to monitor the roll-out of the Three Ones by developing indicators and a system of reporting linked to the UNGASS targets	Not specified	Due now following high level meeting in June 2006	GAPT
M3.4 UK endorsement of UNICEF's Strategic Framework for the Protection, Care and Support of Orphans and Children made vulnerable by HIV and AIDS (UNICEF, 2004)	Not specified[41]	Interim Evaluation	International Division
M3.5 Provision of advice to country teams on implementation of UNICEF's Strategic Framework for the Protection, Care and Support of Orphans and Children made vulnerable by HIV and AIDS	Not specified	Interim Evaluation	GAPT
Supporting Better National Programmes			
M4.1 Number of countries with national plans in place to meet the needs of orphans and children made vulnerable by HIV and AIDS[42]	2005	Annual	GAPT
M4.2 Guidance to UK staff on issues of HIV, AIDS and food security	Not specified	Interim Evaluation	GAPT
M4.3 AIDS communication guidance for our country programmes.	2004	Interim Evaluation	GAPT

[39] Apparently responsibility for implementation has evolved from Global AIDS Policy team in DFID through FCO and now rests with DFID's Human Resources Department
[40] A study assessing this has been published since *Taking Action* was adopted (Shakow, 2006)
[41] DFID endorsed this framework at the time it was developed, which preceded publication of *Taking Action*
[42] UNICEF, USAID and the Futures Group have developed a tool for assessing these along with other elements of other programmes for orphans and vulnerable children (UNICEF et al., 2004)

Milestones by Priority Area	Time Frame	Review Period	Responsible
M4.4 Action taken to strengthen the impact of the Code of Practice on the recruitment of healthcare workers to the UK, to prevent the use by the NHS of agencies that recruit healthcare staff directly from developing countries unless a bilateral agreement has been negotiated with the country concerned.	Not specified	Interim Evaluation	DOH
Taking Action in the Long-Term			
No specific milestones identified			
Translating Strategy into Action			
M6.1 Every UK government department should develop policies to support coordinated and intensified efforts to fight the global HIV/AIDS epidemic	Not specified	Interim Evaluation	Cross Whitehall Group
M6.2 Regular monitoring of progress against *Taking Action*	Not specified	At least annually	DFID
M6.3 DFID's management board reviews progress against *Taking Action* including at least annual review of Director's Delivery Plans	Not specified	Annually	Management Board/CSG
M6.4 AIDS will be reflected in the delivery plans of regional and international directors.	Not specified	At least annually	Management Board/CSG
M6.5. Regular monitoring of CAPs and ISPs concerning HIV and AIDS content	Not specified	Annually	Management Board/CSG/EVD
M6.6 DFID staff work plans reflect HIV and AIDS	Not specified	Not known	DFID management systems/HR
M6.7 Cross Whitehall working group on AIDS established	See 2.3		
M6.8 Cross Whitehall monitoring of *Taking Action*	Not specified	After Interim Evaluation	Cross Whitehall working group
M6.9 Decisions in DFID's annual funding round reflect priorities in *Taking Action*	Not specified	Annual	Directors/CSG
M6.10 Internal business plans and strategies used to monitor implementation of this strategy	Not specified	Not known	Directors/CSG
M6.11 Evaluation of this strategy	2006	Ongoing	EvD

Annex 1: Documents Reviewed

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AIDSMAP (2006) **World Policy News** Web page available on http://www.aidsmap.com/en/news/EA43F6B4-108E-401A-AA57-B490B1CF3AA9.asp on 17th July 2006

APPG (2004) **Averting Catastrophe: AIDS in 21st Century Africa**

DANIDA (2005) **Strategy for Denmark's Support to the International Fight against HIV/AIDS**

DFID (undated) **The Public Service Agreement** Downloaded from http://www.dfid.gov.uk/aboutdfid/psa-sda.asp on 27th June 2006

DFID (2004a) **Taking Action: The UK's Strategy for Tackling HIV and AIDS in the Developing World** Published July 2004

DFID (2004b) **HIV and AIDS Treatment and Care Policy**

DFID (2004c) **Reducing Maternal Deaths: Evidence and Action: A Strategy for DFID**

DFID (2005a) **HIV and AIDS Factsheet** Produced November 2005

DFID (2005b) **DFID's Maternal Health Strategy: Reducing Maternal Deaths: Evidence and Action: First Progress Report: December 2005**

DFID, DOH,DTI, FCO, Her Majesty's Treasury, Inland Revenue and Patent Office (2004) **Increasing Access to Essential Medicines in the Developing World: UK Government Policy and Plans**

Druce, N., Dickinson, C., Attawell, K., Campbell White, A. and Standing, H. (2006) **Strengthening Linkages for Sexual and Reproductive Health, HIV and AIDS: Progress, Barriers and Opportunities for Scaling Up** Report produced in August 2006 by DFID Health Resource Centre. There is also a shorter version available summarising the findings and recommendations

G8 (2005) **G8 Gleneagles 2005: Policy Issues** Downloaded from http://www.g8.gov.uk/servlet/Front?pagename=OpenMarket/Xcelerate/ShowPage&c=Page&cid=1094235520151 on 27.06.06

Gillies, A. (2006) **Country Harmonization and Alignment Tool (CHAT): Draft Version** Version 3.1, produced by UNAIDS and World Bank, August 2006

Global AIDS Alliance (2006) **About the Global AIDS Alliance** Web page on http://www.globalaidsalliance.org/cd_about_us.cfm on 17th July 2006

Global Equity Gauge Alliance (2003) **The Equity Gauge: Concepts, Principles and Guidelines** Published by Global Equity Gauge Alliance and Health Systems Trust

Global Fund (2005) **Measuring the Systems Effects of the Global Fund with a Focus on Additionality, Partnerships and Sustainability** Geneva, May 2005

Global Fund (2006) **Search Centre** Details of all countries with Global Fund grants are available on http://www.theglobalfund.org/en/ on 17th July 2006

Global Health Watch (2005) **Global Health Action 2005-6** advocacy tool published in July 2005 based on first Global Health Watch

Global Task Team (2005) **Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors** Final Report, 14th June 2005

GNP+ (2006) **The Global Network of People Living with HIV/AIDS** Web page on http://www.gnpplus.net/cms/index.php visited 17th July 2006

Governance and Social Development Resource Centre (2006) **Drivers of Change** Web page available on http://www.gsdrc.org/go/topic-guides/drivers-of-change on 17th July 2006

GTZ and IPPF (2005a) **Models of Care Project: Linking HIV/AIDS Treatment, Care and support in Sexual and Reproductive Health Care Settings**

GTZ and IPPF (2005b) **Sexual and Reproductive Health Organizations and the Global Fund: Research into Experiences of IPPF Member Associations in Relation to the Global Fund to Fight AIDS, TB and Malaria**

HIV Vaccines and Microbicides Resource Tracking Working Group (2006) **Adding it All Up: Funding for HIV Vaccine and Microbicide Development, 2000 to 2005**

HM Treasury and DFID (2005) **The International Finance Facility**

Human Rights Watch (2006) **HIV/AIDS and Human Rights** Web page on http://www.hrw.org/doc/?t=hivaids&document_limit=0,2 on 17th July 2006

ICASO (2006a) **International Council of AIDS Service Organisations** Website available on http://www.icaso.org/ - visited on 17th July 2006

ICASO (2006b) **Community Monitoring and Evaluation: Implementation of the UNGASS Declaration of Commitment on HIV/AIDS** Early Release Copy dated May 2006

IDD and Associates (2006) **Evaluation of General Budget Support: Synthesis Report** Produced May 2006

IPPF Western Hemisphere Region (2002) **Have you Integrated STI/HIV Prevention into your Sexual and Reproductive Health Services?**

Janjua, H. (2003) **UK AIDS Aid: An Analysis of DFID's HIV/AIDS Expenditure** ActionAid, November 2003

Kates, J. and Lief, E. (2006) **International Assistance for HIV/AIDS in the Developing World: Taking Stock of the G8, Other Donor Governments and the European Commission** A paper produced by Kaiser Family Foundation and Center for Strategic and International Studies

Lamourelle, G., Harrison, P., Rowley, J. and Warren, M. (2006) **New Prevention Technologies: Trends in Resource Flows for HIV Vaccines and Microbicides** Chapter 6 in report produced by HIV Vaccines and Microbicides Resource Tracking Working Group

Lief, E. and Izazola-Licea, J.A. (2006) **International AIDS Assistance: "New" Money?** A paper produced by Center for Strategic and International Studies and UNAIDS in August 2006

Ministry of Health, Zambia (2005) **Human Resources for Health Strategic Plan: 2006-2011**

MOPAN (2006) **The Multilateral Organisations Performance Assessment Network (MOPAN)** Downloaded from http://www.acdi-cida.gc.ca/CIDAWEB/acdicida.nsf/En/JUD-5292536-HRK on 29th June 2006

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National AIDS Council, Republic of Zambia (2006a) **Third Joint Programme Review of the National HIV/AIDS/STI/TB Intervention Strategic Plan (2002-2005) and Operations of the National AIDS Council for the Year 2005 and the Period 2002-2005** Draft May 2006

National AIDS Council, Republic of Zambia (2006b) **National AIDS Council Response to the Joint Assistance Strategy Zambia (JASZ): Terms of Reference for Cooperating Partner Coordination for HIV and AIDS**

National Audit Office (2004) **Department for International Development: Responding to HIV/AIDS** Report by the Comptroller and Auditor General, HC 664 Session 200302004, 18 June 2004

OECD (undated) **MDG Targets and Indicators** Downloaded from http://www.oecd.org/document/40/0,2340,en_2649_34585_33978664_1_1_1_1,00.html on 27th June 2006

OECD (2006a) **United Kingdom, DAC Peer Review: Main Findings and Recommendations** Downloaded from http://www.oecd.org/document/43/0,2340,en_2649_34603_36881515_1_1_1_1,00.html on 17th July 2006

OECD (2006b) **Paris Declaration: Indicators of Progress: To be Measured Nationally and Monitored Internationally** Downloaded from http://www.oecd.org/dataoecd/57/60/36080258.pdf on 17th July 2006

OECD (2006c) **Working Party on Statistics: Reporting on Aid in Support of HIV/AIDS Control** DCD/DAC/STAT/RD(2006)3/RD4 Produced May 2006

OECD (2006d) **The Paris Declaration** Downloaded from http://www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html on 30th November 2006

Open Society Institute (2006) **Public Health Program: HIV/AIDS Monitoring** Web page on http://www.soros.org/initiatives/health/focus/phw/focus_areas/hiv_aids visited on 17th July 2006

Panos (2006) **Keeping the Promise? A Study of Progress Made in Implementing the UNGASS Declaration of Commitment on HIV/AIDS in Seven Countries** Produced by Panos in May 2006

People's Health Movement, Medact, Global Equity Gauge Alliance and Zed Books (2005) **Global Health Watch 2005-2006: An Alternative World Health Report** – see especially the chapter on sexual and reproductive health pp134-146

Roseberry, W., Seale, A. and Mphuka, S. (2005) **Assessing the Application of the 'Three Ones Principles' in Zambia** DFID Health Systems Resource Centre

Ross, J.A. and Winfrey, W.L. (2002) **Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate** International Family Planning Perspectives, Volume 28, Number 3, September 2002

Scott, A. (2005) **DFID's Assessment of Multilateral Effectiveness: An Overview of Results**

Shakow, A. (2006) **Global Fund – World Bank HIV/AIDS Programs: Comparative Advantage Study** Prepared for the Global Fund and the World Bank, January 2006

Social and Scientific Systems (2006) **Interim Evaluation of 'Taking Action: The UK Government's Strategy for Tackling HIV and AIDS in the Developing World': An Analysis of Trends in UK Government Funding and Activities** DFID, Glasgow, Evaluation Working Paper 18

Sonfield, A. (2006) **Working to Eliminate the World's Unmet Need for Contraception** Guttmacher Policy Review, Winter 2006, Volume 9, Number 1

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UNAIDS (2003) **Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003: Follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS**

UNAIDS (2004) '**Three Ones' Key Principles: Coordination of National Responses to HIV/AIDS: Guiding Principles for National Authorities and their Partners** Presentation to Washington Conference in April 2004

UNAIDS (2005a) **Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators**

UNAIDS (2005b) **The Three Ones: Where We Are and Where We Go from Here** UNAIDS/05.08E May 2005

UNAIDS (2005c) **Resource Needs for an Expanded Response to AIDS in Low- and Middle-Income Countries** Produced August 2005

UNAIDS (2006a) **2006 Report on the Global AIDS Epidemic** Reported to UN High Level Meeting held in June 2006. Country level reports are now available on http://www.unaids.org/en/Publications/2005ungassreporting/default.asp visited on 3rd August 2006

UNAIDS (2006b) **The Three Ones** Downloaded from http://www.unaids.org/en/Coordination/Initiatives/three_ones.asp on 28th June 2006

UNAIDS (2006c) **The Road Towards Universal Access: Scaling up Access to HIV Prevention, Treatment, Care and Support: Concept Paper** January 2006

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UNAIDS (2006e) **The Road Towards Universal Access** Downloaded from http://www.unaids.org/en/Coordination/Initiatives/default.asp on 28th June 2006

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UNGASS (2006) **Draft Resolution Submitted by the President of the General Assembly** at the high-level meeting held in May/June 2006

UN General Assembly (2006a) **Declaration of Commitment on HIV/AIDS: Five Years Later** Report of the Secretary General, Sixtieth Session, Agenda Item 45, 24th March 2006

UN General Assembly (2006b) **Scaling up HIV Prevention, Treatment, Care and Support** Agenda item 45 in 60th session, 24th March 2006

UNICEF (2004) **The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS** Produced in July 2004 with multi-agency support

UNICEF, USAID and the Futures Group (2004) **National Response to Orphans and other Vulnerable Children in sub-Saharan Africa: The OVC Programme Effort Index** Draft dated August 2004

UN Millennium Project (2005) **Combating AIDS in the Developing World** Task Force on HIV/AIDS, Malaria, TB and Access to Essential Medicines, Working Group on HIV/AIDS

UN Statistical Division (2006) **Millennium Development Goals Indicators Database** Downloaded from http://millenniumindicators.un.org/unsd/mi/mi_goals.asp on 27th June 2006

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World AIDS Campaign (2005) **Promises, Promises… Statements, Commitments and Declarations on HIV/AIDS since 2001** Published November 2005

Annex 2: Detailed Indicator Descriptions

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
INTERNATINAL INDICATORS					
I1	AIDS funding requirements for low and middle income countries	This is a global estimate of the funds needed to respond to HIV and AIDS in low and middle income countries. Although this is best available method, there are concerns about its limitations which include limited availability of data and inherent uncertainty about the future. There are also concerns about the objectivity of UNAIDS in preparing these estimates, given that the organisation has an interest in and has been a vocal advocate for more funds being available for the global response to HIV and AIDS	UNAIDS through work of Resource Needs Steering Committee (UNAIDS, 2005c; UNAIDS, 2006a)	Annually	GAPT
I2	Amount of financial flows for HIV and AIDS[1] for the benefit of low- and middle-income countries	This is a global estimate of the funds available to respond to HIV and AIDS in low and middle income countries. UNAIDS estimates include household, national and donor spending.	UNAIDS – best data currently available from Latin America (UNAIDS, 2006a)	Annually	GAPT
I3	Percentage of young women and men aged 15-24 who are HIV	MDG indicator – this has been primarily tracked through antenatal data[2] but population-based data is now available in	Original data from WHO, UNICEF and UNAIDS. Compiled on UN Statistical Division database (UNSD,	Annually	CLEAR team/GAPT

[1] These figures do not include spend on sexual and reproductive health which is tracked separately by UNFPA
[2] For method see UNAIDS, 2005

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
	infected	some countries. Absence of global data for 2001 means that this indicator can only be tracked for individual countries and not globally.	2006) – 26 African countries including 11/16 PSA countries – capital city only UNAIDS reporting on UNGASS Declaration of Commitment (UNAIDS, 2006a)		
I4	Number and percentage of men, women and children with advanced HIV infection receiving combination antiretroviral therapy	This number is tracked globally by UNAIDS, although it is not always clear if this is number of people starting treatment or currently on treatment. UNAIDS is attempting to provide disaggregated data for women, young people and members of vulnerable populations	UNAIDS reports (eg UNAIDS, 2006a). In the past "3 by 5" generated reports (UNAIDS/WHO, 2005). It has not yet been established what reports will be generated by the "universal access" process.	At least annually	GAPT
I5	Annual global investment in microbicide and vaccine research	This indicator focuses specifically on research on vaccines and microbicides. This is because this is what is tracked and reported currently. It does not cover other types of AIDS research of benefit to low and middle income countries and also excludes general AIDS research.	Figures are generated by the HIV Vaccines and Microbicides Resource Tracking Working Group (Lamourelle et al., 2006; HIV Vaccines and Microbicides Resource Tracking Working Group, 2006) and collated into UNAIDS' reports (UNAIDS, 2006a).	Annually	GAPT
I6	Unmet need for contraception	Currently, a number of indicators relevant to reproductive health are tracked as part of monitoring progress towards reaching the MDGs[3]. However, none of these	Primary data source is population-based survey, such as DHS. Currently figures for unmet contraceptive need are available for some countries on	Every 3-5 years	SRH team

[3] For example, condom use rate of the contraceptive prevalence rate (Ind. 19); condom use at last high-risk sex (Ind. 19a); percentage of population aged 15-24 with comprehensive correct knowledge of HIV/AIDS (Ind. 19b); and contraceptive prevalence rate (Ind. 19c)

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
		really tracks access to SRH services comprehensively. DFID supports proposals to replace this indicator with one which measures unmet need for contraceptives. Data for this indicator is currently being collected through DHSs using an agreed method (Sonfield, 2006).	the UNFPA website.		
I7	Organisational effectiveness summaries	DFID is piloting a balanced scorecard approach to measuring multilateral effectiveness. Currently, this is quite general but could be extended to specific thematic areas such as HIV and AIDS	Organisational effectiveness summaries produced by DFID	Annually	International Division
I8	Length and predictability of international financing for HIV and AIDS	Essentially, this would involve tracking the length of funding agreements of major donors to HIV and AIDS responses and the proportion of funding disbursed within the fiscal year for which it was scheduled[4].	This is not currently being tracked systematically, although there has been some documentation of the issues (eg Kates and Lief, 2006; UNAIDS, 2006a). It is proposed that this issue be reviewed as part of the final evaluation through interviews with key informants and review of relevant literature.	Final evaluation	Evaluation Team
I9	Harmonised international system for HIV/AIDS monitoring and	This qualitative indicator measures the degree of harmonisation in the international system for HIV/AIDS monitoring by identifying systems which	This is not currently being tracked systematically. There are a number of separate multiagency initiatives to harmonise these indicators,	Final evaluation	Evaluation Team

[4] Indicator 7 for the Paris Declaration

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
	evaluation	have multi-agency endorsement and comparing them with each other	namely UNGASS monitoring, the 'Global Fund' toolkit and proposed indicators for universal access. A number of agencies, eg UNAIDS have signed up to all these initiatives but there is currently no clarity as to who is responsible for ensuring harmonisation between these. It is proposed that this issue be reviewed as part of the final evaluation through interviews with key informants UNAIDS and review of relevant literature.		
NATIONAL INDICATORS					
N1	Core UNGASS Indicators	UNAIDS has defined a set of indicators for tracking progress against the UNGASS declaration of commitment (UNAIDS, 2005a). These are briefly described in annex 6 (p53) where they are also compared with other harmonised approaches to HIV/AIDS monitoring and evaluation (WHO et al, 2006; UN General Assembly, 2006). They include measures of national AIDS expenditure and a composite policy index	UNGASS country reports which are aggregated by UNAIDS (eg UNAIDS, 2006a)	Every two years	GAPT to collate data for PSA countries
N2	Number of PSA countries reporting each/all of Three	Essentially to measure this indicator there is need to define the criteria that have to be met	UNAIDS publishes aggregated international figures (UNAIDS, 2006a) but these are not	For each UNGASS update –every	GAPT to collate data for PSA countries

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
	Ones in place (including number of countries with functioning national monitoring and evaluation system for HIV and AIDS)	for each of the 'Ones' and who is going to assess these. In addition, it may be desirable to go beyond simply stating whether these things exist and to assess how well they function. ***Note:*** Part of the retrospective review in the final evaluation should address the extent to which: 1. The UK has urged governments to turn the principles of the Three Ones into action. 2. The UK's work with national governments and other partners, including UNAIDS, has strengthened domestic planning, coordination and monitoring.	broken down by individual country although the aggregated figures are based on national reports. UNAIDS report that assessments for individual countries are available. Information may also be available from use of the Country Harmonisation and Alignment Tool being piloted by UNAIDS (Gillies, 2006).	2-3 years	
N3	AIDS funding requirements for individual PSA countries	This is an estimate of the financial resources needed by a country to respond effectively to HIV and AIDS	Although UNAIDS' global assessments of resource needs are aggregated from figures for individual countries, these are not published by UNAIDS and there are no plans to do so. Countries with Global Fund grants make such estimates as part of the application process. It is proposed that this issue be reviewed as part of the final evaluation through interviews with key informants and review of relevant literature.	Final evaluation	Evaluation Team

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
N4	Number of PSA countries with harmonised funding for HIV/AIDS	This indicator could be tracked both descriptively[5] and quantitatively[6]. Various forms of pooling are possible including health sector support, budget support and support to NACs[7]. Pooling may occur in-country or internationally, eg with the Global Fund **Note:** Part of the retrospective review in the final evaluation should address the extent to which: 1. There is a lead donor supporting coordination efforts. 2. There is a minimum level for funding from donors 3. There has been any reduction in the number of donors funding HIV and AIDS	Currently, this data is not available in an aggregated form. It may be possible to collect the descriptive version of the indicator from DFID country offices but the quantitative version will only be possible as national AIDS spending assessments are conducted in more countries. As no system is yet established, it is proposed to try to collect data on this from country case studies during the final evaluation.	Final evaluation	Evaluation Team
N5	Qualitative review of national AIDS response (including length and predictability of financing to national AIDS response)	This indicator will attempt to track the commitments in *Taking Action* regarding the kind of national responses the UK will support. A checklist has been developed for this purpose (see annex 12, p88) Note: In summary issues to be considered in this qualitative assessment include the extent to which national programmes: 1. Are comprehensive, integrating	Currently, there is no system for conducting qualitative assessments specific for *Taking Action* and there are strong concerns among DFID staff about the legitimacy of doing so. It is proposed that this should be done based on review of available documents for PSA countries as part of the final evaluation. It might be followed up in more depth in	Final evaluation	Evaluation Team

[5] By simply describing whether or not there is a pooling mechanism and what it looks like
[6] By seeking to quantify financial flows through pooled and non-pooled mechanisms
[7] Or their equivalent

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
		programmes that prevent, treat, care and mitigate the impact of AIDS 2. Include nationally led treatment and care responses that follow the DFID policy on treatment and care 3. Include a focus on food security 4. Ensure that affordability is not a barrier to accessing health and education, or to services such as HIV testing and contraception. 5. Promote the greater involvement of people living with HIV and AIDS 6. Are scaling up and coordinating civil society initiatives 7. Involve the private sector 8. Analyse and overcome blockages to scaling up 9. Address issues of human resources for health in both the short and long-term 10. Strengthen the links between AIDS and sexual and reproductive health programmes 11. Have long-term and predictable financing	case study countries.		
UK GOVERNMENT CONTRIBUTION					
U1	UK funding for AIDS-related work[8]	This measures UK spending on HIV and AIDS in developing countries and is at the heart of the main spending target in *Taking Action* of £1.5b over three years. Method is currently being finalised. Issues relating to this are discussed in working paper 1	DFID's management information systems, including PRISM	Annually	SRSG

[8] Including disaggregated figures for support to work with OVC; amount and percentage of UK AIDS funding through multilaterals; amount of UK bilateral funding provided to each PSA country for HIV and AIDS; length and predictability of UK AIDS financing; UK annual investment in HIV and AIDS research; and AIDS financing provided through programme partnership agreements with NGOs

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
		of this evaluation (SSS, 2006). It also includes a number of sub-indicators which are essentially disaggregations of the main indicator.			
U2	Qualitative review of UK support to AIDS response	This indicator will attempt to track the commitments in *Taking Action* regarding UK support to national responses to HIV and AIDS. A tool is proposed for this purpose (see annex 13, p89) This has been developed by adapting an existing tool being used within Africa Division. Early use of this tool indicates that some adaptations may be needed to use in countries/regions with concentrated epidemics and for regional programmes. Note: In summary issues to be considered in this qualitative assessment include the extent to which UK support for the national HIV and AIDS response: 1 Is captured in country assistance plans 2 Specifies support for orphans and vulnerable children in country assistance plans	Regional Divisions currently collect this information on an ad hoc basis using different tools and approaches. It is proposed to harmonise this process across regional divisions using a standardised tool (see annex 13, p89).	Six monthly	Regional Divisions/Country Offices
U3	Qualitative review of UK support to HIV and AIDS research	This indicator is in addition to tracking the total funds spent by the UK on HIV and AIDS research. The qualitative assessment should track the	Information on DFID's central research spend should be available from CRD. It would be greatly enhanced if it also included data on any research	Annually	CRD

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
		following issues. The extent to which UK support for HIV and AIDS research is focused on: 1. Microbicides 2. Treatments and new technologies for the poor, women and young people 3. Social, economic and cultural impact of AIDS 4. Building knowledge on how to influence and change the societal and economic impacts of AIDS, including the challenge of growing numbers of orphans 5. Developing global understanding of how the social roles of men and women, boys and girls, increase vulnerability to HIV 6. Innovative treatment regimes that can be safely accessed by marginalised groups 7. Developing better and more effective therapies for children 8. AIDS vaccine development 9. Engaging the users of research – including poor people themselves and DFID staff based overseas – from the outset 10. Sexual and reproductive health research, monitoring and evaluation and applying knowledge and lessons learnt in policy and planning. 11. Paediatric ART and diagnostics	on HIV and AIDS being financed by country offices. This could be gleaned from returns for indicator U2 (see annex 13, p89).		
U4a	UK influence at international events and with global institutions	Challenges with tracking this include difficulties in defining measurable indicators and potentially hindering progress by	Global AIDS Policy Team work plan will provide information on important international events during the remainder of the	Final evaluation	Evaluation Team

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
		declaring political targets in advance of negotiations. This will be assessed during the final evaluation of Taking Action by looking back at achievements in international events and with global institutions, identified in advance by DFID's Global AIDS Policy Team[9]. **Note:** Part of the retrospective review should address: 1. The extent to which the UK has promoted political leadership to advocate for the rights of women, young people and vulnerable groups 2. The extent to which the UK has promoted leadership by and among women, young people and vulnerable groups 3. The extent to which the UK has promoted human rights in relation to tackling HIV and AIDS 4. The extent to which the UK has supported legislative reform to combat stigma and discrimination experienced by people living with HIV 5. The extent to which the UK has advocated internationally for policies, plans and resources that address people's rights to sexual and reproductive health, and continue to address controversial issues such as safe abortion and harmful and coercive practices 6. the extent to which the UK has advocated for integration of and	period of Taking Action. Progress will primarily be assessed through review of relevant secondary sources.		

[9] A number of international events were identified in *Taking Action* and these are listed in table 2 of the main report. In addition, *Taking Action* committed the UK government to promoting the Global Coalition on Women and AIDS, and the ICPD agenda on sexual and reproductive health.

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
		linkages between sexual and reproductive health, HIV and AIDS			
U4b	In-country political influence exerted by FCO and DFID	Challenges with tracking this include difficulties in defining measurable indicators, potentially hindering progress by declaring political targets in advance of negotiations and identifying mechanisms for collecting this data from both DFID and FCO offices in country. It is proposed that this will be assessed during the final evaluation of Taking Action through case studies in selected countries. **Note:** Part of the retrospective review should address: 1. The extent to which the UK has promoted political leadership to advocate for the rights of women, young people and vulnerable groups 2. The extent to which the UK has promoted leadership by and among women, young people and vulnerable groups 3. The extent to which the UK has promoted human rights in relation to tackling HIV and AIDS 4. The extent to which the UK has supported legislative reform to combat stigma and discrimination experienced by people living with HIV 5. The extent to which the UK has worked to ensure that equity and rights are prioritised, including in poverty reduction strategy processes and in the decision-making process	FCO and DFID in-country documents may contain prospective plans for exerting political influence. However, these may be described in general terms only, eg Country Assistance Plans. In addition, some regional divisions/country offices have been producing reports on progress in implementing Taking Action and these may contain relevant information.	Final evaluation	Evaluation Team

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
		around scaling up treatment 6. The extent to which the UK has advocated nationally for policies, plans and resources that address people's rights to sexual and reproductive health, and continue to address controversial issues such as safe abortion and harmful and coercive practices 7. The extent to which the UK has influenced the adoption and use of the International OVC Framework (UNICEF, 2004)			
U4c	UK support to key regional political institutions	Institutions mentioned in *Taking Action* are: • The African Union • New Partnership for Africa's Development (NEPAD) • UN Economic Commission for Africa • Asia-Pacific Leadership Forum (APLF) • Commission for Africa • SADC Support will be assessed both quantitatively (in terms of finances) and qualitatively.	DFID's Management Information Systems should have information on funds involved. Qualitative information may need to be gathered through interviews.	Final evaluation	Evaluation Team
U5	Support to multilateral organisations[10] as reflected in ISPs	This involves assessing documents relating to multilaterals to determine how well HIV is covered within those documents and how well what was planned has been	It is proposed to track this indicator by retrospective review during the end of strategy evaluation. This will be based on available information, including ISPs	Final evaluation	Evaluation Team

[10] Including the Global Fund

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
		implemented. A system of scoring ISPs was used during this evaluation for preparation of working paper 1 (SSS, 2006, p70). **Note:** Part of the retrospective review should address the extent to which: 1. Individual multilateral agencies have demonstrated effectiveness 2. Individual multilateral agencies are significant funders 3. Individual multilateral agencies provide high level technical assistance 4. Individual multilateral agencies have a coordination role 5. Individual multilateral agencies have strengthened their capacity to support effective national action 6. The UK has used its influence, and membership of institutions' governing bodies, to improve the effectiveness, equity and efficiency of international support for national responses to AIDS 7. Particular agencies have been supported to do the following: • UNFPA – to make contraception more freely available by improving access and reducing prices • World Food Programme and UNICEF to improve planning systems for food security 8. UNICEF has the ability to deliver comprehensive responses to orphans and vulnerable children			

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
U6	UK support to increase access to medicines	Qualitative indicator based on the questions listed below[11]: Note: Part of the end of strategy evaluation should assess the extent to which the UK: 1. Supported countries to improve access to medicines including through increasing poor people's access to health services (disaggregated for women and children) 2. Supported developing countries to understand and make use of flexibilities within WTO rules governing intellectual property 3. Worked with the pharmaceutical industry to ensure the long-term supply of affordable medicines to developing countries 4. Worked with the pharmaceutical industry to stimulate 'best practice' by companies as they engage in developing country markets 5. Stimulated increased research and development of medicines and healthcare products relevant to developing country health needs 6. Supported improved access to sexual and reproductive health commodities, such as contraceptives and condoms 7. Supported provision of ART and Cotrimoxazole prophylaxis to HIV positive children through the availability of diagnostics and appropriate formulations[12]	Questions asked of key informants during final evaluation	Final evaluation	Evaluation Team
U7	Influence to strengthen	This is a qualitative indicator which will be reviewed in the end	Interviews with DFID staff, other MERG members, country	Final evaluation	Evaluation Team

[11] Based on DFID et al., 2004
[12] This question is relevant to questions 1,4 and 5

Indicator Number	Indicator Name	Indicator Description	Data Source	Frequency of Collection	Responsibility within DFID
	monitoring and evaluation of HIV and AIDS	of strategy evaluation. Note – this review needs to specifically cover 1. UK role within the MERG 2. UK's provision of in-country technical assistance to build national monitoring and evaluation capacity	case studies		

Annex 3: Baseline Data

I1: AIDS funding requirements for low- and middle-income countries

Current UNAIDS estimates (UNAIDS, 2005c; UNAIDS, 2006a) are:

2006 - $14.9b
2007 - $18.1b
2008 - $22.1b

Disaggregated figures for prevention, care and treatment, support for orphans and vulnerable children, programme support and infrastructure and human resources etc. are available.

I2: Amount of financial flows for the benefit of low- and middle-income countries

UNAIDS estimates (UNAIDS, 2006a) that funding available for the response to AIDS in low and middle income countries in 2005 was US$8.3b. Disaggregated figures for domestic, national and donor spending are available. Issues relating to tracking and disaggregating this indicator have been covered in working paper 1 of this evaluation (SSS, 2006).

Figures are also available for OECD countries (OECD, 2006c; UNAIDS and OECD, 2006c; Kates and Lief, 2006). These show that funds disbursed by OECD countries rose from US$1.3b in 2000 to US$2.7b in 2004. There is strong evidence of additionality of these funds (Lief and Izazola, 2006). Reasons given for UNAIDS publishing figures in addition to those from OECD are speed and the need for greater disaggregation of data (UNAIDS, undated).

I3: Percentage of young women and men aged 15-24 who are HIV infected

Baseline data for this indicator is shown in annex 4 (p49) with notes on data sources. This data is provided for Africa only. It is not widely available for other countries because these are experiencing epidemics concentrated among particular sub-populations. Therefore, data on prevalence among these sub-populations is more relevant and this is presented in annex 5 (p51).

Current trends in HIV prevalence in PSA countries are briefly documented here (based on UNAIDS, 2006a):

DRC	Insufficient data	13
Ethiopia	Decline in urban areas	

[13] Colour code indicates overall trend in terms of HIV prevalence, i.e. green = declining HIV prevalence; orange = stable HIV prevalence; red = rising HIV prevalence

Ghana	Stable HIV prevalence
Kenya	Declining national HIV prevalence
Lesotho	Stable but very high HIV prevalence
Malawi	Stable but very high HIV prevalence
Mozambique	Spreading through transport routes
Nigeria	Stable HIV prevalence
Rwanda	Decline in urban areas
Sierra Leone	Stable HIV prevalence
South Africa	Increasing HIV prevalence
Sudan	Significant spread
Tanzania	Stable HIV prevalence
Uganda	Stable HIV prevalence
Zambia	Stable but very high HIV prevalence
Zimbabwe	Declining national HIV prevalence
Bangladesh	Signs of HIV outbreak among injecting drug users
Cambodia	Steady ongoing decline in HIV prevalence
China	Increasing HIV prevalence
India	Declining HIV prevalence in four states
Indonesia	Increasing HIV prevalence
Nepal	Insufficient data
Pakistan	Signs of HIV outbreak among injecting drug users
Vietnam	Increasing HIV prevalence

I4: Number and percentage of men, women and children with advanced HIV infection receiving combination antiretroviral therapy

By end of 2005, it was estimated that more than 1.2m people were on antiretroviral drugs in low and middle income countries. Figures[14] for PSA countries are as follows:

Country	2003	2005 M	2005 F	2005 Total[15]
DRC	0	-	-	2.7-4.0
Ethiopia	1.0	8.2	6.2	7.0-7.7
Ghana	1.8	5.6	4.6	4.8-7.0
Kenya	3	-	-	17.0-24.0
Lesotho	<1	-	-	13.6-14.0
Malawi	1.8	14.9	19.7	17.7-20.0
Mozambique	0.0	7.4	7.4	7.4-9.0
Nigeria	1.5	-	-	5.7-7.0
Rwanda	<1	-	-	39.0
Sierra Leone	0.0	-	-	2.0
South Africa	0.0	-	-	13-21

[14] As percentage of people with advanced HIV infection receiving antiretrovirals
[15] As a range of results from different methods. Colour coding is red=<10%; orange=10-20%; green=>30%. In case of overlapping ranges, lower colour is used

Country	2003	2005		
		M	F	Total[15]
Sudan	-	-	-	
Tanzania	<1	-	-	7.0
Uganda	6.3	-	-	51-57.4
Zambia	0.0	-	-	19.3-27
Zimbabwe	0.0	-	-	8-9.1
Bangladesh	0	-	-	1-8.9
Cambodia	3	-	-	35.1-57.0
China	5	-	-	18.3-25
India	2	-	-	6.8-7.0
Indonesia	2.7	-	-	30-94.3
Nepal	-	-	-	1-11.1
Pakistan	2.2	-	-	1.2-2.0[16]
Vietnam	1.0	-	-	12.0-58.9

Reports from "3 by 5" initiative reported no evidence of gender biases in access to ART (UNAIDS/WHO, 2005). However, this was based on available data and relatively few countries disaggregate numbers by gender. UNAIDS has ranked countries as to whether particular countries were treating as many women with ART as might be expected[17]. Results for PSA countries are (UNAIDS, 2006a):

Less women on ART than expected	Women on ART as expected	More women on ART than expected
Ethiopia	Mozambique	Malawi
Ghana		Nigeria
Kenya		Rwanda
Uganda		South Africa
India		Tanzania
Vietnam		Zambia
		Zimbabwe
		Cambodia
		China

In order to have equitable access for children, Malawi and Mozambique would be expected to have children constituting 13% of all those on ART, but the numbers were in fact 5 and 7%[18] (UNAIDS/WHO, 2005). Figures for other PSA countries (UNAIDS, 2006a) are:

- Ghana – 3%
- Kenya – 8%
- Nigeria – 3%

[16] Pakistan is only PSA country where no progress seems to have been made on ART since 2003
[17] As proportion of total on treatment
[18] 5 and 6% in UNAIDS, 2006a

- Rwanda – 7%
- South Africa – 8%
- Tanzania – 11%
- Uganda – 9%
- Zambia – 8%
- Zimbabwe – 7%
- Cambodia – 11%
- China – 4%
- India – 4%
- Vietnam – 4%

There is little available data on ART access for the most vulnerable populations. UNAIDS raises concerns that sex workers, MSM, IDUs, prisoners, refugees, IDPs and other mobile populations all find it difficult to access this therapy (UNAIDS, 2006a). ART scale-up has been slowest where the epidemic is concentrated among these populations (UNAIDS/WHO, 2005).

I5: Annual global investment in microbicide and vaccine research

In 2004, it was estimated that there was approximately $682m available for research into an HIV vaccine. Of this, 88% came from public funds, 10% from industry and 2% from private philanthropy. Non-commercial investment in vaccine development rose from US$327m in 2000 to US$614m by April 2005 (Lamourelle et al., 2006; HIV Vaccines and Microbicides Resource Tracking Working Group, 2006).

By 2005, non-commercial investment in microbicide research stood at $163.4m per year as compared to $65.1m in 2000.

Figures for other forms of international HIV research are not systematically produced. However, some figures are available, including that in 2005, the US spent US$ 384m on international HIV research other than microbicides and vaccines, France spent US$31.1m and Canada spent US$1.4m (Kates and Lief, 2006).

I6: Unmet need for contraception

Based on 55 national surveys, it was estimated in 2002 that 122.7m women in developing countries and the former Soviet Union had unmet need for contraceptives[19]. Based on figures on the UNFPA website, figures for PSA countries are:

[19] Based on most recent UNFPA figures, the number of women with unmet contraceptive need in PSA countries (excluding DRC, Lesotho, Sierra Leone, Sudan, and China) was 59.8m. Of these 81% are in Asia and more than half (52%) were in India alone.

Country	1990 (%)	Most recent figures (%)	Most recent absolute figures (m)
DRC	-	-	-
Ethiopia	-	35.8	3.3
Ghana	65.9	23.0	0.6
Kenya	60.3	23.9	0.3
Lesotho	-	-	-
Malawi	36.3	29.7	0.5
Mozambique	-	22.5	0.7
Nigeria	20.8	17.4	3.0
Rwanda	40.4	35.6	0.3
Sierra Leone	-	-	-
South Africa	-	15.0	0.6
Sudan	-	28.9	-
Tanzania	30.1	21.8	1.2
Uganda	53.7	34.6	1.2
Zambia	33.4	27.4	0.4
Zimbabwe	34.2	12.9	0.2
Bangladesh	-	15.3	4.0
Cambodia	-	32.6	0.7
China	-	-	-
India	-	15.8	31.3
Indonesia	12.7	8.6	3.7
Nepal	-	27.8	1.2
Pakistan	-	28.0	6.9
Vietnam	-	4.8	0.9

I7: Organisational effectiveness summaries

Currently, this work is at a very early stage so no baselines are yet available.

I8: Length and predictability of international financing for HIV and AIDS

There does not appear to be any systematically aggregated data, although UNAIDS report that funding for long-term programmes has increased by 13.3% (UNAIDS, 2006a, p.237). Some descriptions of aid instruments used and time frames involved are available in the literature (Kates and Lief, 2006).

I9: Harmonised international system for HIV/AIDS monitoring and evaluation

Annex 6 (p53) analyses the extent to which different attempts to harmonise HIV/AIDS monitoring and evaluation internationally harmonise with each other (see section 2.12 of main report). Within the three systems identified, there is only complete consensus over three of 47 indicators. There is partial agreement over a further eight indicators while 31 indicators appear in one system only. There are five indicators where there are significant methodological differences between systems.

N1: Core UNGASS Indicators

Data for these indicators was collected by UNAIDS in 2003 and 2005 (see UNAIDS, 2006a). This is summarised for PSA countries in annex 7 (p59).

Figures on national budgets for HIV and AIDS for PSA countries are also available from their most recent proposal to Global Fund (all figures in US$m)[20,21]

Country	2002	2003	2004	2005	2006	2007	2008	2009	2010
DRC	25.8	16.9	7.8	7.8	-	-	-	-	-
Ethiopia	-	-	119.4	120.2	147.7	157.5	167.2	-	-
Ghana	-	-	68	85	101	111	112	125	141
Kenya	No data table								
Lesotho	-	-	-	24.0	20.0	17.7	15.9	7.3	7.3
Malawi	-	-	-	-	45.8	41.5	30.2	31.7	33.1
Mozambique	No data table								
Nigeria	-	-	51.7	65.2	48.5	43.8	35.8	1.5	1.5
Rwanda	-	18.2	19.6	21.7	22.7	-	-	-	-
Sierra Leone	-	-	6.6	5.2	2.1	-	-	-	-
South Africa	No data table								
Sudan	2.3	2.0	0.9	0.5	0.5	0.5	0.5	-	-
Tanzania[22]	47	69	170	185	168	30	30	-	-
Uganda	-	36	42.4	51.6	-	-	-	-	-
Zambia	-	-	-	67	92	99	107	122	-

[20] Downloaded from http://www.theglobalfund.org/en/. These figures have been endorsed by countries' coordinating mechanisms but have not been externally verified. This work was conducted prior to R6 proposals being made available so only covers R1-5

[21] Decline in projected funding over time in some countries is evidence of unpredictability of much AIDS funding

[22] The figures in the Tanzanian application are given as $371, $507 etc. and it is assumed that these should be millions

Country	2002	2003	2004	2005	2006	2007	2008	2009	2010
Zimbabwe	-	-	6.8	19.8	23.5	27.9	36.5	-	-
Bangladesh	No data table								
Cambodia	-	-	40.9	46.0	42.2	36.9	35.2	31.5	27.1
China	-	-	206.3	271.8	282.0	306.1	313.1	304.3	296.0
India	-	-	74	87	100	107	111	-	-
Indonesia	-	-	-	30.2	33.2	24.7	22.0	22.3	-
Nepal	No data table								
Pakistan	No data table								
Vietnam	No data table								

UNAIDS and OECD have recently produced figures of external resource flows to countries for HIV and AIDS (UNAIDS and OECD, 2006). Top ten recipients of AIDS aid in 2004 were Uganda (US$169m); DRC (US$152m); South Africa (US$148m); China (US$107m); Tanzania (US$93m); Kenya (US$86m); Mozambique (US$82m); Ethiopia (US$72m); Nigeria (US$72m) and Zambia (US$62m). All are PSA countries. Funds going to other African countries were US$787m; Asia - US$193m; Oceania – US$25m; Europe – US$31m; and Americas and the Caribbean – US$192m.

Work by CSIS and UNAIDS in 13 countries (Lief and Izazola-Licea, 2006) shows that increasing finance flows for HIV and AIDS have been accompanied by increasing amounts of money for development overall. The largest part of the funds has come from the US and the Global Fund. In all countries, there has been an increase in domestic financing for the response to HIV and AIDS. Although overall financing for health grew both overall, and in some other sectors, eg infectious disease control; and policy and management, many sub-sectors of health were either financially static or declined, eg family planning and reproductive health.

N2: Number of PSA countries reporting each/all of Three Ones in place (including number of countries with functioning national monitoring and evaluation system for HIV and AIDS)

Globally, UNAIDS reported that:

- 90% of countries have a national AIDS strategy
- 85% of countries have a single AIDS coordinating body
- 50% of countries have a national monitoring and evaluation system for HIV and AIDS (UNAIDS, 2006a, chapter 11, p254)

N3: AIDS funding requirements for individual PSA countries

Figures from PSA countries' most recent proposal to Global Fund[23] (all figures in US$m).

Country	2002	2003	2004	2005	2006	2007	2008	2009	2010
DRC	50	55	60	66	72.6	-	-	-	-
Ethiopia	-	-	210	220	250	280	300	-	-
Ghana	-	-	105	122	138	159	163	179	199
Kenya	No data table								
Lesotho	-	-	-	26.1	36.5	38.0	33.8	39.4	42.9
Malawi	-	-	-	-	49.4	55.7	54.9	57.1	57.2
Mozambique	No data table								
Nigeria	-	-	103.0	183.4	253.6	361.9	468.2	762.0	770.0
Rwanda	-	23	33	45.5	53.5	-	-	-	-
Sierra Leone	-	-	19.2	23.9	32.9	36.1	41.0	-	-
South Africa	No data table								
Sudan	-	-	4.6	5.6	6.2	7.2	7.7	-	-
Tanzania[24]	-	-	371	507	636	779	925	-	-
Uganda	-	200	200	200	200	-	-	-	-
Zambia	-	-	-	136	144	157	173	203	-
Zimbabwe	-	-	25	52	72.9	122	160	-	-
Bangladesh	No data table								
Cambodia	-	-	49.6	52.9	55.4	57.4	63.8	57.1	58.4
China	-	-	630	700	750	800	800	800	800
India	-	-	805	805	805	805	805	-	-
Indonesia	-	-	-	43	51.6	35.6	32.7	34.4	-
Nepal	No data table								
Pakistan	No data table								
Vietnam	No data table								

[23] Downloaded from http://www.theglobalfund.org/en/. These figures have been endorsed by countries' coordinating mechanisms but have not been externally verified. This work was conducted prior to R6 proposals being made available so only covers R1-5

[24] The figures in the Tanzanian application are given as $371, $507 etc. and it is assumed that these should be millions

N4: Number of PSA countries with harmonised funding for HIV/AIDS

Baseline data not available.

N5: Qualitative review of national AIDS response (including length and predictability of financing to national AIDS response)

Baseline data not available overall. Although data for the length and predictability of financing is not yet being systematically collected through National AIDS Accounts, an approximation of the predictability of funding can be gained from countries own budget forecasting (see indicator N3, p45)[25].

Last year of budget forecast as percentage of first year

<50%	50-100%	>100%
DRC (30%) Lesotho (30%) Nigeria (2.9%) Sudan (22%) Kenya, Mozambique, South Africa, Bangladesh, Nepal, Pakistan and Vietnam all no data	Malawi (72%) Tanzania (64%) Cambodia (66%) Indonesia (74%)	Ethiopia (140%) Ghana (207%) Rwanda (125%) Uganda (143%) Zambia (182%) Zimbabwe (536%) China (144%) India (150%)

U1: UK funding for AIDS-related work

DFID has reported figures for the period from 2000/1 to 2003/4. These were:

2000/1	£197m
2001/2	£197m
2002/3	£274m
2003/4	£346m[26]

At the time of preparing this working paper, no official figures were available from DFID for 2004/5 or beyond as the method is still being finalised and data processed. Official disaggregated figures for OVC funding, funding through multilaterals, PPAs etc. are also not yet available from that period.

[25] Calculations are based on expressing the budget figure for the latest year forecasted as a percentage of the next year forecast, so if country x has a budget of $100m for 2007 and $50m for 2010, the ratio would be 50%. It is acknowledged that figures between countries may not be comparable because budgeting methods differ as does the length of period involved.

[26] These figures do not tally with figures reported by OECD for the UK of US$320.5m-US$373.6m for 2003, and US$197.3-US$233.9m for 2004 (OECD, 2006c) or US$688m for 2005 (UNAIDS, undated; Kates and Lief, 2006). Reasons for these differences have been discussed in working paper 1 produced for this evaluation (SSS, 2006)

Although baseline figures for percentage of funding through multilaterals exist up to 2003/4, these may be revised with the adoption of a new method for spending on HIV and AIDS from 2004/5. It is therefore advisable to delay defining these baselines until those figures are published. There have been a number of external reviews of the current baselines (Janjua, 2003; SSS, 2006). A recent OECD publication (OECD, 2006c) reported that in 2003, US$98.7m of US$320.5m total UK financing for HIV and AIDS went through multilaterals (31%) and that this percentage rose to 39% in 2004[27].

Based on figures supplied by CRD (SSS, 2006, section 4.16, p18) DFID spent just over £20m[28] on HIV and AIDS research in 2005/6. However, these figures only include health and education research. The bulk of this (>£15m) is for microbicides and vaccines.

U2: Qualitative review of UK support to AIDS response

Some baseline data has been collected by Regional Divisions from country offices from 2004-2006. This has been done on a relatively ad hoc basis and has used a variety of reporting templates. There are no systematically, aggregated documents based on data collected through this process.

U3: Qualitative review of UK support to HIV and AIDS research

No systematic baseline data available. A key challenge is that there is no global data on expenditure on HIV and AIDS research for the developing world with the exception of microbicides and vaccines.

U4a: UK influence at international events and with global institutions

Baseline data is being collected as part of this interim evaluation, focusing on retrospective literature analysis relevant to section 2 of table A from the evaluation design documents. This will be available as an annex to the final report.

U4b: In-country influence exerted by FCO and DFID

During 2004-6, DFID's Regional Divisions consulted countries on progress made in implementing *Taking Action* (see indicator U2). This included measures taken to promote national political leadership regarding HIV and AIDS. Data from this process could be used as a baseline assessment of this indicator. Also some anecdotal evidence is available from country case studies conducted as part of this evaluation.

[27] US$76.5m of a total of US$197.3m
[28] This figure excludes £3.44m which was spent on these projects/programmes but was not considered as expended on HIV and AIDS

U4c: UK support to key regional political institutions

The following projects/programmes were identified related to the institutions named in *Taking Action* during the work for working paper 1 of this evaluation (SSS, 2006)

MIS Code	Brief Project Description	Planned Time Period	Financial Commitment (£)
7326200003	Pre-feasibility study of investment options for African ICT infrastructure	2003-4	25,000
001542075	Flexible support to UNECA Rapid Reaction Fund	2001-3	750,000
001542114	Budget support to Economic Commission for Africa	2003-6	2,350,000
187555014	APLF on HIV/AIDS and development	2003-5	500,000
001542117	Commission for Africa	2004-5	3,500,000
06257001	SADC Strategic Indicative Plan for Organ on Politics and Defence	2004-7	200,000
068500003	Regional Hunger and Vulnerability Programme	2005-8	4,500,000
782622244	Equity and HIV/AIDS	2003	18,000
786620065	AIDS manual, Natal University	2000	34,000

U5: Support to multilaterals as reflected in institutional strategy papers

Two previous assessments have been made of DFID's ISPs with multilateral agencies and the extent to which they adequately focus on HIV and AIDS (NAO, 2004; SSS, 2006). These can serve as qualitative baselines for this indicator.

U6: UK support to increase access to medicines

Some data on work done to date was included in the UK's plans and policy for increasing access to medicines (DFID et al., 2004)

U7: UK influence to strengthen monitoring and evaluation of HIV and AIDS

No baseline data yet identified.

Annex 4: HIV Prevalence Rate among Young People Aged 15-24: 2000-2005

Country	DFID PSA Country	UNSD Millennium Indicator Database	2000	2001	2002	2003	2004	2005		Data Sources
								F	M	
Angola	No	Yes		6			2.8	2.5	0.9	UNSD Millennium Indicator Database
Benin	No	Yes	4	4.1	2			1.1	0.4	UNGASS Report 2006
Botswana	No	Yes	32	34	31	33		15.3	5.7	
Burkina Faso	No	Yes			2			1.4	0.5	
Burundi	No	Yes	13	10	14		8.6	2.3	0.8	
Cameroon	No	Yes		13	7			4.9	1.4	
Central African Republic	No	Yes			14			7.3	2.5	
Chad	No	Yes			7			2.2	0.9	
Congo	No	Yes			3			3.7	1.2	
Cote d'Ivoire	No	Yes		10	5			5.1	1.7	
DRC	Yes	No						2.2	0.8	
Djibouti	No	Yes			3			2.1	0.7	
Ethiopia	Yes	Yes	15	14		11.5				
Ghana	Yes	Yes	3	4	3	4		1.3	0.2	
Kenya	Yes	No						5.2	1.0	
Lesotho	Yes	Yes				28		14.1	5.9	
Malawi	Yes	Yes		15		18		9.6	3.4	
Mali	No	Yes				2		1.2	0.4	
Mozambique	Yes	Yes	12	14	15			10.7	3.6	
Nigeria	Yes	Yes				4		2.7	0.9	
Rwanda	Yes	Yes		9.8	12			1.9	0.8	
Senegal	No	Yes			1			0.6	0.2	
Sierra Leone	Yes	No						1.1	0.4	
South Africa	Yes	Yes		30	32		25.2	14.8	4.5	

Country	DFID PSA Country	UNSD Millennium Indicator Database	2000	2001	2002	2003	2004	2005		Data Sources
								F	M	
Sudan	Yes	No								
Swaziland	No	Yes	38		39		37.3	22.7	7.7	
Tanzania	Yes	Yes	7.5	9	7			3.8	2.8	
Togo	No	Yes		5		9		2.2	0.8	
Uganda	Yes	Yes	8.5		8			5.0	2.3	
Zambia	Yes	Yes			22		20.7	14.7	4.4	
Zimbabwe	Yes	No		29.8			18.6			

Annex 5: HIV Prevalence Rate among Vulnerable Groups Aged 15-24: 2000-2005

Country	DFID PSA Country	UNSD Millennium Indicator Database	2000	2001	2002	2003	2004	2005	Vulnerable Groups
Angola	No	Yes		33.3					Injecting Drug Users
Benin	No	Yes		60.5					Sex workers
Botswana	No	Yes							Men who have Sex with Men
Burkina Faso	No	Yes						20.8	
Burundi	No	Yes							
Cameroon	No	Yes							
Central African Republic	No	Yes							
Chad	No	Yes							
Congo	No	Yes							
Cote d'Ivoire	No	Yes	28.0						
DRC	Yes	No					12.4		
Djibouti	No	Yes							
Ethiopia	Yes	Yes							
Ghana	Yes	Yes							
Kenya	Yes	No	25.5						
Lesotho	Yes	Yes							
Malawi	Yes	Yes							
Mali	No	Yes	21.0					31.6	
Mozambique	Yes	Yes							
Nigeria	Yes	Yes							
Rwanda	Yes	Yes							
Senegal	No	Yes	13.0					27.1 21.5	
Sierra Leone	Yes	No							
South Africa	Yes	Yes							
Sudan	Yes	No							

Country	DFID PSA Country	UNSD Millennium Indicator Database	2000	2001	2002	2003	2004	2005	Vulnerable Groups
Swaziland	No	Yes							Injecting Drug Users
Tanzania	Yes	Yes							Sex workers
Togo	No	Yes						53.9	Men who have Sex with Men
Uganda	Yes	Yes							
Zambia	Yes	Yes							
Zimbabwe	Yes	No							
Bangladesh	Yes	No					0.2	4.9 0.4	
Cambodia	Yes	No	26.3						
China	Yes	No	0 0.2					8.3 0.5 1.5	
India	Yes	No	5.0 9.4						
Indonesia	Yes	No	65.5 0.0						
Nepal	Yes	No	50.0 17.1					2.0 3.9	
Pakistan	Yes	No		0.0				22.9	
Vietnam	Yes	No	17.5 10.0					30.6 6.5	

Annex 6: Review of Different Proposed Approaches for Harmonising HIV and AIDS Indicators

		UNGASS[29]	'Global Fund' Toolkit[30]	Universal Access[31]
Global indicators		✓	✗	✗
Indicator levels		National commitment and action Knowledge and behaviour Impact	Routine Outcome/impact	Core, recommended and interim indicators. Core and recommended divided by themes: treatment; care and support; prevention; national commitment
Distinguishes different types of epidemics in country		✓	✗	✗[32]
Detailed instructions available on how to measure indicators		✓	✗	✗
Specific Indicators[33]				
Government funding for HIV/AIDS		✓✓[34]	✗	✓

[29] UNAIDS, 2005a
[30] Top Ten only - WHO et al., 2006
[31] UNAIDS, 2006i
[32] Although UNAIDS does not provide different indicators for generalised and concentrated epidemics, there is a note that in countries with low prevalence or concentrated epidemics, coverage of prevention programmes targeting most-at-risk populations should be a core indicator but only recommended in generalised epidemics
[33] Colour coding – = fully harmonised across three indicator sets; = present in at least two indicator sets; = mentioned in one indicator set only; = major methodological differences between indicators
[34] Two ticks means this is a core indicator for both generalized and concentrated epidemics

		UNGASS[29]	'Global Fund' Toolkit[30]	Universal Access[31]
Government HIV/AIDS policies		✓✓	×	✓[35]
Life-skills-based education in schools		✓	×	×
Workplace HIV/AIDS control		✓	×	×
STI: comprehensive case management		✓	×	×
MTCT: ARV prophylaxis		✓	✓	✓
HIV treatment: ARV combination therapy		✓	✓	✓
Support for children affected by HIV/AIDS		✓	×	✓
Blood safety		✓	×	×
Young women and men's knowledge about HIV prevention		✓	×	✓®[36,37]
Sex before the age of 15 among young women and men[KIS38]		✓	×	✓
Percentage of 15-19 year olds who never had sex[KIS]		×	✓	×
Percentage of 15-24 year olds who never had sex in the last year of those who ever had sex[KIS]		×	✓	×
Higher-risk sex among young women and		✓[39]	✓[40]	×

[35] Some of the interim indicators proposed seem to overlap with the national composite policy index, eg a defined oversight structure to be established to monitor and report annually on the enforcement of policies to protect human rights, which includes the active participation of people living with HIV and civil society. It is surprising that they do not reference this index.
[36] But questions differ from those defined under UNGASS
[37] Recommended indicator
[38] Indicators marked like this feature in the USAID-supported Key Indicators Survey (USAID, 2006).
[39] Defined as sex with a non-marital, non cohabiting partner in last year
[40] Defined as sex with more than one partner in the last year

		UNGASS[29]	'Global Fund' Toolkit[30]	Universal Access[31]
men[KIS]				
Young women's and men's condom use with non-regular partners[KIS]		✓[41]	✓[42]	✗
Orphan's school attendance		✓	✗	✗
Reduction in HIV prevalence (15-24 year olds)		✓	✓	✗
HIV treatment: survival after 12 months on antiretroviral therapy		✓	✓	✓®
Reduction in MTCT		✓	✓	✗
Most-at-risk population: HIV testing		✓©[43]	✗	✗
Most-at-risk populations: prevention programmes		✓©	✗	✓®[44,45]
Most-at-risk populations: knowledge about HIV prevention		✓©	✗	✗
Sex workers: condom use		✓©	✗	✗
MSM: condom use		✓©	✗	✗
IDUs: safe injecting and sexual practices		✓©	✗	✗
Most-at-risk populations: reduction in HIV		✓©	✗	✗

[41] Defined as condom use at last sex with non-regular partner
[42] Defined as consistent use of condoms with non-regular partner
[43] Core indicator for concentrated epidemics
[44] This is measured as coverage. Instructions about when this indicator should be used are conflicting. With the indicator it says this is recommended in countries with low prevalence and concentrated epidemics, and that it should be a core indicator in concentrated epidemics. Earlier in the text, it suggests that this should be a core indicator in both concentrated epidemics and countries with low prevalence. This seems to imply that it should be a recommended indicator in generalised epidemics
[45] There is also an interim indicator 'estimation of size and location of most-at-risk populations'. This is included here because this information is needed as the denominator of the coverage calculation

		UNGASS[29]	'Global Fund' Toolkit[30]	Universal Access[31]
prevalence				
Number of people counselled and tested for HIV including provision of test results		✗	✓	✓[46]
Number of condoms distributed to people		✗	✓	✓[47]
Number of people benefiting from community-based programs (specify, a. Prevention b. Orphan support c. Care and support)		✗	✓	✗
Number of cases treated for infections associated with HIV (specify, a. Preventive therapy for TB/HIV, b. STIs with counselling)		✗	✓	✗
Number of service deliverers trained		✗	✓	✓[48]
Monitoring the implementation of the "Three Ones" principles, using the UNAIDS country checklist		✗	✗	✓®
Number of ANC sites and estimated capacity to provide PMTCT services		✗	✗	✓[49]
Number of testing and counselling sites in country		✗	✗	✓
Number of TB clinics, hospitals which have		✗	✗	✓

[46] This is recorded as percentage of general population not absolute number
[47] Disaggregated by public and private sector
[48] Unlike the Global Fund 'top ten' indicator which is focused on number of people trained, interim indicators are focused on number of training programmes and are disaggregated to training of health care workers in non-discrimination, confidentiality and informed consent; sensitivity training for law enforcement staff
[49] Denotes 'interim' indicator

		UNGASS[29]	'Global Fund' Toolkit[30]	Universal Access[31]
instituted provider-initiated routine offer of HIV testing				
Number of VCT sites in country that serve defined most-at-risk populations		✗	✗	✓
Stock out rates: percentage of facilities that experienced a stock out during a specific period or on day of facility visit		✗	✗	✓
Percentage of health care facilities with basic treatment services (clinical care, laboratory capacity, and sustainable pharmaceuticals supply)		✗	✗	✓
Numbers and distribution of necessary health service staff (physicians, nurses, clinical officers, counsellors, lab technicians and pharmacists) have been estimated		✗	✗	✓
Resource needs have been estimated to scale up to 2010 targets and goals		✗	✗	✓
Percentage of members in national AIDS coordinating body (NAC) who represent sectors of civil society		✗	✗	✓
Targets set for equitable access to key prevention,		✗	✗	✓

		UNGASS[29]	'Global Fund' Toolkit[30]	Universal Access[31]
treatment, care and support interventions for defined populations				
Number of national and community campaigns to reduce HIV stigma and discrimination		✗	✗	✓
Number of income-generation schemes for women care-givers put into place		✗	✗	✓
Number of legal and social support services for women care-givers and victims of sexual violence		✗	✗	✓
Number of legal support services for people living with HIV		✗	✗	✓
Number of programmes to keep girls in secondary schools		✗	✗	✓

Annex 7: Data for Core UNGASS Indicators for PSA Countries[50]

AFRICA																
Indicator	**DRC**	**Eth**	**Gha**	**Ken**	**Les**	**Mal**	**Moz**	**Nig**	**Rwa**	**SL**	**RSA**	**Sud**	**Tan**	**Uga**	**Zam**	**Zim**
Government funding for HIV/AIDS (US$m)[51]	3.6	-	9.3	33.2[52]	1.4	8.7	2.6	6.5	1.7	-	446.5[53]	-	45.0	18.8	32.0[54]	12.1
Government funding for HIV/AIDS per capita (US$)[55]	0.06	-	0.42	0.97	0.78	0.67	0.13	0.05	0.19	-	9.4	-	1.17	0.65	2.74	0.93
Government HIV/AIDS policies	No data provided															
Life-skills-based education in schools (%)[56]	-	97[57]	-	61[58]	-	100[59]	-	19[60]	-	-	-	-	19[61]	100[62]	60[63]	75[64]
Workplace HIV/AIDS control (%)[65] [66]	4.8	33.3	10.0	-	0.0	47.0	3.2	46.9	-	-	-	-	-	-	80.0	-
STI: comprehensive case management (%)[67] [68]	-	-	-	50*	-	-	-	41[69]	28	-	-	-	-	40	10	57*
MTCT: ARV prophylaxis	0.6	0.3	1.3	9.3	5.1	2.3	3.4	0.2	9.4	-	14.6	0.0	0.3	12.0	4.0	4.4

[50] From UNAIDS, 2006a
[51] Information on trends also available in UNAIDS, 2006a, annex 3, p548
[52] Preliminary figures
[53] Preliminary figures
[54] Preliminary figures
[55] Colour code based on per capita figures – red = <0.5; orange =0.5-1.0; green= >1.0; blank = no data
[56] Colour code – red = <50%; orange = 50-75%; green = >75%; blank = no data
[57] This figure is for 2003 and is overall for both primary (100%) and secondary (77%). Figures for 2005 are primary (75%) and secondary (82%)
[58] This figure is for 2005 and is overall for both primary (62%) and secondary (49%). Overall figure for 2003 was 5%
[59] For both primary and secondary in 2005 – compared to 6.2% overall in 2003
[60] Overall in 2005
[61] Overall in 2003
[62] Primary in 2003
[63] Overall in 2005 compared to 1.5% overall in 2003
[64] Overall in 2003
[65] Percentage of large companies/enterprises with HIV/AIDS programmes and policies in 2005 – public and private sector combined
[66] Colour code – red = <25%; orange = 25-75%; green = >75%; blank = no data
[67] 2005 data aggregated for sex – except where marked with * where data is for 2003
[68] Colour code – red = <50%; orange = 50-75%; green = >75%; blank = no data
[69] Figures for women only in 2005. Figure for men was 46%

AFRICA																
Indicator		**DRC**	**Eth**	**Gha**	**Ken**	**Les**	**Mal**	**Moz**	**Nig**	**Rwa**	**SL**	**RSA**	**Sud**	**Tan**	**Uga**	**Zam**	**Zim**
(%)[70 71]							[72]										
HIV treatment: ARV combination therapy (%)[73]		4.0	7.0	7.0	19.7	14.0	20.0	9.0	7.0	39.0	2.0	21.0	1.0	7.0	56.0	27.0	8.0
Support for children affected by HIV/AIDS (%)[74 75]		-	3.6	-	10.3	25.0	-	-	-	-	-	-	-	-	-	13.4	-
Blood safety (%)[76 77]		70*	100	100 *	100	100	100	100	100	100*	20*	100	-	100 *	100	100	100
Young women and men's knowledge about HIV prevention[78]	M	-	-	44.0	47.0	-	36.0	33.0	21.0	-	-	-	-	49.0	-	33.0	56.3
	F	-	-	38.0	34.0	-	23.5	20.0	18.0	-	-	-	-	44.0	-	31.0	54.1
Sex before the age of 15 among young women and men (%)[79]	M	-	40.3	3.9	30.9	27.5	-	-	7.9	-	-	-	-	10.7	74.0	-	8.5
	F	-	41.5	7.4	14.5	14.4	-	27,7	20.3	-	-	-	-	10.1	26.0	17.5	8.1
Higher-risk sex among young women and men (%)[80]	M	-	37.9	83.0	84.0	89.5	62.1	84.0	78.0	-	-	-	-	81.0	16.3	86.0	78.6
	F	-	7.4	50.0	30.0	43.3	13.9	37.0	29.0	-	-	-	-	36.0	12.2	30.0	23.3
Young women's and men's condom use	M	-	36.1	52.0	47.0	48.0	47.0	33.0	46.0	41.0	-	-	-	47.0	55.0	40.0	56.5
	F	-	14.6	33.0	25.0	50.0	35.0	29.0	24.0	28.0	-	-	-	42.0	53.0	35.0	42.6

[70] In some cases, more than one value is available from different methods (UNAIDS 2006a, annex 3, p554) – in this case the value quoted in the country-specific sheets is used
[71] Colour code – red = <25%; orange = 25-75%; green = >75%; blank = no data
[72] 2004 figures
[73] Colour code – red = <25%; orange = 25-50%; green = >50%
[74] Disaggregated figures by sex and rural/urban available (UNAIDS, 2006a)
[75] Colour code – red = <25%; orange = 25-50%; green = >50%; blank = no data
[76] Figures for 2005 except where marked with * where they are for 2001
[77] Colour code – red = <75%; orange = 75-99%; green = 100%; blank = no data
[78] Colour code – red = <25%; orange = 25-50%; green = >50%; blank = no data
[79] Colour code – red = >50%; orange = 10-50%; green = <10%; blank = no data
[80] Colour code – red = >75%; orange = 25-75%; green = <25%; blank = no data

AFRICA																	
Indicator		**DRC**	**Eth**	**Gha**	**Ken**	**Les**	**Mal**	**Moz**	**Nig**	**Rwa**	**SL**	**RSA**	**Sud**	**Tan**	**Uga**	**Zam**	**Zim**
with non-regular partners (%)[81]																	
Orphan's school attendance (%)	Orphans[82]	50	26	65	88	79	81	63	-	64	35	-	-	73	88	73	90
	Non-orphans[83]	70	43	81	92	91	87	78	-	80	50	-	-	90	93	78	92
	Ratio[84]	0.71	0.60	0.80	0.96	0.87	0.93	0.80	-	0.80	0.70	-	-	0.81	0.95	0.94	0.98
Reduction in HIV prevalence (15-24 year olds)		See annex 4 (p49)															
HIV treatment: survival after 12 months on ART[85]		-	88.6[86]	-	-	-	83.0	-	98.2	-	-	-	-	-	-	-	-
Reduction in MTCT		No data															
Most-at-risk populations: prevention programmes (%)[87]		-	-	50.0[88]	17.0[89] 2.0[90]	-	-	5.0[91] 0.5[92]	-	-	-	-	-	-	10.0[93]	-	40.0[94]
Most-at-risk populations: reduction in HIV prevalence		See annex 5 (p51)															

[81] Colour code – red = <25%; orange = 25-75%; green = >75%; blank = no data
[82] Colour code – red = <50%; orange = 50-75%; green = >75%; blank = no data
[83] Colour code – red = <50%; orange = 50-75%; green = >75%; blank = no data
[84] Colour code – red =<75%; orange = 75-90%; green = >90%; blank = no data
[85] Colour code – blank = no data; green = >75%
[86] Data disaggregated by sex available
[87] Colour code – red = <25%; orange = 25-60%; green = >60%; blank = no data
[88] Sex workers
[89] Sex workers
[90] MSM
[91] Sex workers
[92] IDUs
[93] Sex workers
[94] Sex workers

ASIA									
Indicator		**Ban**	**Cam**	**Chi**	**Ind**	**Indo**	**Nep**	**Pak**	**Vie**
Government funding for HIV/AIDS (US$m)[95]		-	1.0	99.3	73.3	13.0	0.08	2.4	5.6
Government funding for HIV/AIDS per capita (US$)[96]		-	0.07	0.07	0.07	0.06	0.003	0.02	0.07
Government HIV/AIDS policies		No data provided							
HIV treatment: ARV combination therapy (%)[97]		1.0	36.0	25.0	7.0	30.0	1.0	2.0	12.0
Most-at-risk population: HIV testing (%)[98]	IDUs	3.2	-	-	-[99]	18.1	-	-	-
	Sex workers	1.6	-	-	-	14.8	-	-	-
	MSM	-	-	-	-	15.4	-	-	-
Most-at-risk populations: prevention programmes (%)[100]	IDUs	7.0	97.0	45.0	47.8	15.0	<0.5	28.4	69.1
	Sex workers	71.6	60.0	25.0	52.4	37.3	35.2	11.0	81.0
	MSM	77.0	17.0	8.0	45.0	1.3	5.4	22.0	-
Most-at-risk populations: knowledge about HIV prevention (%)[101]	IDUs	14.0	6.7	36.0	-	-	49.9	-	34.4
	Sex workers	23.3	23.8	23.5	-	-	16.9	-	24.2
	MSM	13.5	43.3	37.3	-	-	27.3	-	-
Sex workers: condom use[102]		39.8	96.0	68.5[103]	-	54.7	67.1	22.6	90.4

[95] Information on trends also available in UNAIDS, 2006a, annex 3, p548
[96] Colour code based on per capita figures – red = <0.5; orange =0.5-1.0; green= >1.0; blank = no data
[97] Colour code – red = <25%; orange = 25-50%; green = >50%
[98] Colour code – blank = no data; orange = 1-10%; green = >10%
[99] Aggregated figure of 28.9% for all most-at-risk populations
[100] Colour code – red = <25%; orange = 25-60%; green = >60%; blank = no data
[101] Colour code – red = <25%; orange = 25-50%; green = >50%; blank = no data
[102] Colour code – red = <25%; orange = 25-75%; green = >75%; blank = no data
[103] Females only

ASIA									
Indicator		**Ban**	**Cam**	**Chi**	**Ind**	**Indo**	**Nep**	**Pak**	**Vie**
MSM: condom use[104]		49.2	-	41.1	-	47.6	-	7.6	-
IDUs: safe injecting and sexual practices[105]	M <25	8.3	-	-	-	18.9	-	-	81.8
	F <25	31.3	-	-	-	27.3	-	-	-
	M >25	16.2	-	-	-	19.2	-	-	89.1
	F >25	68.3	-	-	-	8.7	-	-	-
Most-at-risk populations: reduction in HIV prevalence		See annex 5, p51							

[104] Colour code – red = <25%; orange = 25-75%; green = >75%; blank = no data
[105] Colour code – red = <25%; orange = 25-75%; green = >75%; blank = no data

Annex 8: Responsibilities at a Glance

Department/Team	Indicators			Milestones
	Collating External Data	For Routine Monitoring	For Final Evaluation	
Global AIDS Policy Team (GAPT)	I1; I2; I3[106]; I4; I5; N1; N2			M2.7[107]; M2.8[108]; M3.1; M3.3; M3.5; M4.1; M4.2; M4.3;
Corporate Strategy Group (CSG)				M2.6; M6.3[109]; M6.4[110]; M6.5[111]; M6.9[112]; M6.10[113];
Country Led Approaches and Results Team (CLEAR)	I3[114]			
Sexual and Reproductive Health Team	I6			
Statistical Reporting and Support Group (SRSG)		U1		M1.1[115]; M1.3[116];
International Division		I7		M1.1[117]; M1.3[118]; M3.4;
Global Health Partnerships Team				M3.2;
Central Research Department (CRD)		U3		
Evaluation Department (EVD)				M6.5[119]; M6.11;
Human Resources (HR)				M2.7[120]; M2.8[121]; M6.6;
Directors				MIL6.9[122]; M6.10[123]
Management Board				M6.3[124]; M6.4[125];

[106] In support role with CLEAR
[107] With FCO and DFID HR
[108] With FCO and DFID HR
[109] With Management Board
[110] With Management Board
[111] With Management Board and EVD
[112] With Directors
[113] With Management Board and EVD
[114] With support from GAPT
[115] With IDAD
[116] With IDAD
[117] With SRSG
[118] With SRSG
[119] With Management Board and CSG
[120] With GAPT and FCO
[121] With GAPT and FCO
[122] With CSG
[123] With CSG

Department/Team	Indicators			Milestones
	Collating External Data	For Routine Monitoring	For Final Evaluation	
				M6.5[126];
Regional Divisions and Country Offices		U2		
Interim evaluation team				M2.1; M2.2; M2.3; M2.4;
Final evaluation team			I8; I9; N3; N4; N5; U4; U5; U6; U7	
Cross Whitehall Group				M6.1; M6.8;
DFID[127]				M6.2;
Her Majesty's Treasury (HMT)				M1.2;
Foreign and Commonwealth Office (FCO)				M2.7[128]; M2.8[129];
Department of Health (DOH)				M4.4;
Unallocated				M2.5

[124] With CSG
[125] With CSG
[126] With CSG and EVD
[127] In general
[128] With GAPT and DFID HR
[129] With GAPT and DFID HR

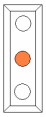
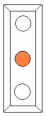
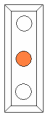
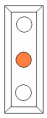
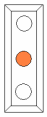
Annex 9: Glossary

AIDS	Acquired Immunodeficiency Syndrome
AIDSMAP	Website providing information on HIV and AIDS
ANC	Antenatal Clinic
APD	Africa Policy Department
APLF	Asia Pacific Leadership Forum
APLWHA	Associations of People Living with HIV and AIDS
APPG	All Party Parliamentary Group
ART	Antiretroviral Therapy
ARV	Antiretroviral
B	Billion
CAP	Country Assistance Plan
CDC	Centers for Disease Control
CHAT	Country Harmonisation and Alignment Tool
CIDA	Canadian International Development Agency
CLEAR	Country Led Approaches and Results
CRD	Central Research Department
CSG	Corporate Strategy Group
CSIS	Center for Strategic and International Studies
CSW	Commercial Sex Worker
DAC	Development Assistance Committee
DANIDA	Danish International Development Agency
DFID	Department for International Development
DHS	Demographic Health Survey
DOH	Department of Health
DRC	Democratic Republic of Congo
DTI	Department of Trade and Industry
EU	European Union
EVD	Evaluation Department
F	Female
FCO	Foreign and Commonwealth Office
G8	Group of Eight
GAPT	Global AIDS Policy Team
GBS	General Budget Support
GFATM	Global fund to Fight AIDS, TB and Malaria
GNP+	Global Network of People Living with HIV/AIDS
GTT	Global Task Team
GTZ	German Development Agency
HIV	Human Immunodeficiency Virus
HM	Her Majesty
HMG	Her Majesty’s Government
HMT	Her Majesty’s Treasury
HR	Human Resources
ICASO	International Council of AIDS Service Organisations
ICPD	International Conference on Population and Development

ICT	Information Communication Technology
IDAD	International Division Advisory Department
IDD	International Development Department
IDU	Injecting Drug User
IFF	International Finance Facility
IPPF	International Planned Parenthood Federation
INGO	International NGO
ISP	Institutional Strategy Paper
LSHTM	London School of Hygiene and Tropical Medicine
M	Male; million
M&E	Monitoring and Evaluation
MAP	Multi-country HIV/AIDS Program
MDG	Millennium Development Goal
MERG	Monitoring and Evaluation Reference Group
MOF	Ministry of Finance
MOH	Ministry of Health
MOPAN	Multilateral Organisations Performance Assessment Network
MSI	Marie Stopes International
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NAC	National AIDS Commission (Council)
NAO	National Audit Office
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organisation
NHS	National Health Service
NPA	National Programme of Action
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
OVC	Orphans and Vulnerable Children
PCB	Programme Coordinating Board (UNAIDS)
PEPFAR	President's Emergency Plan for AIDS Relief
PIMS	Policy Marker Information System
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PPA	Programme Partnership Agreement
PRISM	Performance Reporting Information System for Management
PRSP	Poverty Reduction Strategy Paper
PSA	Public Service Agreement
R&D	Research and Development
SADC	Southern African Development Community
SBS	Sectoral Budget Support
SRH(R)	Sexual and Reproductive Health (and Rights)
SRSG	Statistical Reporting and Support Group
SSS	Social and Scientific Systems
STI	Sexually Transmitted Infection
SWAP	Sector-wide Approach

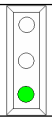
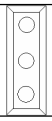
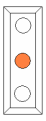
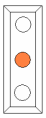
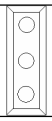
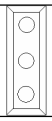
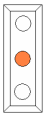
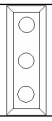
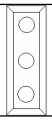
TB	Tuberculosis
TRIPS	Trade-related Aspects of Intellectual Property Rights
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNECA	United Nations Economic Commission for Africa
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNSD	United Nations Statistics Division
US	United States
US$	US Dollar
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organisation
WTO	World Trade Organisation

Annex 10: Assessment of Baseline Situation with Proposed Indicators

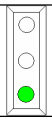
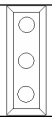
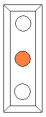
Indicator Number	Indicator Name	Comment	BL[130]	Trend[131]
INTERNATIONAL INDICATORS				
I1	AIDS funding requirements for low- and middle-income countries	Although these figures are available from UNAIDS, there are concerns about the validity and objectivity of these.		
I2	Amount of financial flows for the benefit of low- and middle-income countries	Although this amount has risen substantially, it is still lagging behind estimated need and the gap between these continues to widen. There are also substantial differences between methods used by different countries.		
I3	Percentage of young women and men aged 15-24 who are HIV infected	Six PSA countries show evidence of declining HIV prevalence; in eight HIV prevalence is stable; in eight HIV prevalence is rising and in two there is insufficient data.		
I4	Number and percentage of men, women and children with advanced HIV infection receiving combination antiretroviral therapy	All PSA countries apart from Sudan have data on this indicator. Of those, all but Nepal have comparative data for 2003 and 2005. In all of them, except Pakistan, provision of ART has increased. In some cases, Kenya, Lesotho, Malawi, Rwanda, South Africa, Uganda, Zambia, Cambodia, China, Indonesia and Vietnam, this increase is very considerable. Nine PSA countries have more women on ART than might be expected, while six have less. All PSA countries have fewer children on ART than might be expected. There are particular concerns over the lack of data on ART access for the most vulnerable populations.		 
I5	Annual global investment in microbicide and vaccine research	Non-commercial investment in research into an HIV vaccine rose from around $327m in 2000 t0 $614m in 2004. Similarly, non-commercial investment in microbicide research rose from $65.1m in 2000 to $163.4m in 2005.		
I6	Unmet need for contraception	Ten PSA figures have comparative figures for 1990 and a later date. In all cases, unmet contraceptive need fell. A further ten countries have current figures. Four (DRC, Lesotho, Sierra Leone and China have no data).		
I7	Organisational effectiveness summaries	Currently, there is no agreed way of assessing the effectiveness of multilateral agencies, especially in terms of the response to HIV and AIDS both internationally and within particular countries.		

[130] Adequacy of baseline data – green = good data available; amber = data available but some concerns over quality; red = significant concerns over data quality; blank = no data available

[131] Data for trends to date – green = positive trend; amber = trend is mixed and/or of some concern; red = negative trend; blank = no trend data

Indicator Number	Indicator Name	Comment	BL[130]	Trend[131]
I8	Length and predictability of international financing for HIV and AIDS	No systematically available data.		
I9	Harmonised international system for HIV/AIDS monitoring and evaluation	At the time *Taking Action* was introduced, there had been attempts to harmonise this system through the UNGASS process. Now, there are a number of different attempts to do this eg UNGASS, Universal Access and the 'Global Fund' toolkit. However, these are poorly harmonised with each other (see annex 6, p53)		
COUNTRY INDICATORS				
N1	Core UNGASS Indicators	The UNGASS process has been a significant catalyst in making data more available and in improving its quality[132].		
N2	Number of PSA countries reporting each/all of Three Ones in place	Although baseline data is reported on by UNAIDS, this was not disaggregated for individual countries in the report to the high level meeting in June 2006 although country reports are now available on the UNAIDS website.		
N3	AIDS funding requirements for individual PSA countries	There is currently no systematic way of estimating this although some data is available from countries' applications to the Global Fund.		
N4	Number of PSA countries with harmonised funding for HIV/AIDS	No baseline data systematically available.		
N5	Qualitative review of national AIDS response	No baseline data systematically available to monitor the extent to which commitments made in *Taking Action* are being fulfilled.		
UK GOVERNMENT CONTRIBUTION				
U1	UK funding for AIDS-related work	Baseline figures to 2003/4 are available although there are still some issues relating to methods which are common to all organisations seeking to measure this.		
U2	Qualitative review of UK support to AIDS response	No baseline data systematically available.		
U3	Qualitative review of UK support to HIV and AIDS research	No systematic baseline data available. A key challenge is that there is no global data on expenditure on HIV and AIDS research for the developing world with the exception of microbicides and vaccines.		

[132] The traffic light rating for this indicator represents this positive process and does not represent an opinion on the status of individual indicators.

Indicator Number	Indicator Name	Comment	BL[130]	Trend[131]
U4a	UK influence at international events and with global institutions	Baseline data has been collected as part of this interim evaluation and will be included in the final report. It shows the strong influence that the UK has had in this area.		
U4b	In-country political influence exerted by FCO and DFID	No baseline data systematically available although reports from country offices to divisions could be used for this purpose. Also some examples from country case studies		
U4c	UK support to key regional political institutions	Baseline financial data for support to institutions mentioned in *Taking Action* is available.		
U5	Support to multilateral organisations as reflected in ISPs	There is evidence of considerable improvement of institutional strategy papers in terms of the way they address HIV and AIDS since when they were reviewed by the National Audit Office.		
U6	UK support to increase access to medicines	Some baseline data exists in the UK's plan and policy for increasing access to medicines (DFID et al., 2004) but precise indicators for this area in relation to HIV and AIDS have not yet been defined.		
U7	UK influence to strengthen monitoring and evaluation of HIV and AIDS	No baseline data yet identified.		

Annex 11: Comments Received from Stakeholders on Draft Document

1. Target Tuberculosis

I have had a very brief look at the draft and have to admit, to my shame, that I have not yet looked properly at the DfID site and the principal document. At the risk of people saying that I would say that because I work for a TB charity, I would like to say that there is no mention of TB. As you will be aware there is a very close link between TB and HIV/AIDS. Indeed, in all of the current publicity about XDR TB, the cases mentioned in South Africa show that of 53 people diagnosed, 52 died within 25 days of diagnosis and 44 of those were tested for HIV and all were positive. Certainly in the TB fora TB and HIV are increasingly being put together. It would be good to see the close link acknowledged in DfID and other documents.

Alastair Burtt, Chief Executive, Target Tuberculosis

2. International Planned Parenthood Federation

IPPF International Planned Parenthood Federation

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www.ippf.org info@ippf.or

Dr Roger Drew
By email: roger.drew2@btinternet.com

27 October 2006 Ref: ML/RM

Dear Dr Drew

The International Planned Parenthood Federation (IPPF) welcomes the excellent work undertaken by you and your team on the Department for International Development's (DFID) "Interim Evaluation of Taking Action: The UK Government's Strategy for Tackling HIV and AIDS in the Developing World."

In particular we note the clarity of your proposed evaluation framework, indicator set and priority milestones for the implementation of the Taking Action Strategy. The recognition of the interconnectivity as outlined in Figure 1 is a particularly useful guide. However, at present the priority actions do not reflect the significant role played by civil society organizations and sexual and reproductive health and rights in tackling the epidemic.

In the Taking Action Strategy we note that the Government of the UK paid particular attention to the fact that women, young people and orphans are at extra risk of HIV. In the years since the strategy was prepared, an increasing body of evidence has accumulated to show that a key intervention to reducing the risk of HIV is through assuring sexual and reproductive health and rights. This evidence is recognized in the UK All Party Parliamentary Group on Population, Development and Reproductive Health's Report on the Parliamentary Hearings linking sexual and reproductive health and HIV/AIDS (2004) and more recently by Hilary Benn, Secretary of State for International Development:

"One has to look at the fight against AIDS and the promotion of reproductive and sexual health together, because the two are entirely integral."

House of Commons, 10 May 2006

"Tackling AIDS is not only about money. It is also about culture, social attitudes and not ignoring what we know works – sexual and reproductive health and rights, condoms and clean needles. HIV prevention, and care and support for people living with HIV and AIDS, must be based on evidence and not on ideology. Tackling stigma and discrimination, protecting human rights and promoting gender equality are essential to make progress."

UN General Assembly High-Level Meeting on AIDS, New York, 2 June 2006

These arguments are supported at the international level through the Glion Call to Action, The New York Call to Commitment, the Global Coalition on Women and AIDS and, most recently, in the Maputo Plan of Action for the

Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights.

With minor modifications and additions to your existing framework, the contribution made by sexual and reproductive health and rights can be more fairly reflected. As such, IPPF recommends the following amendments to the Evaluation Framework and Indicator Set in the section on the UK Government's Contribution to reflect this important contribution (figure 1):

1. Additional indicator under closing the funding gap that calculates **UK funding for prevention of MTCT+ programmes**.
2. Additional indicator under closing the funding gap that calculates **UK funding for sexual and reproductive health and rights organizations for HIV/AIDS**
3. Amending indicator UK7 to read "Amount of AIDS funding through multilaterals **and INGOs**"
4. Amending UK8 to read "HIV/AIDS funding through multilaterals **and INGOs** in post conflict/other countries"
5. Additional indicator under improving the international response that calculates **"UK support to increase access to preventative supplies (female and male condoms)"**
6. Amend indicator UK10 to read **"UK funding to HIV and AIDS response by country (including multilateral and INGO)"**

We would be pleased to expand on any of the above points and our rationale for their inclusion. Please feel free to contact my colleague, Matthew Lindley, Head of Resource Mobilization, at mlindley@ippf.org, if you would like further details.

Yours sincerely

Dr Gill Greer
Director General

3. Plan International

Coming from the premise that the content of the UK government's document itself should not be called into question, Plan's response has focused on the indicators suggested in the evaluation. In general, Plan feels that Roger Drew has done a very thorough job and we very much welcome this work.

First of all, it was felt by Plan staff that there are too many indicators. For overall monitoring of aid effectiveness, fewer indicators would be more efficient (especially in the "UK" category of indicators). It is important that it is kept realistic and manageable. The international level has the obvious risk of focusing heavily on planned commitments – unless they are defined very specifically and made to reflect what is actually happening, disaggregated at least to the main intervention areas, they can end up being mainly a desk exercise.

INT1: Good, but the huge uncertainty and the political nature of this indicator need to be taken into account. One of the main problems is that UNAIDS, the agency collecting this information, is also charged with global advocacy for the international response to AIDS. There is an inherent conflict of interest.

INT3: Plan is unsure as to what is being measured and how useful it is to measure it. Although it is important to always know the international political environment, it is something that needs to be assessed and documented periodically, rather than placed into an "indicator box".

INT4: Keeping updated organisational effectiveness scorecards for major organisations is a good idea. Again, this is part of the environmental monitoring as under INT3, and should probably be presented apart from the indicator list. (DFID had a consultancy on effectiveness of PPA holders just over a year ago – could some of these findings/recommendations perhaps be used?)

INT5: This needs to be disaggregated by sex. Overall, disaggregation on sex and 'diversity' (eg disability, marginalisation, poverty, rural/urban) seems to be missing. There is of course a limit to how much detail should be at the international level, but by some token there is a lower limit where one figure becomes meaningless because of the degree of variation of how that one figure is calculated in different countries and levels.

INT6: Probably OK, if underlying method has some qualitative aspects.

INT7: Again, needs to be disaggregated by sex and with separate reporting for children under 5 and for children 5-18. In the wording of the indicator Plan would prefer to see "advanced HIV infection" changed to "eligible men, women, children ...". (People with CD4<200 are eligible in most countries even if they do not have "advanced HIV disease").

INT8: Plan feels that this is redundant and also not measurable. However, if possible, it may be useful to track the proportion of international funds allocated for each fiscal year that have actually been disbursed. One could maybe just follow a series of "sentinel funding sources" (Global Fund, World Bank, USAID, DfID, European Union).

INT10: Again, this is very difficult to measure and should be part of the contextual information collected (see note on INT3).

NAT2: This should be based on expenditure estimates rather than on budgets.

NAT4: There could be a number of difficulties here. In countries where there are Health SWAPS and/or education SWAPS, tracking of the AIDS funding may be difficult. Countries that have basket-fund approaches for AIDS would be doing real well, but these approaches are not the most appropriate in every situation.

NAT5: This should include an assessment on how well the Three Ones are functioning.

NAT7: This has to be done but needs to be taken out of the "indicator box". Instead, standardised terms of reference and standardised reporting format on assessing national AIDS responses should be developed.

NAT8: Same response as to INT8

NAT9: This indicator should be "nationalised". It may be possible to develop a simple score card to assign a value according to the quality of the national monitoring effort in each country.

UK2: Fine - although there will be problems with allocating spending on generalised social protection programs.

UK7: Plan had some problems disentangling UK6 and UK7.

UK8: This will not give you any information about "middle income countries" which is also being asked for.

UK10 - 14: There are simply too many UK indicators for routine monitoring. Some of this information is necessary for periodic evaluation and should be specifically asked for in the terms of reference of these evaluations, but much of this is not routine monitoring information that should be in a monitoring framework.

What about an indicator to track UK funding for the international response to AIDS through UK NGOs?

4. DFID's Sexual and Reproductive Health Team

Thanks for notes from the meeting. It was good to have the opportunity to discuss with you how the evaluation framework & indicators might take more account of the central place that SRHR has in the AIDS response - and DFID's commitment to make this link.

Suggested indicators:

International/Closing the funding gap
We would like to see an additional indicator at this level that tracks SRH funding - this is collected by UNFPA (Reproductive health spend & spend on family planning commodities). Funding to these areas appears to have dropped off in recent years - frequently attributed to the fact that AIDS financing has taken precedence. Given the UK commitment to the importance of SRH for the AIDS response it would be appropriate for us to track changes in SRH spend in addition to INT 1 AIDS funding. We could check if SRH spend can also be broken down to inform INT 2.

UK Government Contribution/Closing the funding gap
We already track SRH funding (in the same way as AIDS funding) & it would be appropriate to include and indicator on UK funding for SRH. Whilst this funding is included in the AIDS funding (so we'd need to be clear that these indicators overlap) it would be useful to retain profile on our SRH spend so that we can be sure that we are increasing here year on year as well as to the overall AIDS response. (similarly to OVC spend that has been singled out).

UK Government Contribution/Strengthening Political Leadership
The UK has already demonstrated some leadership in calling for stronger links between SRH the AIDS response. As we discussed our (DFID) view is that SRH is central to the AIDS response. I'm not entirely clear how UK3 breaks down - can this either include a focus on the UK demonstrating leadership in on ensuring that SRH is central to the AIDS response or can we please make this a separate indicator.

UK Government Contribution/Improving the International Response
Does UK9 include SRH supplies? Could it? Critical that we have condoms and contraception available well as ARVs!

Country/Supporting Better National Programmes
NAT 7 Thanks for sending the breakdown of NAT 7. It is good to see that it includes reference to 'strengthen SRH services & links between activities on AIDS and those on SRH' under *consider issues of linkages & co-ordination.* I feel it is also important that 'sexual & reproductive rights' are flagged along with 'focus of human rights' (including SR rights) under *consider important contextual issues*

and along with 'prioritise women' - include women's access to a full range of SRH supplies & services under *consider the needs of particular population groups*

Thanks for adapting the APD data collection tool. Perhaps it needs to be tested ... but I'm not convinced that people always read footnotes & am concerned that inclusion of SRH & the linkages (along with other key issues that we flagged) only in a footnote might mean that it gets lost. I think it would be better to include in the main text - though still as a prompt rather than as an additional question.

5. Marie Stopes International and London School of Hygiene and Tropical Medicine

This submission to the *Taking Action* evaluation process is made jointly by Marie Stopes International (MSI) and the London School of Hygiene and Tropical Medicine (LSHTM). We believe that the international effort against HIV/AIDS could be made significantly more efficient and effective if greater priority were given to the provision of integrated services. The recommendations below are intended enable the evaluation process to include effective and relevant measures of DFID support for HIV/AIDS and its integration – or 'linkage' - with SRH services and programmes.

Our recommendations refer to 'Proposed Evaluation Framework and Indicator Set' in the annexes of *Measuring Success: Indicators and Approaches (DRAFT)*.

'Taking Action' and SRH

The importance of sexual reproductive health services is a recurrent theme in Taking Action. In addition to successfully defining them as integral to HIV prevention, Taking Action is explicit on the particular importance of SRH services to efforts aimed at women and young people.

We regard the inclusion of commitments on SRH expenditure as one of the defining strengths of the UK HIV/AIDS strategy. In the context of a decline in financial support for SRH in global aid spending – both within HIV/AIDS budgets and also within total ODA – the significance of this inclusion was not lost.

In particular, we wish to highlight a commitment – made with regard to improving national programmes for women, young people and vulnerable groups - concerning the linkage of HIV/AIDS and SRH services:

> The UK Government will:
>
> - Strengthen *the links between* AIDS and sexual and reproductive health programmes.
>
> (*Taking Action* p56 – emphasis added)

We maintain that the purpose of linking HIV/AIDS and SRH programmes is to benefit from the advantages of integrated services at the point of delivery. The next section briefly lists some of the advantages of doing so.

The Value of Linkage

The following points derive from the practical experience of the Marie Stopes partnership in providing HIV/AIDS services from its SRH clinics in high-prevalence countries and from the wider research expertise of LSHTM.

1. Providing SRH and HIV/AIDS services from the same clinic is a highly cost-effective means of spending scarce resources in high prevalence settings. Staff, facility, overhead, equipment and administrative costs can all be shared.
2. SRH clinics are often uniquely well positioned to provide HIV/AIDS services: They have an existing base of sexually-active clients – *including women, young people and sex workers* – who already trust the facility to provide confidential advice and services on sexual issues.
3. Many clients report that they value the ability to access HIV/AIDS services without the stigma of being seen to attend an HIV/AIDS clinic.
4. In high prevalence settings, there is an obvious value in being able to offer PMTCT services to women who come for pre- and post-natal care services.
5. It is important that those diagnosed as HIV+ are quickly provided access to STI treatment to reduce the incidence of transmission.
6. SRH practitioners have expertise valuable to many of the challenges in HIV prevention, including encouraging long-term compliance with barrier methods, effective VCT methods and education/awareness programmes.
7. Providing SRH services from a facility that is attended by HIV positive clients better enables PLWHA to attain their right to sexual reproductive health care.

Despite these benefits and despite numerous promises on linkage - including the ICPD, the Glion Call to Action and the New York Call to Commitment - donors and governments have yet to demonstrate adequate support for enabling SRH and VCT clinics to expand their range of activities and provide integrated services.

Recommendations for Indicators

We believe that elevating the profile of SRH within current thinking on HIV/AIDS is an essential step towards improving access to integrated services.

We also believe that donors can do more to specifically address the shortage of integrated service provision.

In light of the above, we commend the existing draft 'evaluation framework and indicator set' proposals for measuring support for SRH and linkage. These are:

- INT6: DFID support for the measure of unmet need for contraception to be included in monitoring progress towards the MDGs,
- NAT7: Which includes the extent to which links between HIV/AIDS and SRH programmes are strengthened in the qualitative review of national programmes,

- UK3: Which Includes DFID advocacy for international policies, plans and resources that address the right to SRH including safe abortion and freedom from harmful practices.

We commend all these proposals and urge the evaluation process to ensure that they are carried through to the final stage of the evaluation.

Given the crucial but still under-valued role that SRH linkage has to play in reversing the spread of HIV/AIDS, we believe that the evaluation process can and should go significantly further. We make four recommendations:

1. UK11 – Qualitative review of UK support to AIDS response
Most importantly, national health systems need adopt a focus on providing integrated services. **We therefore urge DFID to include an assessment of CAP support for integrated service provision in the qualitative review of UK11.**

2. UK funding for reproductive health
The global aid system for HIV/AIDS must also take on a greater focus on integration and we ask DFID to 'lead by doing'. **As an explicit part of its HIV/AIDS strategy, we urge DFID to track the portion of its HIV/AIDS budget that is given to SRH expenditure**. We suggest that this indicator would be listed as a "UK Government Contribution" to "Closing the Funding Gap" alongside UK1 and UK2.

3. UK9 - UK support to increase access to medicines
Given the valuable role that SRH has to play in combating HIV/AIDS, it is important that the measure of UK support to improve access to medicines should include SRH supplies, including contraceptives and life-saving obstetric equipment and drugs. **UK support for access to SRH supplies should feature as an integral part of indicator UK9.**

4. UK3 – UK influence at international events and global institutions
DFID advocacy also has great potential to improve the global HIV/AIDS response. **We urge DFID to add the following to the existing components of the UK3 'retrospective review': "The extent to which DFID has advocated internationally for programmes and resources that support the integration of HIV/AIDS and SRH services."**

The UK can help to ensure that hundreds of millions of sexually active people in countries suffering from the worst effects of the HIV/AIDS epidemic gain access to integrated HIV/AIDS-SRH services. We hope that the evaluation process recognises the value of this frequently over-looked objective by adopting the above recommendations.

6. World Vision UK

I've gone through the Working Paper and Annexes on Indicators which you prepared and I'm very impressed with your thoroughness. The following comments relate to the indicators for measuring progress regarding orphans and vulnerable children.

Working Paper

1. Page 1 section 2.2: Article 65 of the 2001 Declaration of Commitment, specifies that, in addition to the need to have OVC National Plans in place by 2005, countries should have national policies and strategies in place by 2003 and implemented by 2005. It is very important that the OVC National Plans are implemented in policy contexts where either specific policies for orphans and vulnerable children or children's policies are in place, since these will provide the legislative framework for policy implementation and law enforcement. The best indicator to use is the composite OVC Policy Index that UNICEF has already compiled and will be updating for the Global Partners Forum. This should be mentioned here and in the Annex 2.

2. Regarding the same section: In several countries (Uganda and Zambia) there is contested government ownership of OVC National Plans: those produced through government-led processes and those produced through the RAAAP process. The question must be asked, which National OVC Plan is considered most legitimate and when is a plan to be considered government-owned? Furthermore, it is necessary to ask to what extent government ownership of the OVC NPAs spreads beyond the government department responsible for children, especially to ministries of finance and local government. This wider ownership should be reflected by the inclusion of OVC resource requirements in PRSPs, national development plans, National AIDS Strategies and Medium Term Expenditure Frameworks. In terms of indicators this would best be captured by using the UNICEF composite OVC Policy Index.

3. Page 4 section 2.11: The latest UNAIDS operational guidelines for tracking universal access (October 2006) identify seven core indicators of which the one for Care and Support relates to: the percentage of OVC (boy/girl) aged under 18 living in households whose household have received a basic external support package. There is a footnote which specifies: "Currently this is one of the least well-reported indicators and **special attention should be paid to it**" P19 UNAIDS 2006. This has implications for ensuring DFID Field Office support for strengthening national M&E systems.

4. Table 1 Milestones MIL 1.3 UK funding levels to UNICEF's work with orphans. There are two issues with this milestone. The first, is that it places the onus on UNICEF to be regularly collecting this information and

reporting on where and on what the funds have been spent to ensure that resources are reaching OVC. Does UNICEF have an adequate monitoring system in place to do this? The second, is the need to investigate the extent to which it is true that all funds allocated to UNICEF benefit OVC because my understanding is that this is not necessarily the case. This requires more detailed analysis to identify the extent to which this is a correct assumption.

5. Table 1 Milestone 3.4 UK endorsement of UNICEF Strategic Framework. The UK had endorsed the Framework before Taking Action was published! The critical requirement is that the UK Government takes leadership to encourage other donors to endorse the Framework, which should be assessed under Indicators UK3 UK4 and UK5.

6. Table 1 Milestone 3.5. The most important requirement for DFID regarding the Framework, is encourage DFID Field Offices to use it as the basis for supporting national governments to prepare OVC National Plans of Action. To assist this work I suggest that an additional, but more specific, indicator for this purpose would to require that "Guidelines for operationalising the Framework are prepared to assist DFID Field Offices (and other donors). I've had discussions with several donors (CIDA and Irish Aid) who have expressed interest in being involved in the preparation of such guidelines.

7. Table1 Milestone 4.1. I agree that this milestone is important, but repeat the concerns about genuine government ownership, which I raised in para 2. I suggest making use additionally of the UNICEF composite OVC Policy Index which includes the existence of OVC policies and National Plans, but also makes a qualitative assessment of the probability of them being implemented.

Annex 2

8. Page 8 Indicator INT 4. It is important that DFID includes UNICEF's organisational effectiveness to measure its ability to support the broad range of OVC actions outlined in Taking Action. This will need to bear in mind the issues outlined under point 4 above.

9. Page 13 Indicator NAT 6. It is important to capture the extent to which DFID Field Offices have supported the strengthening of national M&E systems to track progress against the UNGASS declaration of commitment. This is particularly important regarding the Core Indicator for OVC Number 8: "Percentage of OVC whose households received free basic external support in caring for the child", which, as has been mentioned by UNAIDS, is one of the least well reported. The concern is that it is also an area on which UK tracking is very weak; a point highlighted in the Comment column in Annex 10 about the Assessment of Baseline Situation with Proposed Indicators, which indicates that there is "No baseline data yet available." Page 57.

10. Page 14 Indicator NAT 7. I recommend that the proposed qualitative assessment should consider including identifying the use of the OVC Framework by Field Offices in support of the production of OVC National Plans, as well as support for the strengthening national M&E systems to use the UNGASS Declaration of Commitment Core Indicator No. 8 on external support for OVC.

11. Page 15 Indicator UK2. I'm unclear whether PIMS markers for AIDS (or reproductive health) and an OVC sector code will be used rather than using AIDS and an Education marker, as had been suggested in Discussion Paper 1. Whichever indicator is used, there is a danger that the actual amounts of support may be over or under-estimated. As a result I strongly suggest that a short piece of follow-up research is conducted in perhaps 3 countries as examples to identify in more detail what aspects of OVC programming would be included and excluded as a result of using these indicators. This is an area that World Vision UK is interested in collaborating in as part of its research on resource tracking.

12. Page 16 Indicator UK2 Note. As part of the retrospective study, consideration should be given of the extent to which additional funding has been provided not only to implementing the OVC Framework but also to the implementation of the OVC National Plans of Action.

13. Page 17 Indicator UK4 Note. Include UK leadership and influence to use the OVC Framework.

14. Page 18 Indicator UK5. Include support to regional political institutions to support the OVC response.

15. Page 19/20 Indicator UK6. Include UNICEF's ability to deliver comprehensive OVC response as one of the important multilateral institutions, and not only its ability to improve planning for food security with WFP.

16. Page 21 Indicator UK9 Note. Under Note 1The evaluation should consider the ability to support countries to provide paediatric treatment, including the development of plans for rolling out Cotrimoxazole to all children who need to be on it. Note 4 & 5 should include research to develop cheap and rapid diagnostics for children and appropriate formulations for children at different ages.

17. Page 23 Indicator UK13. Note 2. Include analysis of research on paediatric treatment and diagnostics.

Stuart Kean
Senior HIV and AIDS Policy Adviser,
World Vision UK

7. DFID's Country-Led Approaches and Results (CLEAR) Team

Thanks for this opportunity to comment on this paper. I have gathered comments from my team mates

1. On the whole we agree with the broad framework of what is being proposed. The paper identifies many of the challenges. We have a couple of general comments followed by specifics:-

2. **Greater disaggregation**
a) Generally the indicators are fine as far as they go. For them to be meaningful however in terms of improving targeting/focus/identifying gaps in implementation, and impact some would need to be **disaggregated** more at international and national levels - eg INT 1 and INT 2 by areas of spend or research.

This would help us identify progress in traditionally under funded areas etc. INT 7 this data definitely needs to be disaggregated by sex and age for starters.

b) Again at the national level indicators we agree we need overall figures but again it would be helpful if there was greater disaggregation of this information in terms of areas of spend eg OVC, and target groups eg sex, but in certain countries, caste and ethnicity might be equally important.

3. **Clear team responsibility**
We can confirm that CLEAR not CSG would be responsible for INT 5 and suggest you add Phil Cockerill, who has specialist knowledge of HIV AIDS statistics in DFID. Sources look OK but note UNSD is only a channel (albeit key and the one we should be using), original data is brought together by WHO-UNICEF and/or UNAIDS.

4. **International responsiveness** - reference to Paris Declaration would be helpful

Specifics

Table 1 - to note will need updating given recent restructuring (eg IDAD).
Table 1 - MIL3.3 notes that this will be reviewed following high level meeting in June 2006 - if meeting has taken place this should be incorporated.

Annex 2:
INT1 - Question the value and use of this indicator unless it's used to influence budget and resource allocation decisions (internationally and nationally). There are so many difficulties with this measure - eg if the global price of drugs drops dramatically then the amount of funding required may also drop but the actual incidence of HIV/AIDS may not and the top-line figure may give a distorted indication of the actual situation on the ground.

INT9 - meant to measure annual global investment in HIV and AIDS research but excludes much general AIDS research; also need for clarification with UNAIDS on what is tracked in terms of research (there are a number of indicators where the authors seem to be unclear about the data sources or what information is available from UNAIDS - document would be strengthened by checking out some of these unknowns (eg INT9, NAT3).

Nat 5 agree very much with the need for developing criteria for assessing if the 3 ones have been met. Nat 7 the qualitative review in assessing comprehensiveness of national plans - this also needs to assess inclusion, discrimination and stigma issues. Nat 8 suggest it also looks at the extent to which donors are aligning behind the national plans and the % of funding reported on budget as part of our commitments to Paris

UK6 - to be assessed at end of strategy evaluation - that's ok - but wonder if there is value in interim assessment to then inform how this part of the strategy is strengthened and taken forward. What do we gain by finding out at the end that this was weak and could have been strengthened?

UK10 - very similar to UK7 and UK8 - perhaps these could be merged into one funding indicator?

UK12 - data source is given as DFID's management information systems - but this indicator could be more than DFID? Not sure if other govt depts provide financing for HIV/AIDS.

8. DFID's Statistical Reporting and Support Group (SRSG)

Elaine asked me to confirm SRSG's ability to deliver on the progress measures identified as being our responsibility in the working paper. Most of the potential problem areas have already been highlighted in the indicator descriptions in Annex 2. But, pending formal approval of our recent proposal to measure overall funding and ongoing data quality work, my synopsis would be the following:

UK1-UK funding for AIDS-related work: OK

UK2-UK funding for work with OVC: OK

UK7-Amount of AIDS funding through multilaterals: OK - building block of proposed overall funding measure

UK8-UK HIV/AIDS funding through multilaterals in post-conflict/other countries: Currently only able to provide country spend for bilaterals excluding PPA, also difficult to allocate budget support figures accurately

UK10-UK funding to HIV and AIDS response by country (including multilateral): See above - can't do multilaterals

UK12-Length and predictability of UK financing for HIV and AIDS: Indicator needs to be more firmly defined but should not present any problems

UK13-UK annual investment in HIV and AIDS research: On the quantitative side we need to do a bit of digging to determine whether there is any non ODA research which may count but should be OK. I assume that the qualitative work will be undertaken by CRD.

Let me know if you need any further clarification.

Annex 12: Review of National Responses to HIV and AIDS: Checklist

To what extent does the national response:

Consider important contextual issues	• address stigma and discrimination • focus on human rights, including sexual and reproductive rights • address impact on food security (generalised epidemics only) • support legislation to end discrimination and regulate the conduct of public institutions, such as the police; • work with the formal justice sector
Consider issues of linkages and coordination	• strengthen health systems • strengthen sexual and reproductive health services and links between activities on AIDS and those on SRH • turn the principles of the Three Ones into action, including alignment with national systems • receive funding through pooled mechanisms • have a lead donor for HIV and AIDS • have a specified minimum level for funding from donors • have fewer donors funding HIV and AIDS • reflect a comprehensive and integrated approach
Consider needs of particular population groups	• prioritise women (including strengthening girls access to education; improved access to medicines; access to employment, education and social protection; gender violence; access to full range of SRH supplies & services) • prioritise young people • prioritise vulnerable groups (including support to harm reduction programmes) • provide for the needs of orphans and vulnerable children (including schooling, access to health care and social protection) • allow the meaningful involvement of PLWHA (e.g. in decision-making)
Consider issues of capacity	• reflect strengthened domestic planning, coordination and monitoring • improve access to medicines (including use of WTO flexibilities on intellectual property rights) • contribute to the scaling up and greater coordination of civil society initiatives • support the involvement of the private and informal sectors in the national response • have long-term and predictable financing
Deliver essential services	• include effective nationally led treatment and care responses

Annex 13: Review of DFID Support to National AIDS Responses

Country Name:

Country overview

Epidemic status

Please give a brief summary of the status of the epidemic in your country. This section should include latest statistics on the epidemic (including prevalence and incidence rates, and figures on OVC and gender) and a brief overview of the national response.

Aid environment and mechanisms

Please give a brief summary of the aid environment in your country and the main funding mechanisms employed by both DFID and other donors.

HIV and AIDS key actors

Who are the key external actors in the HIV and AIDS response in your country? Is funding received from GFATM, PEPFAR and WB MAP? Who are the other key donors?

DFID response to HIV and AIDS

Please use the table below to provide an overview of your country programme's response to HIV and AIDS. Please include all activities that directly and indirectly relate to HIV and AIDS including GBS, SBS, SWAPS and projects.

Title: **Purpose:** **Date:** **Allocation:** **Implementing agent:**
Title: **Purpose:** **Date:** **Allocation:** **Implementing agent:**
Title: **Purpose:** **Date:** **Allocation:** **Implementing agent:**
Title: **Purpose:** **Date:** **Allocation:** **Implementing agent:**

Using the headings below please provide highlights of how DFID is responding to HIV and AIDS. Please also include relevant activities relating to sexual and reproductive health focusing particularly on linkages between SRH, HIV and AIDS. We are interested in key activities, any innovative approaches and specific areas of progress. You do not need to provide information on all the interventions listed above. This section should highlight key issues.

Support to comprehensive and integrated approach

Prevention

Care and support

Treatment (adult and paediatric) [Please include details of any activities to improve access to medicines, including use of flexibilities within WTO rules on intellectual property]
Current estimated need; Current coverage; Donor response (GFATM, PEPFAR, MAP); DFID response and support:

Impact mitigation

Research (eg AIDS impact assessments, surveillance surveys, clinical trials)

Health systems strengthening and resources

Women [Please highlight any activities in the following areas – girls access to education; advocacy for the rights of women; promoting leadership by and among women; women's access to medicines; women's access to employment, education and social protection; gender-based violence; access to a full range of SRH supplies & services. Please highlight, in particular, any linkages of SRH and HIV services]

Youth [Please highlight any activities in the following areas – advocacy for the rights of young people; promoting leadership by and among young people]

OVC [Including particularly education, health care and social protection]

PLWHA [Including particularly any support for the meaningful involvement of PLWHA and for involving those affected by AIDS in decision-making]

Other marginalised/vulnerable populations (eg CSW, IDU, MSM…) [Please highlight any activities in the following areas – advocacy for the rights of vulnerable groups; promoting leadership by and among members of vulnerable groups. Please include any support to harm reduction activities for IDU]

Interventions to address important contextual issues (such as human rights, stigma and discrimination, legislation, food security)

Donor coordination/harmonisation

Collaboration with bilaterals and multilaterals

Does DFID work in collaboration with bilateral and multilateral organisations in your country, including bilateral donors, GFATM, World Bank, EC, UNAIDS and its cosponsors? Please describe the nature of this collaboration, including any bilateral funding through multilateral organisations.

The 3 ones

How has DFID helped to progress the 3 ones in your country? Please state DFIDs direct involvement in this area. We are also interested in a broad overview of the status of your country in terms of the 3 ones, the extent to which UK support is aligned with national systems and a summary of the key actors involved and how DFID is working with them.

AIDS Financing

Please provide a brief summary of AIDS financing in your country. We are interested in the amount of funding available from all sources, whether this funding is appropriately channelled and whether it has opportunity costs or benefits for other sectors. Please highlight any financing gaps and how DFID funds fit into the overall picture.

Progress towards a fourth one

Is DFID involved in any attempts to establish a pooled funding mechanism for the HIV and AIDS response in your country? Please give information about the status of these attempts and the organisations involved. [In particular, please include information on progress towards having a lead donor on HIV and AIDS, specifying a minimum level for funding from donors and reducing the number of donors funding HIV and AIDS.]

GTT

How is DFID ensuring progress is being made at the national level to achieve the recommendations of the Global Task Team? Has a plan for achieving these recommendations been developed?

Supporting country led development

Collaboration with government organisations

Aside from the interventions listed above, to what extent has DFID worked in collaboration with government organisations (eg NAC, MoH, MoF) to strengthen national leadership, implementation and capacity[133] in the HIV and AIDS response? Please state the nature of any collaboration.

[133] In particular in the areas of domestic planning, coordination and monitoring

Collaboration with local organisations
To what extent has DFID worked with local NGOs, CBOs, FBOs, networks and APLWHA to strengthen local capacity and leadership in the HIV and AIDS response? What about the private/informal sector(s)?

Policy dialogue and influencing
How does DFID engage in and influence policy dialogue and decision making in your country? Please give details of any networks, working groups, committees etc of which DFID is a member.

Regional institutions
How have regional institutions engaged in the AIDS response in your country. Please give examples of DFID involvement with regional institutions and the broader engagement of these institutions with national government and non-government organisations.

Mainstreaming HIV and AIDS

External mainstreaming
To what extent are HIV and AIDS mainstreamed within national DFID strategies, CAPs and country programmes? Please give a brief summary.

How does DFIDs involvement help to ensure a successful multisectoral response to HIV and AIDS?

Internal mainstreaming
Does your country office have an HIV and AIDS workplace policy and is this being utilised?

Is there an HMG HIV and AIDS committee in your country? Please give details of any important activities the committee has or is undertaking.

Implementing Taking Action

Achievements
What do you consider to be the 3 key achievements in implementing Taking Action in your country?

Factors influencing implementation
What are the key factors facilitating/hindering implementation?

Guidance and support
Do you need any specific advice or support from the centre in implementing Taking Action or in responding to HIV and AIDS and OVC more generally?

The Future
Please highlight any areas of the HIV and AIDS response that require further attention in future. Please state how DFID can engage in these areas.

DEPARTMENT FOR INTERNATIONAL DEVELOPMENT

DFID, the Department for International Development: leading the British government's fight against world poverty.

One in five people in the world today, over 1 billion people, live in poverty on less than one dollar a day. In an increasingly interdependent world, many problems – like conflict, crime, pollution, and diseases such as HIV and AIDS – are caused or made worse by poverty.

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