13. Discussion and Conclusions

Overview

13.1 *Taking Action* and its spending targets galvanised UK Government, in general, and DFID, in particular, to give a higher profile to HIV and AIDS. It is a comprehensive and bold strategic statement which fits well into DFID's poverty focus and strong championing of the Millennium Development Goals. It sets out the UK's position on a wide range of issues relating to HIV and AIDS and is 'empowering', i.e. focused on what can be done, rather than a 'restrictive' framework, i.e. focused on what can not be done.

Progress on *Taking Action's* Six Priority Actions (see Chapter 3, p7)

13.2 Although there has been some progress in all of *Taking Action's* six priority areas, this has been greatest in the areas of strengthening political leadership and improving the international response. The UK has contributed to *closing the funding gap* in two main ways (from section 3.4, p9). First, the UK has increased its own direct financial support to the international response to HIV and AIDS. It is the second largest funder of the response, after the US, and remains committed to meet the spending targets within *Taking Action*, both on HIV and AIDS overall (£1.5 billion over three years) and in regard to orphans and vulnerable children (£150 million over three years). Recently published figures for 2004/5 to 2005/6 show that spending increased by 30%. Spending will need to increase at the same rate in both 2006/7 and 2007/8 if the targets are to be met. The UK is on track to meet or exceed financial commitments made to the Global Fund, UNFPA and UNAIDS. The UK has committed to fund its 'fair share' of the Global Fund and will meet this if it provides the funds it has pledged for 2006 and 2007. Second, the UK has championed efforts to increase funding from other sources internationally, including support to new funding mechanisms, such as UNITAID and the IFF. Nevertheless, although the international community is on-track to meet existing commitments to the international response to HIV and AIDS, best-available evidence shows that the global funding gap continues to grow.

13.3 The UK has contributed to *strengthening political leadership* in two main areas (from section 3.13, p14). First, the UK has played an active leadership role internationally through its Presidencies of the G8 and EU in 2005, and in important processes, such as UNGASS, the Global Task Team and the push for 'universal access'. The Cross-Whitehall nature of *Taking Action* has been helpful to underpin this role. In particular, the UK has courageously championed the needs of those most vulnerable to HIV infection and this has been an essential counter-weight to the perspective of other stakeholders who fail to recognise so fully the importance of these groups. In addition, the UK has also been a strong advocate of the importance of sexual and reproductive health rights in the response to HIV and AIDS. Second, both the FCO and DFID have been active at country level influencing national responses to HIV and AIDS and advocating for stronger leadership. Collaboration between FCO and DFID varies from very strong in some countries, e.g. Zambia, to weak in others, e.g. Russia. Critical

support has been provided to some national governments to enable them to tackle politically sensitive subjects, e.g. harm reduction among injecting drug users in China. However, in some other countries, the UK could perhaps have done more to challenge political leadership that is not based on evidence, e.g. the focus on abstinence-only as an HIV prevention approach among young people in Zambia and Zimbabwe, and the Russian Government's continued unwillingness to focus the national response to HIV effective programmes among the most vulnerable, particularly injecting drug users.

13.4 The UK has played a strong and central role in *improving the international response* to HIV and AIDS, particularly by supporting the implementation of the Paris Declaration on Aid Effectiveness, advocating for greater harmonisation of efforts and improved coordination (from section 3.19, p15). This has been seen in expanded support for UNAIDS, in general, and the Three Ones, in particular. It has also been seen in the UK's role in the Global Task Team and its evaluation. However, there are competing harmonisation agendas, which are seen in:

- Issues around coordinating bodies, e.g. National AIDS Councils, Country Coordinating Mechanisms and Ministries of Health.
- Tensions in building monitoring and evaluation capacity, i.e. the extent to which one system for HIV and AIDS, as stated in the Three Ones, forms part of an overall Health Management Information System.

13.5 Overall, there is a greater focus now on HIV and AIDS in Institutional Strategies that govern relationships between DFID and multilateral agencies than previously. DFID has also taken preliminary steps to critically evaluate the performance of multilaterals through the use of organisational effectiveness summaries. While there has been some notable improvement in EC engagement on HIV and AIDS, e.g. the EU statement on prevention and the recently adopted EU strategy for partnership in Africa, there is still scope for a more active EC financial, policy and technical response to the epidemic in developing and middle-income countries. The potential tension between UK support for UN reform and increased funding of individual UN agencies as implementation partners by DFID country offices needs to be explored and monitored carefully.

13.6 The UK has contributed to *better national programmes* through championing the issue of aid effectiveness (see from section 3.30, p18 and section 13.4). The UK has a strong reputation as a flexible and responsive donor and is pioneering the use of poverty reduction budget support. However, the effective use of such instruments requires a long-term perspective and this creates a tension because of the need for an urgent response to HIV and AIDS. In particular, this can result in the impression that the UK is more focused on building sustainable, national capacity and less concerned about the immediate need to achieve coverage with essential HIV/AIDS services than other bilateral donors, such as the US. Because of the way the UK increasingly funds activities through PRBS and sectoral support, it is difficult to obtain evidence concerning many of the specific commitments in *Taking Action* related to this priority action.

13.7 Other issues relating to better national programmes include:

- One strength of *Taking Action* is that it explicitly authorises use of UK funds to finance ART.
- The UK has recognised and championed the need for more work in fragile states if the Millennium Development Goals are to be met. Increasingly, such work is being structured around OECD guidelines for effective work in fragile states.
- The growing recognition that funds alone are not enough to respond to HIV and AIDS, particularly in countries facing severe shortages of human resources for health. The UK is providing essential support to national strategies to respond to these shortages, e.g. in Malawi.

13.8 *Taking Action* states that the UK will support national responses to HIV and AIDS in countries in which DFID has or will have no presence – many of which are experiencing severe HIV epidemics, e.g. China and Russia – through multilateral agencies. Based on experience to date there are doubts about whether this is the most effective approach, given the limited influence of UN agencies in middle-income countries and the nature of their role. A mix of approaches that also involves the FCO, civil society networks and organisations, and private foundations may be more appropriate.

13.9 The UK's support for *long-term action* has included DFID support for essential HIV and AIDS research, particularly on microbicides and vaccines (from section 3.36, p19). DFID also supports other forms of research, e.g. social and economic research, but it is difficult to know what is needed in these areas because data on international funding for AIDS research, collected by UNAIDS, is limited to microbicides and vaccines. The UK funds other AIDS research, e.g. through the Department of Health but this spending is not included in DFID's figures for UK spending on HIV and AIDS.

13.10 The UK has also championed the need for long-term, predictable financing for developing countries by supporting the establishment of an International Finance Facility and making ten year partnership commitments to a number of countries. However, progress on the IFF has been slower than expected. DFID's Country Assistance Plans do not yet all fully reflect this longer-term focus.

13.11 In terms of *translating strategy into action* the Cross-Whitehall coherence group is perceived as a useful forum for dialogue and promoting joined up action around specific events (from section 3.42, p21). However, the roles and responsibilities of other government departments are not clearly defined in *Taking Action* and, in practice, most actions have been taken by DFID. Although DFID has produced regular updates on implementing *Taking Action* there is no systematic approach for doing this across DFID or across Whitehall. This reflects a wider issue, which is that tracking implementation of strategies currently receives less attention than formulating them.

13.12 The UK has pioneered the introduction of a workplace policy on HIV and AIDS, but it is unclear if this is being implemented consistently across country

offices and government departments, or the extent to which it reflects changes in UK legislation, such as the Disability Discrimination Act.

Distribution of UK-supported Activities Match Priorities in *Taking Action* (see Chapter 4, p22)

13.13 Overall, the distribution of UK-supported activities matches the six priority actions specified in *Taking Action*. However, it is difficult to assess this rigorously because of the absence of clear indicators and targets as might be found in a monitoring framework. Most of the information that is available is from DFID. There is relatively little information available about what other government departments have been doing to implement *Taking Action*.

13.14 There is evidence that levels of UK support for particular countries are appropriate. For example, the degree of focus on HIV and AIDS in Country Assistance Plans broadly matches levels of adult HIV prevalence in particular countries. However, some countries appear to receive less UK funding for HIV and AIDS than might be expected based on consideration of their disease burden. Reasons for this may include:

- The UK is providing financial resources through other bilateral channels, such as poverty reduction budget support, e.g. Mozambique, Tanzania.
- The UK is providing financial resources to some countries through multilateral channels, such as the Global Fund.
- Countries receive sufficient financial resources from other sources, e.g. Haiti.
- Considerable logistical barriers to providing aid, e.g. Burundi, Liberia, DRC.

13.15 It is difficult for DFID to provide disaggregated information on how its funds are spent on HIV and AIDS. This is because of the way it funds, e.g. through sectoral and budget support, or through integrated programmes of prevention, care and treatment. It is also difficult because current information systems do not track this. Available information has been supplemented by work conducted for this evaluation:

- From 1997-2005, 44-63% of UK bilateral expenditure on HIV and AIDS was provided as technical cooperation.
- There is increasing use of sectoral and general budget support to fund responses to HIV and AIDS.
- The number of HIV/AIDS projects/programmes with an element of policy dialogue is increasing.
- Bilateral funds provided by DFID country offices to UN agencies have increased since 2003/4.
- Levels of funding provided to National AIDS Councils increased between 2003/4 and 2005/6.

- DFID is supporting an increasing number of activities to build national monitoring and evaluation capacity relating to poverty, health and HIV/AIDS.
- Just under half of all projects/programmes identified have a particular focus on women, young people or other vulnerable group. There is evidence of increasing spend on projects/programmes related to young people, orphans and vulnerable children, and other vulnerable groups. The apparent decline in spending on projects/programmes focused on women is due to a decline in expenditure on specific reproductive health projects/programmes as activities within these appear to be either captured within HIV/AIDS-marked programmes/projects or absorbed into health sectoral funding.

Decision Making in Practice (see Chapter 5, p40)

13.16 DFID has a system of planning and programming structured around the PSA, DDPs, CAPs and Institutional Strategies (IS). Until recently, there was no mechanism to ensure that strategies, such as *Taking Action*, were reflected in these documents. Steps taken by DFID to address this include:

- Guidance from the Resource Management Group as to what should be in DDPs, including specific instructions relating to the AIDS spending target.
- Provision for DDPs to be reviewed and updated annually to reflect new developments.
- Requirement that new strategies include an implementation plan, e.g. Gender Equality Action Plan introduced in 2006.

13.17 Although some resource decisions are made centrally, DFID is a highly decentralised organisation with many funding decisions being made by country offices. Country heads of office and health advisers have a great deal of autonomy. This enables the UK to be flexible and responsive in the way it provides funds but also means that the priorities and sector background of country staff have a significant influence on decisions. Balancing country and corporate priorities is challenging on occasions. Factors influencing decision making include:

- Type of partner – for bilateral funds, the UK's preferred partner is national government. However, in some situations financial aid to government may need to be supported by different forms of technical cooperation. In such settings, choice of partner may be influenced by many factors, including ease of procurement.
- National needs assessments – sources of information include written reports and views of key stakeholders including government, other bilaterals, UN agencies and the World Bank. Although civil society organisations, including associations of PLWHA, may have a voice through National AIDS Councils and/or Country Coordinating Mechanisms they may not have access to direct channels of communication available to others.

- Barriers to progress e.g. human resources for health – although these may not be given sufficient weight, particularly where such issues are not adequately reflected in the national situation analysis.
- Norms and values – the UK's commitment to the Paris Declaration has had a strong influence on decision making with DFID staff actively looking for opportunities to harmonise with other donors and to align activities with national priorities.
- Evidence of what works and recent technical developments – although staff endeavour to keep up-to-date, pressures of work restrict opportunities to do this proactively.
- Corporate directives – including new policies and strategies, and the pressure to reduce head count and 'do more with less'.

13.18 Incentives for DFID staff to ensure that decisions reflect the priorities in *Taking Action* include the requirement to provide regular progress reports to Ministers as well as the spending targets. There are no obvious incentives for other government departments to ensure that decisions taken reflect *Taking Action*.

Use of Country-led Aid Instruments in Responses to HIV and AIDS (see Chapter 6, p55)

13.19 The UK has been a strong champion of the Paris Declaration and of country-led approaches to development and has spearheaded the introduction of new aid instruments, such as general and sectoral budget support. These require the development of a nationally-owned poverty reduction strategy, which forms the basis for the provision of development assistance. However, HIV and AIDS are poorly reflected in many poverty reduction strategies. Until this situation is addressed, these strategies will not provide a sound basis for effective responses to HIV and AIDS.

13.20 Use of PRBS is at an early stage although there is growing experience in funding sectors and cross-cutting issues through this aid instrument. Although there is some positive experience of using PRBS to fund responses to HIV and AIDS, there are also concerns that, in some cases, insufficient priority has been given to HIV and AIDS. Challenges to supporting the national response to HIV and AIDS through budget support include general issues relating to the introduction and use of this aid instrument and those that are more specific to HIV and AIDS including:

- The urgency of the need for an effective, scaled-up response.
- The relative newness and weakness of institutions for HIV and AIDS e.g. NACs when compared to established sectoral ministries.
- The need for innovative and pilot approaches which are better funded through instruments other than PRBS.
- The fact that many national HIV epidemics are concentrated among particular vulnerable groups, such as injecting drug users, sex workers, men who have sex with men and prisoners, who may be marginalised from political processes.

- The concern that funding to civil society organisations, which play a critical role in the response to HIV and AIDS, may be undermined by the shift to PRBS. DFID is not able to provide information on total AIDS funding through civil society organisations, largely because the amount spent by country offices on funding for civil society is not captured centrally.

13.21 Consequently, in most countries where the UK funds through budget support, e.g. Tanzania, Uganda and Zambia, additional financing for the response to HIV and AIDS has been provided through other aid instruments. In some, e.g. India, UK support has transitioned from projects to earmarked budget support and will, from 2007, be provided as unearmarked, sub-sectoral budget support through the National AIDS Control Organisation. Experience in both India and Vietnam has shown that budget support can be used to finance the response to HIV and AIDS if the policy framework and political commitment are right. Experience in China and Russia demonstrates that a variety of aid instruments can form part of a country-led approach, particularly in countries which have limited dependence on official development assistance.

13.22 Countries usually prioritise a disease when it is a significant cause of illness and death. This is a problematic approach in the case of HIV because of the long time lag between infection and onset of illness. For this reason, surveillance data about the levels of HIV infection is of critical importance. But data from the general population only will not detect epidemics occurring among most at-risk population groups such as injecting drug users, sex workers, men who have sex with men and prisoners. Because these populations engage in illegal or socially unacceptable behaviour, they are often marginalised and 'difficult-to-reach'.

13.23 A recent evaluation of the World Bank's assistance for HIV and AIDS control concluded that national AIDS strategies were often a poor basis for programming because most 'do not prioritise or cost activities'. Rather, they tend to set out broad areas of focus with no discussion of relative importance or effectiveness. Strategies generated are so similar that the evaluation concluded that a generic package of HIV/AIDS areas of focus and interventions would have served just as well. In particular, insufficient focus is placed on the most at-risk populations, and they tend to be given the same level of priority as large 'vulnerable' groups, such as women and young people. This occurs, in part, because of the inclusive, consensus-based processes used to produce strategies, which mean that issues are included to accommodate organisational agendas. There is often no accepted process for deciding which issues are not to be prioritised. Although some prioritisation may occur when budgets are set, few of the strategies reviewed had budgets and even in these the basis for prioritisation was not clear.

13.24 There are particular challenges in relation to the provision of antiretroviral therapy to people with advanced HIV infection. Because of the relatively high cost of providing this treatment, it may be difficult to justify its provision on public health grounds in resource-constrained settings. But, because of the effectiveness of these drugs, people living with HIV and AIDS prioritise their provision above anything else. This creates a public policy tension which currently is being largely addressed in many countries by funding ART provision through significant short-term, external, off-budget resources, e.g. from the Global Fund and the US Government. Given the nature of treatment, funds will

be required over the long-term. Identifying ways to provide long-term funding, one of the commitments in *Taking Action,* will be a key challenge for donors and governments.

13.25 The UK has employed a number of strategies to influence decision making and priority setting when these appear to be inappropriate, including:

- Provision of evidence from epidemiological and behavioural data. In Pakistan, data of high HIV prevalence among injecting drug users in one city led to a recognition that the country faces a concentrated HIV epidemic.
- Pilot projects to demonstrate the technical and political feasibility of controversial interventions, e.g. harm reduction in Russia and China.
- Policy dialogue with public officials and key leaders – this may be particularly effective when done jointly with other donors and multilaterals, e.g. as through the Joint Assistance Strategy in Zambia (JASZ).
- Engaging civil society to advocate and hold governments to account, e.g. support to organisations of PLWHA in India.
- Using aid instruments with some degree of conditionality, e.g. use of projects and/or earmarked funds. Experience from India shows that this has been an effective approach in transitioning to a more country-led approach.

13.26 There are concerns among some DFID staff that central support for multilateral partners may undermine the overall emphasis on country-led approaches. There is evidence that the UN is moving toward more country-led approaches, but progress is slow and is challenged by continued direct in-country funding to individual agencies.

13.27 The Global Fund's principles commit it to country-led approaches. In practice, country-led approaches are interpreted and implemented somewhat differently by the Global Fund than by DFID. In some areas DFID has adopted the principles of the Paris Declaration on Aid Effectiveness more effectively than the Global Fund, e.g. harmonisation and alignment. In others, such as mutual accountability and managing for results, the Global Fund is demonstrating leadership.

Focus on Women, Young People and Other Vulnerable Groups (see Chapter 7, p73)

13.28 It is difficult to assess the extent to which UK funding and support for activities related to HIV and AIDS are benefiting women, young people and other vulnerable groups. This is partly because of the aid instruments used by the UK to provide funding and partly because DFID's information systems do not track this information. As part of this evaluation, we identified 1,424 projects/programmes supported by DFID between 1987 and 2006 with a principal or significant impact on HIV, AIDS or reproductive health. Of these:

- 619 (43%) had a discernible focus on either women (329), young people (109), orphans and vulnerable children (178) or other vulnerable groups (175). Some projects/programmes benefited more than one of these groups.
- Expenditure on projects/programmes with a discernible focus on young people, orphans and vulnerable children and other vulnerable groups increased between 2003/4 and 2005/6.
- Expenditure on projects/programmes with a discernible focus on women decreased between 2003/4 and 2005/6, although figures for 2005/6 were incomplete, i.e. to February 2006. This apparent decrease appears to be due to a reduction in the number of specific reproductive health programmes as activities have been captured within AIDS marked projects/programmes or integrated into health sectoral support. During the same period, the number of AIDS-related projects/programmes with a significant or principal impact on gender rose.

13.29 There are concerns that support for gender interventions has not adequately emphasised the roles and needs of men and boys or tackling the underlying causes of gender inequalities. There are, however, many examples of UK funding and activities benefiting *women*. These include:

- UK funding for and championing of microbicide research – from 2000 to 2005, total available funding for this research internationally rose from US$65 million to US$163 million.
- Financial support to multilateral organisations with a focus on women, e.g. UNFPA and UNIFEM.
- Activities by international NGOs using funds provided by DFID under Programme Partnership Agreements, e.g. ActionAid's work on gender using the Stepping Stones tool.
- Support for activities which address the links between gender-based violence, HIV and AIDS, e.g. work by Oxfam in Mozambique and IOM in Zimbabwe.

13.30 There is evidence of positive outcomes for women in some of DFID's PSA countries. For example:

- In the ten PSA countries where comparative data exists for 1990 and the present time, unmet contraceptive need declined in all of them. However, these figures show that in PSA countries, more than 60m women still have unmet contraceptive need.
- Overall, women appear to be well-represented among recipients of anti-retroviral therapy, although experience varies from country to country, and there are doubts about the reliability of available data.

13.31 Similarly, there is evidence of positive outcomes for *young people* in three DFID's African PSA countries, with declining HIV prevalence among those aged 15-24 in e.g. Kenya, Rwanda and Zimbabwe. However, HIV prevalence is

static in eight countries and rising in three, Mozambique, South Africa and Sudan. Data is insufficient in DRC.

13.32 There are concerns that the UK's influence on HIV programming for young people has not been sufficient to prevent a shift to abstinence-only programmes. This is seen in the wording of some national strategies, e.g. Zambia. Evidence of the effect this may be having can be found in Zambia's latest demographic health survey where age of sexual debut had increased but condom use by young people with non-regular partners had declined. There are also concerns that insufficient emphasis has been given to the most vulnerable young people, including those that are not in school, and to children less likely to be reached by social protection measures, e.g. street children.

13.33 In a recent report, UNAIDS identified four sub-populations as particularly at risk of HIV infection yet neglected by the international response. These are injecting drug users, sex workers, men who have sex with men and prisoners. With the exception of prisoners, who are not mentioned in *Taking Action*, the UK has strongly championed the need for programming to focus on these *vulnerable groups*. This has been done both internationally, e.g. in relation to the follow-up meeting held in June 2006 to review implementation of the 2001 UNGASS Declaration of Commitment, and in-country with focused support being provided to a number of countries with concentrated epidemics, e.g. China, India, Pakistan and Vietnam to provide effective prevention programmes for these groups, including harm reduction and drug substitution therapy. Although these concentrated epidemics are spreading rapidly, they are mostly occurring in middle-income countries. Preparations for closure of DFID offices, e.g. in Russia, have reduced UK support for programming for these vulnerable groups, and support is likely to decline further unless an effective way can be found of providing this in the absence of a DFID office.

13.34 *Taking Action* committed the UK to provide £150 million over three years for programmes to meet the needs of *orphans and other children made vulnerable by HIV and AIDS*. This target is problematic for two main reasons. First, it is framed as a subset of HIV and AIDS spending. This contradicts programme guidance in the Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS, endorsed by DFID, which exhorts programmes to 'focus on the most vulnerable children and communities, not only children orphaned by AIDS'. Reasons for this include the risk of increasing stigma and discrimination, denying support to children with profound needs and creating perverse incentives for being HIV positive. Second, the current system of tracking spend would significantly underestimate spend. Work carried out for this evaluation indicates that the UK appears to be making progress towards the OVC spending target.

13.35 There are many examples of DFID-supported programming for orphans and vulnerable children, particularly in Africa. These include:

- Support to child-focused organisations, such as UNICEF and Save the Children. For example, DFID has supported operational research conducted by Save the Children into use of social protection measures to benefit vulnerable children. DFID provides support to UNICEF both

centrally and in-country. Countries in which DFID provides funds to UNICEF or plans to do so include Ghana, Kenya, Nigeria, Sierra Leone and Sudan.

- Programmes specific to the needs of OVC, such as the Programme of Support in Zimbabwe.
- Components focused on OVC as part of broader programmes on HIV and AIDS e.g. support to CBOs providing home-based care in Kenya and to NGOs in Zambia, support through Christian Aid in DRC, financial support to Ghana's National Strategic Framework on HIV and AIDS, funding for the Anglican church in South Africa, the rapid funding envelope in Tanzania for NGOs, and support to an umbrella programme financing CSOs in Uganda.
- Activities which benefit vulnerable children as part of broader development programmes e.g. support to CARE to deliver community-level social protection programmes in Zambia, support to the Productive Safety Nets Programme in Ethiopia and support through UNICEF to the Government of Ghana's social protection strategy. In countries where DFID provides most of its financial aid through poverty reduction budget support, e.g. Tanzania and Uganda, these funds can be used by government to address the needs of OVC.

13.36 The UK has provided funding to *organisations of PLWHA* in-country, both directly, e.g. in India, and indirectly, through a Programme Partnership Agreement with the International HIV/AIDS Alliance. Part of the Alliance's PPA is focused on increasing the participation of beneficiaries, including PLWHA, at all levels of HIV programming. UK support to these organisations has been hindered in some countries, e.g. Zambia and Zimbabwe, by the weak capacity of these institutions. DFID also provides financial support to international networks of PLWHA, including ICW and GNP+.

Systems and Staff Resources (see Chapter 8, p104)

13.37 There has been a marked increase in the percentage of DFID staff with AIDS-related objectives and success criteria in their Personal Development Plans/Performance Management Frameworks since the introduction of *Taking Action*. For example, in 2003, less than 1% of senior DFID staff had an AIDS-related objective, whereas since 2004, the figure has been between 5-10%. Similarly, the percentage of senior DFID staff with AIDS-related success criteria rose from 1-2% before *Taking Action* was introduced and has been 15-25% since. Job descriptions refer to HIV where appropriate and this is taken into account in recruitment. Although there is no standard briefing on HIV during staff induction nor any shared understanding of AIDS competence required by staff, evidence from the country case studies conducted for this evaluation shows that DFID advisers have high levels of AIDS-related skills and knowledge.

13.38 Ongoing professional learning related to HIV and AIDS is organised by the Heads of Profession and the Global AIDS Policy Team. Retreats also provide an opportunity for ongoing professional development and a day was dedicated to

HIV and AIDS at the human development retreat in February 2007. However, HIV and AIDS have featured on the agenda of retreats for other cadres to a limited extent over the last three years.

13.39 An issue which affects staffing is the UK Government's commitment to 'do more with less', and the specific commitment to reduce DFID staff levels from 2,872 in 2005 to 2,560 by March 2008. As of April 2006, DFID had 64 health advisers. Of these, 33 were deployed in country offices, 21 in the UK and the remainder were seconded to other organisations, deployed to UK Missions or employed as DFID heads of office. While most PSA countries have health advisers, some do not. A recent study reported a 14.5% reduction in the number of health advisers. Reduced staffing has been a factor in programming decisions and has also resulted in lack of clarity about responsibilities e.g. who is responsible for OVC in the absence of a social development adviser. Strategies being adopted to deal with 'doing more with less' include use of hybrid advisers, silent partnerships, consultants and outsourcing.

13.40 DFID has a number of knowledge and information systems relating to HIV and AIDS. These include PRISM, QUEST, the e-library, Global AIDS Team web pages, AIDS Portal, Research Portal and the Best Practice Guide. There is some duplication, and limited links, between these systems and some are out of date. DFID reports that efforts are being made to improve and streamline systems and ensure that staff have access to a 'one stop shop' for information.

Measuring the Success of *Taking Action* (see Chapter 9, p119)

13.41 There is an expectation from the House of Commons International Development Committee and others that DFID will report at least annually on its progress in responding to HIV and AIDS. However, the many commitments in *Taking Action* are not captured in an overall framework for monitoring the strategy. Chapter 9 (p119) of this report discusses how this might be done more systematically in the future. There are particular challenges in monitoring progress with *Taking Action* across Whitehall, not least because the strategy does not set out explicit roles and responsibilities of other government departments in implementing the strategy. Since *Taking Action* was introduced, DFID country offices and regional divisions have submitted narrative reports on implementation progress every six months or so. However, there is currently no standard format or agreed timetable for doing this, and reporting may not address all key commitments made in *Taking Action.*

13.42 As noted above, *Taking Action* does not include a monitoring and evaluation framework, which makes it hard to track progress systematically. The strategy does contain a number of explicit and implicit indicators in the form of global targets on HIV and AIDS and commitments under each of the six priority actions. It is difficult to track all of these commitments because they are so numerous and because some, e.g. on the nature of national responses to HIV and AIDS, conflict with DFID's approach of harmonising with other donors and aligning around national priorities rather than UK interests. Indicators to measure the international and national response to HIV and AIDS are in place and are being tracked e.g. by UNAIDS. The availability of data on these is better than it

has been, e.g. through processes such as following up the UNGASS declaration. However, there are many areas in which capacity needs to be strengthened to improve data quality and availability. There are also a number of initiatives to harmonise indicators internationally, e.g. UNGASS, Global Fund toolkit, 'universal access' but these do not always tally with each other.

13.43 The monitoring and evaluation framework proposed in Chapter 9 of this report is structured around *Taking Action*'s six priority areas and the following four levels:

- International – focused on overall progress internationally using, wherever possible, existing indicators that are being tracked by others, e.g. UNAIDS.
- Country – focused on national responses in PSA countries; these should use data generated by national M&E systems and the UK should continue and expand efforts to support these.
- UK Government contribution – these indicators will need to be tracked by DFID.
- Milestones – time-bound processes specified in *Taking Action.*

13.44 These levels are not all equal in terms of priority or the UK's responsibility for tracking. The first two levels will provide information on the context in which the UK is providing support and on the outcomes/impact to which UK support is contributing. The UK would not be expected to track these indicators as this will be done by UNAIDS and country M&E systems. The UK should provide support to build capacity where it is lacking and DFID will need to aggregate data from these bodies for reports on the progress of implementing *Taking Action*. DFID would be responsible for tracking and reporting on both indicators of the UK Government's contribution and milestones. However, the indicators of UK Government contribution are of a higher priority than the milestones.

Continued Relevance of *Taking Action* (see Chapter 10, p127)

13.45 *Taking Action* is a comprehensive strategy on HIV and AIDS. However, it is less useful in prioritising or guiding action. It includes statements which reflect the UK's position on a range of issues and some strategic choices, e.g. the establishment of a spending target on AIDS. Overall, it is an extremely relevant strategy. It may need updating as there are a number of issues which have emerged since it was conceived in 2004. These include the push for universal access to HIV prevention, care and treatment; the emergence of new global partners and initiatives; and the development of new DFID and UK Government documents, e.g. the 2006 White Paper. In addition, middle-income countries, such as China and Russia, do not view a strategy for the developing world as relevant to their situation.

Managing Tensions between Top-Down AIDS Targets and a Flexible, Country-Led Approach (see Chapter 11, p141)

13.46 Tensions are not unique to having a spending target or to the UK Government. They occur with any central policy in a decentralised organisation and affect many agencies. These tensions can be particularly problematic if there are a large number of central policies, strategies and targets. Areas in which tensions occur include:

- Time frame – country-led approaches emphasise long-term sustainable solutions, whereas central targets, such as the AIDS spending target, are focused more on the urgent and the immediate.
- Extent to which focus is on building national capacity – this is at the heart of country-led approaches but largely a means to an end for central targets.
- Whether the focus is primarily on the ends, i.e. results, or the means. Central targets focus on achieving certain results, e.g. spending a certain amount of money, whereas country-led approaches are concerned about the way in which that is done.
- Different types of accountability – central spending targets are largely focused on financial accountability, whereas country-led approaches are concerned with broader issues of legitimacy and democracy.
- Burden of donor reporting is likely to be increased by central targets and lessened through country-led approaches.
- Source of quality standards – international best practice for central targets and national stakeholder experience for country-led approaches.

13.47 Although the main rationale for a spending target is to make sure enough money is going to a priority issue, it is also an effective way of raising the political and public profile of an issue and of giving 'traction' to a strategy within a government department. However, there are both conceptual and practical arguments against spending targets. The main conceptual arguments against are that central targets create statistical anomalies and perverse incentives, contradict the UK's commitment to country-led approaches and see the UK's contribution in isolation from other donors. Practical problems with a spending target have included:

- Process, particularly over the degree of consultation needed
- Problems of level, i.e. if the spending target is set too high or too low
- Method, particularly if this is not clear before the level is set
- Information systems, which need to be adequate for the task of tracking progress

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

spending are to rise in the next two years in line with the requirements of the spending target.

13.49 There is no evidence yet that limitations in absorptive capacity have affected the UK's ability to meet the spending target. However, there are concerns in some countries about aspects of absorptive capacity, e.g. inadequate human resources in Zambia and the ability of UN agencies to handle large increases in funds in Zimbabwe. These concerns are significant when considering increased levels of international funding for AIDS overall rather than the UK contribution in isolation.

Lessons for Future Strategies from the Process of Developing *Taking Action* (see Chapter 12, p152)

13.50 A key feature of the development of *Taking Action* was extensive consultation with DFID's external stakeholders, in particular NGOs, other government departments and parliamentarians. *Taking Action* is an excellent model for managing external consultation on strategy development. While there was also consultation within DFID, consultation concerning the spending target could have been stronger. More specifically, the imperatives behind the introduction of a spending target were not clearly communicated to DFID staff and the implications of managing a spending target were not fully identified.

13.51 If there is to be a spending target in future:

- The process of target setting should be transparent and involve consultation with staff and other stakeholders about how targets are arrived at and how they will be delivered.
- The target should be embedded within DFID's business model including allocation of resources.
- The method for calculating spend should be established in advance and based on information systems that are fit for purpose. Better systems for providing information on the level and focus of spend might also help to inform decisions about resource allocation as well as strengthening monitoring of progress.

13.52 Strategies, not just spending targets, should be embedded in DFID's business model (i.e. PSA, DDPs, CAPs). Appropriate incentives need to be in places. The use of implementation or action plans is currently being promoted as a way of doing this. Experience should be reviewed to see if it produces the desired results.

13.53 As a Cross-Whitehall strategy, *Taking Action* enabled DFID to engage with other government departments. While the Cross-Whitehall coherence group has been a useful forum for information exchange, focused inter-departmental working groups e.g. on G8 2005 and Access to Medicines have been most effective. Cross-Whitehall strategies are of benefit when the issue is of cross-cutting interest. The advantages are less obvious when the strategy reflects the agenda of one or two departments. Further thought might be given to developing criteria to determine whether future strategies should be cross-

Whitehall in nature, and when a strategy or another approach, such as joint policy papers, might be appropriate.

13.54 *Taking Action* does not set out how the strategy fits with other DFID strategies or with other government strategies on HIV and AIDS, e.g. the Department of Health's National Strategy for Sexual Health and HIV in England. *Taking Action* did not specify the roles and responsibilities of other government departments in delivering the strategy. This has made it more difficult to measure results.

14. Issues for Consideration

14.1 In order to close the funding gap and improve tracking of spend, the UK Government should consider:

- Ways in which it can work with international and national partners to address inadequacies in data on resources required for the response to HIV and AIDS. This should include supporting efforts to improve availability of country-level data on financial needs and available resources. Absence of this information makes it difficult to assess the appropriateness of distribution of funds between countries.
- Measures it could take to ensure that the Global Fund receives longer term and more predictable financing. The Global Fund is one possible mechanism for UK funding of countries where DFID does not have a bilateral presence. This could be accompanied by continued efforts to promote harmonisation between the Global Fund, other donors and national systems.
- How to work with international partners to to address the financial implications of the global commitment to 'universal access', including antiretroviral therapy. This could lead to advocating for more effective international monitoring of progress against funding commitments.
- Ways in which it could participate more vigorously in dialogue on tracking resources and spend, e.g. with OECD DAC, UNAIDS, NAO and UK NGOs.

14.2 In order to strengthen political leadership and the international response, the UK Government should consider:

- Exploring the implications of Three Ones for harmonisation and coordination beyond AIDS. For example, the Three Ones envisages one national coordinating authority for AIDS but it is not always clear how this interacts with bodies for coordination of other related issues, such as other infectious diseases or reproductive health. Similar issues arise for the action framework on HIV and AIDS, e.g. how it fits with the health strategy; and the national M&E system for HIV and AIDS and how this fits with other systems, e.g. Health Management Information Systems.
- The role of the FCO in delivering *Taking Action* in countries where DFID does not have a presence. There is also a need for steps to improve cooperation between DFID and FCO in some countries.
- How it could strengthen monitoring the effectiveness of support for UN agencies such as UNAIDS. section 3.22 (p16) includes discussion of the use of organisational effectiveness summaries for this purpose.
- How DFID will engage with and seek to influence new global health partnerships and actors.

- How DFID will manage its relationship with UNITAID, including monitoring its effectiveness and impact, and its coherence with other long-term efforts and aid instruments.

- Explore ways in which DFID can support the reformed UN system, both centrally and at country level, particularly to shift from individually-funded UN HIV activities to streamlined funding of a consolidated UN country programme on HIV and AIDS. Care will be needed to ensure that support to vulnerable groups and sexual and reproductive health are maintained and that DFID country programmes are still able to respond flexibly and effectively to local needs.

- Review the role of UK support to multilaterals in the global response to HIV and AIDS. This could include commissioning a working paper, to contribute to the final evaluation of *Taking Action*, which could cover a number of issues relating to multilaterals including:

  - How to strengthen UK efforts to influence the EC to increase focus on HIV and AIDS, including the use of 'MDG contracts' focused on specific outcomes.

  - How to use opportunities to influence multilateral partners, in particular the EC and World Bank, to ensure that their support for HIV and AIDS gives adequate priority to the needs of women, young people and vulnerable groups. This includes using approaches such as that taken in Central Asia and participation in the upcoming MAP evaluation.

  - How effective multilaterals are as a channel for UK support in middle income countries in which DFID has no bilateral presence.

  - How to strengthen UK efforts to promote harmonisation between the Global Fund and national systems.

  - How DFID can strengthen links between ISs and CAPs. In particular, this could explore whether guidance should be produced by International Division summarising implications of new ISs for CAPs, and vice versa by Regional Divisions.

  - How to strengthen monitoring of multilateral spend and effectiveness in specific 'sectors' including HIV and AIDS.

14.3 To support better national programmes, the UK should:

- Consider further analysis of:
  - Types of aid instruments which can be used in a country-led approach to HIV and AIDS in different contexts.
  - Experience of financing HIV and AIDS through budget and sectoral support.
  - Implications of increasing aid flows in post-conflict and other fragile states; and approach to delivering effective HIV and AIDS programming and services in post-conflict settings.
  - Independent reviews of the effectiveness and impact of the Three Ones in different settings.

- Sustain and strengthen UK efforts to improve access to medicines including efforts to promote differential pricing and support countries on TRIPS issues through the cross-Whitehall Access to Medicines group.
- Strengthen government ministries responsible for women, young people, children and vulnerable groups, including undertaking institutional audits of their capacity.
- Review the role of civil society in responses to HIV and AIDS beyond holding government to account and providing services in fragile states – e.g. as provider of services that are 'difficult', innovative and/or community-based and, more specifically, review the most appropriate strategies for funding CSOs e.g. through intermediaries.
- Support increased engagement of women, young people, vulnerable groups and PLWHA in national consultation processes and in UK-supported programme design, planning, delivery and evaluation. This should include determining at what level and at what stage engagement is most effective and monitoring the impact of increased engagement on improved outcomes.
- Ensure that issues related to women, young people and vulnerable groups are integrated into DFID's plans (e.g. DDPs, RAPs and CAPs) and country programming. This reinforces the IDC recommendation that issues such as HIV-related stigma and discrimination be addressed in all DFID country programmes.
- Build on lessons learned from efforts to strengthen linkages between SRH and HIV services. The UK could contribute by:
  - Assisting national governments to develop programmes which integrate SRH and responses to HIV and AIDS.
  - Supporting research to gather evidence into the benefits of linking SRH and responses to HIV and AIDS.
  - Supporting efforts to develop indicators which measure the degree to which SRH and responses to HIV and AIDS are being linked and/or integrated.

14.4 In order to improve long-term action and sustainability, the UK Government could consider:

- Supporting a situational analysis of research funding currently available for HIV and AIDS other than for microbicides and vaccines. Findings could be used to identify gaps and to inform choices as to how UK funding could be used most strategically to support HIV and AIDS research.
- Building on existing efforts to capture research funded through country offices and to strengthen research-policy links.
- Ensuring that research findings are disseminated effectively to DFID UK and country staff.
- Ways to work with other donors to sustain support for vaccine and microbicide research to ensure that adequate financing is available for larger scale clinical trials of products that are further along the research and development pipeline.

14.5 In order to improve translation of strategy into action, the UK could consider ways to strengthen the use of monitoring information and lessons learned to inform decision making.

14.6 In order to improve staffing and systems with regard to *Taking Action*, the UK Government could consider:

- Implementing briefing on HIV for all staff. There should be two levels of HIV briefing focused on knowledge and skills – a basic level for all cadres of advisory staff and a more advanced level for those staff working specifically on issues related to HIV and AIDS. It would also be helpful to clarify who is best-placed to provide staff with continuing professional education on HIV and AIDS.
- Evaluating the relevance and usefulness of guidance provided relating to HIV and AIDS.
- Implementing proposals to review DFID HIV and AIDS information sources and to streamline and link systems. This should aim to have one electronic repository for information with multiple entry points, rather than multiple repositories with limited entry points.
- Strengthening systems for: monitoring implementation of strategies, e.g. by limiting the number of strategies and ensuring each has an action plan; provision of technical guidance and information; lesson learning; and dissemination of research.