4. *Taking Action* Implementation – Distribution of UK Funding and Activities

In Brief

Question: Overall, does the distribution of current UK-supported HIV and AIDS activities reflect the priorities laid out in *Taking Action?* If not, why not?

The absence of a monitoring framework with clear indicators in *Taking Action* makes it difficult to assess rigorously the extent to which the distribution of current UK-supported HIV and AIDS activities reflects priorities in *Taking Action*. Obtaining disaggregated information on how DFID funds are spent on HIV and AIDS is difficult, because of the instruments used for funding, e.g. sectoral and budget support, and because current systems do not track this information. There is relatively little information available about what other government departments have done to implement *Taking Action*. Nevertheless, this evaluation concludes that some progress has been made in all six of *Taking Action's* priority areas, with the most progress in strengthening political leadership and improving the international response (see section 3, p7).

Analysis for this evaluation shows that the UK is supporting an increasing number of HIV and AIDS-related projects and programmes (see Figure 4, p24). More of these are of a large size, i.e. over £10 million (see Figure 5, p24). In the last two years, just over four fifths of the UK's support for HIV and AIDS was provided through bilateral channels and just under one fifth through multilateral channels. Although much support for political leadership is not projectised, 9% of all projects/programmes on HIV and AIDS show demonstrable evidence of policy dialogue. This number is increasing (see Figure 16, p32).

Almost half (48%) of all HIV and AIDS projects/programmes supported by DFID since 1987 have been in Africa (see Figure 6, p25). There is evidence that the UK's financial support to countries is largely appropriate for their burden of disease. However, there are some countries that appear to receive less AIDS funding from the UK than their burden of disease warrants (see Figure 21, p36). The UK works through a variety of in-country partners, including in particular Ministries of Health. There is evidence of increased expenditure through National AIDS Commissions and UN Agencies (see Figure 13, p30). In 2005/6, DFID provided more than £20 million to UN agencies in-country for HIV and AIDS projects/programmes. Less than half of this was in fragile states or middle-income countries (see section 4.9, p28). DFID is committed to funding integrated response to HIV and AIDS.

The way in which funding is provided and limitations of information systems make it difficult to analyse how much the UK is spending on specific elements of these responses, e.g. prevention, care, support and treatment. Questions on this, however, can be answered by providing figures about responses in PSA countries and what the UK is doing financially to support the national response. This will require improved national capacity for M&E. DFID has increasingly been supporting the building of this capacity (see Figure 17, p33). DFID has also increased support to specific AIDS projects, health programmes and broader enabling actions. There is evidence that support to specific reproductive health programmes has reduced (see Figure 19, p35).

Trends in UK Government Funding[48] and Activities[49]

Caveat

All figures in this Chapter are based on a qualitative analysis of DFID information systems conducted in February 2006 for a working paper produced for this evaluation (SSS, 2006a). These are **NOT** official DFID figures. In order to successfully understand, interpret and use these figures, it is essential that the methods used to generate them are fully understood (see Annex 1 of the working paper).

4.1 This Chapter analyses distribution of and trends in UK Government funding and activities. It starts by considering trends in numbers of projects/programmes and financial commitments. It analyses funding and activities by a number of fields including aid instrument; bilateral and multilateral spend; partner organisations; focus of work HIV and AIDS; policy dialogue; building capacity for monitoring and evaluation; and AIDS specificity of approaches. It then considers the appropriateness of country support in relation to the burden of HIV and AIDS. It concludes by highlighting some of the implications for information systems used to track distribution and trends in UK Government funding and activities.

Trends in Number of Projects/Programmes and Financial Commitment

4.2 The number of HIV/AIDS-related projects/programmes[50] has been rising. Total new commitment per year[51] also rose (see Figure 4, p24). These trends started well before *Taking Action* was launched but have been reinforced since then. The size of HIV/AIDS-related projects/programmes has also increased (see Figure 5, p24), with around 80% of commitment in 2005/6 going to large projects/programmes over £10 million.

4.3 About half of all HIV/AIDS-related projects/programmes (48%) were in Africa[52], about one fifth in Asia (19%) and 12% in Europe, Middle East and the

[48] All financial information in this section was originally collected and analysed in February 2006. At that time, DFID was in transition between different methods for calculating AIDS spending. Consequently, analysis was done in a way that was based on DFID's 'old method' of calculating spend (see section 3, Table 2, p10). This involved including 100% of all commitments and expenditures of projects/programmes in our data set. Figures relating to 17 projects/programmes identified as PRBS were excluded because of the pending changes in methods for calculating AIDS spending. In addition, as data was collected in February 2006, expenditure figures for 2005/6 are incomplete. **For these reasons, care needs to be taken in interpreting these figures, particularly the absolute values as these may not be comparable to figures currently available under the 'new method'. For this reason, all graphs and charts based on financial figures are marked as follows**  . In a few cases, figures were re-calculated using the new method. Where this has been done (Figure 13, p30 and Figure 21, p36), this is clearly marked in the text. In none of these cases did the re-calculation materially affect the trends observed.

[49] Information in this section is taken from Working Paper 1, produced for this evaluation (SSS, 2006a)

[50] That is projects/programmes meeting the selection criteria specified in Annex 1 of Working Paper 1 (SSS, 2006a). Overall, 1,424 projects/programmes met these criteria and were included in the data set.

[51] That is the total financial commitment made to a project/programme at the time that it starts. This may be for several years. These figures are **not** comparable to annual expenditure figures.

[52] Some of the non-geographic projects/programmes may also have a focus on Africa. This would not be captured in this figure.

Americas (EMAD)[53]. The remaining 20% were non-geographic. Figure 6 (p25) shows the regional trend over time with the largest growth being seen in projects/programmes in Africa followed by non-geographic support.

Figure 4. Trends in Number and Size of DFID Projects/Programmes Related to HIV and AIDS: 1987-2006[54]

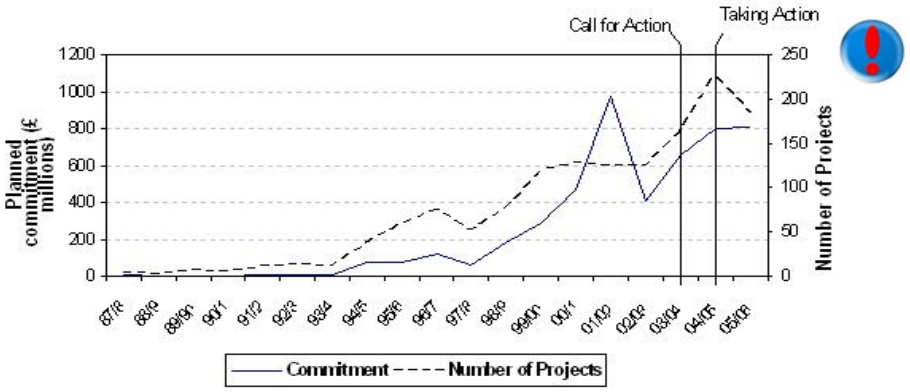
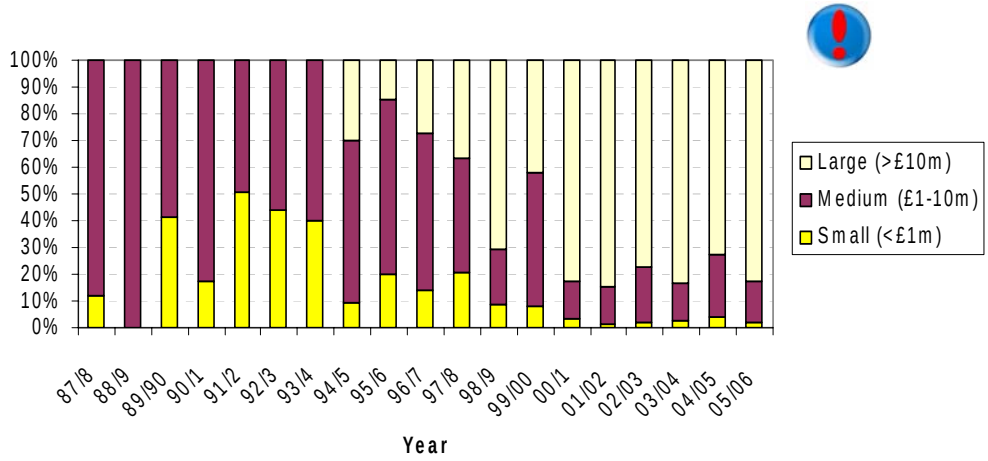


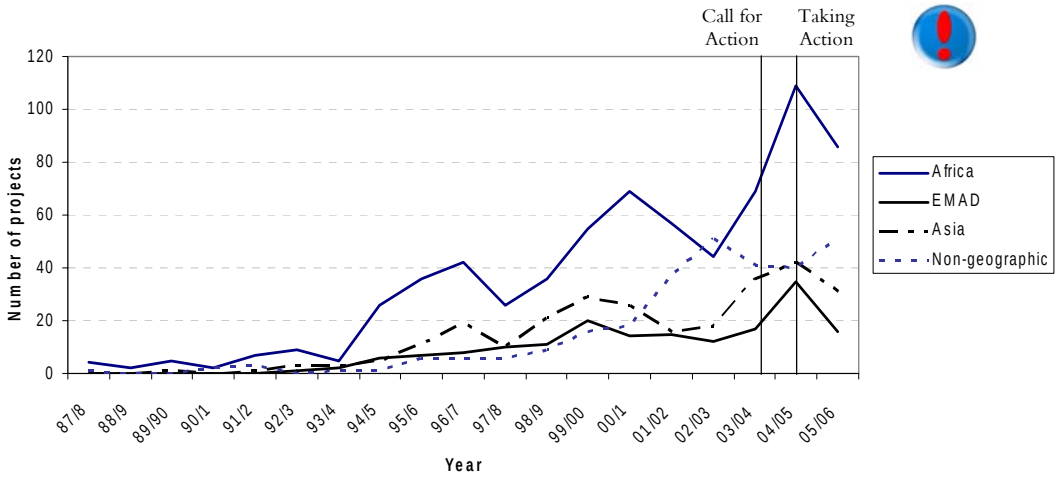
Figure 5. Planned Financial Commitment to New HIV and AIDS-related Projects/Programmes of Different Sizes



[53] DFID currently operates according to a Public Service Agreement for 2005-8. The 6th target within that is to ensure that the proportion of DFID's bilateral programme going to low-income countries is at least 90% (see DFID, 2005c). This is known within DFID as the '90/10 target' and means that EMAD, as a region with many countries outside the category of low income, is increasingly operating through multilaterals and pursuing an 'influencing' agenda rather than through direct bilateral expenditure.

[54] The large peak of commitment in 2001/2 occurred because a number of large multi-year projects/programmes began in that year. These included £259m to the Global Fund, £241m to 5 PPAs and several large TC projects/programmes including £82m to Nigeria, £75m to Bangladesh, £40m to Malawi and £32m to South Africa.

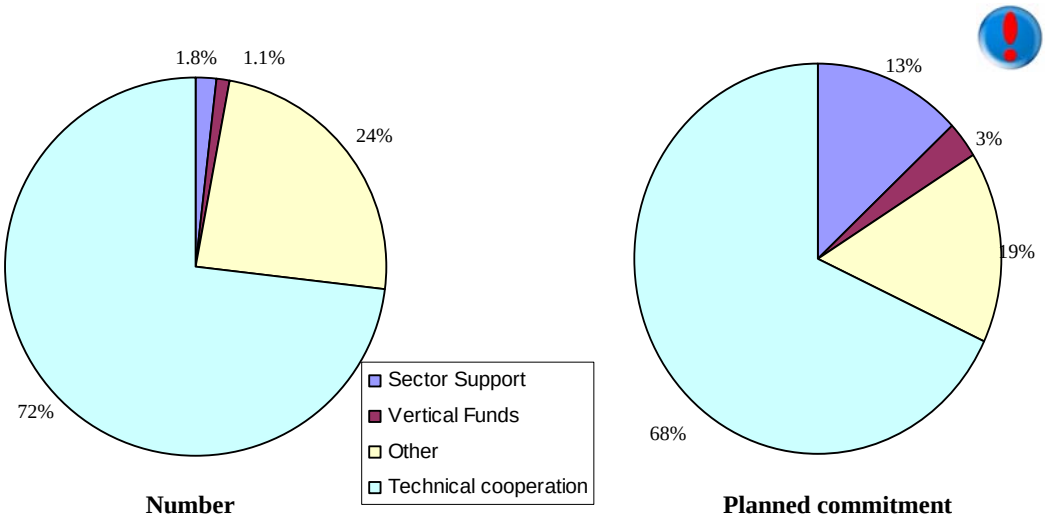
Figure 6. Regional Analysis of Number of New HIV and AIDS-related Projects/Programmes 1987-2006



Analysis by Aid Instrument[55]

4.4 Almost three quarters (72%)[56] of the projects/programmes in the dataset fall into the category of technical cooperation (see Figure 7). This is higher than the figure of 25% for DFID as a whole (DFID, 2006b).

Figure 7. Percentage of HIV and AIDS-related Projects/Programmes by Aid Instrument (by Number and Planned Commitment)

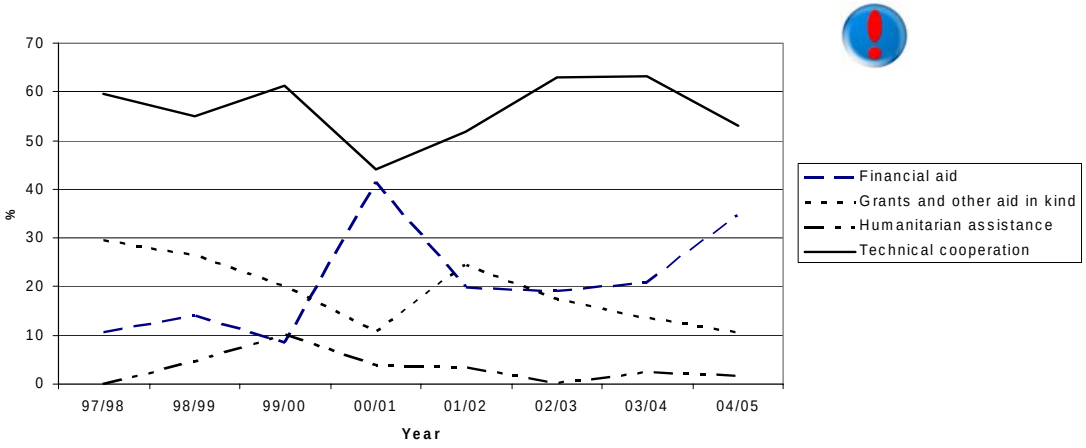


[55] Challenges were encountered in trying to analyse the dataset by aid instrument. There was no uniformly agreed classification of aid instruments within DFID (Colenso, 2005; DFID 2006a; Foster and Leavy, 2001). Work is ongoing to try to develop this as part of the work of the Aid Effectiveness Team.

[56] For the purpose of counting number of projects, 17 "general budget support" projects/programmes are included but are excluded for the purpose of financial analysis.

4.5 These figures are broadly comparable to those produced by DFID's Statistical Reporting and Support Group (SRSG), shown graphically in Figure 8. These show that 44-63% of bilateral expenditure on HIV and AIDS between 1997 and 2005 was spent through technical cooperation.

Figure 8. Figures for DFID Bilateral Expenditure on HIV and AIDS from 1997-2005 by Aid Instrument (Source: SRSG)



4.6 The term technical cooperation is applied to all projects/programmes that are not financial aid, i.e. direct government to government financing. A wide range of services fall within this category. A rapid review of 200 technical cooperation projects/programmes revealed that they contained elements[57] of:

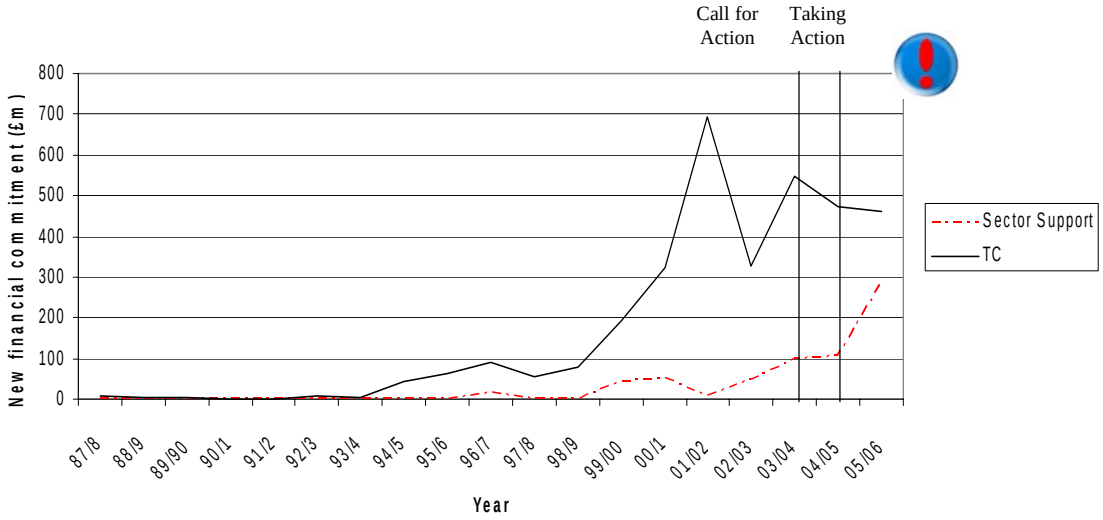
- Service delivery (104) including projects/programmes in the following fields – family planning, reproductive health, TB, general health services and HIV/AIDS-related activities
- Supply of pharmaceuticals, health products and equipment (27) including contraceptives, condoms, reagents
- Research (21) including surveys, evaluations, reviews, statistics, appraisals
- Capacity development (19)
- Partnership and networking (13)
- Policy formulation (12) including health reform, guidelines, strategies, vision, PRSP consultation
- Support to government (11)
- Management (10) including planning, project/programme design and staffing
- Training (9)
- Support to NGOs (8)
- Consultancy (8)[58]
- Infrastructure (3)
- Pilot projects (2)
- Sustainable financing (1)

[57] Each project/programme was classified in as many categories as seemed appropriate.

[58] This may be what is commonly thought of as technical assistance. This comprises a very small proportion of what is classified by DFID as technical cooperation.

4.7 Of the 28% of projects/programmes not classified as technical cooperation, half were classified as projects[59] with the remainder spread across different categories including sector support[60] (1.7%) and vertical funds[61] (1%). Technical cooperation is also the largest category (68%) by value of planned commitment, but sector support (13%) occupies a larger percentage by value. The new financial commitments made through sector support have been rising since 2001/2 while the amount being committed to technical cooperation has remained largely the same (see Figure 9). There is little discernible change in patterns of expenditure analysed by aid instrument between 2003/4 and 2005/6[62].

Figure 9. New Financial Commitment to HIV and AIDS-related Projects/Programmes (£m) by Year of Start Date According to Main Instruments



4.8 Analysis of use of different aid instruments in different regions (see Figure 10, p28) shows that in all regions technical cooperation is the most commonly used aid instrument for HIV/AIDS-related projects/programmes. For example, in Africa, it accounts for 70% of all HIV and AIDS projects/programmes by number. Projects account for 18% of the remainder with other aid instruments accounting for 3% or less each. Multilateral grants and block grants/programme partnership agreements (PPAs) are only found in the non-geographic category.

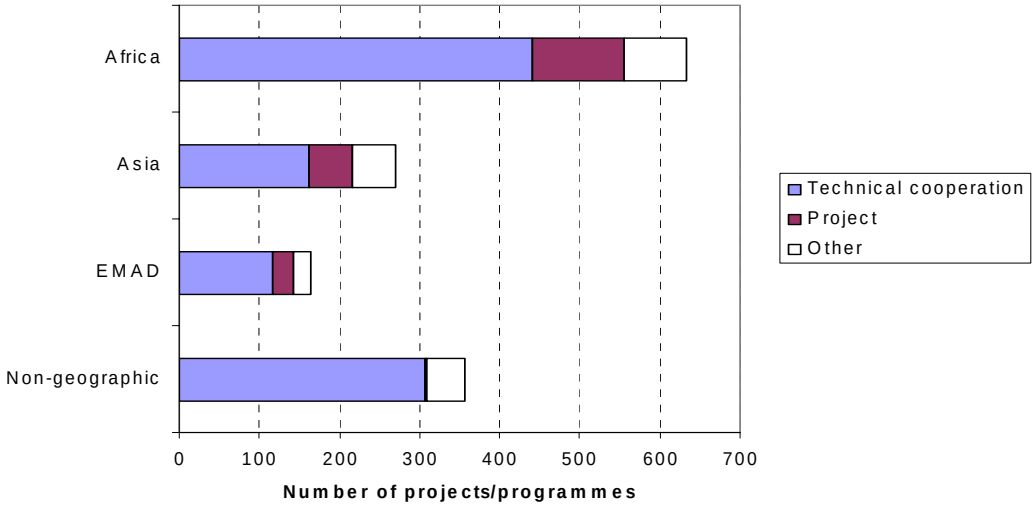
[59] Projects, as an aid instrument constitute 14% of the dataset by number but only 1% of total planned commitment.

[60] Mainly health and education

[61] These are disease-specific funds, including support to National AIDS Commissions (NACs).

[62] Spending changes as a result of new policy are likely to be seen first in new financial commitments and only later in expenditure figures as much expenditure is occurring on the basis of historic decisions.

Figure 10. Spread of Use of Aid Instruments across Different Regions/DFID Divisions for HIV and AIDS-related Projects/Programmes



Bilateral or Multilateral

4.9 According to DFID official figures, multilateral expenditure accounted for just under one fifth (19%) of spending on HIV and AIDS in both 2004/5 and 2005/6[63]. In these calculations, money provided by DFID country offices to multilateral agencies in country is counted as bilateral. There has been a steady increase in money being spent in this way (see Figure 11, p29). In 2005/6[64], we identified just over £20 million of bilateral money spent on HIV and AIDS where the major partner appeared to be a UN agency. Of this, 43% was in fragile states, 3% in middle-income countries (MICS) and 54% in other countries[65]. These findings indicate that the increase in DFID bilateral spending on HIV and AIDS through UN agencies is not occurring only in fragile states or MICS[66]. This method of funding also means that, in 2006, the UK provided the lowest proportion of its funding 'on budget' of any of UNAIDS' five major funders (see section 3.11, p13).

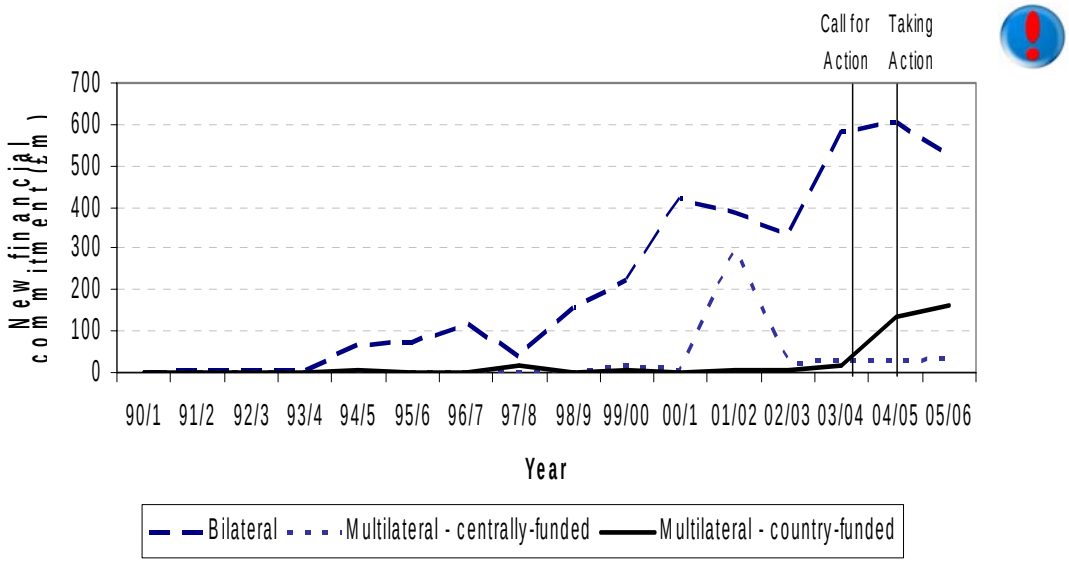
[63] In 2004/5, multilateral expenditure on HIV and AIDS was £55m of a total of £298m. In 2005/6, it accounted for £67m of a total of £385m.

[64] To February

[65] There were five countries in the 'other' category – India, Mozambique, Rwanda, Uganda and Zambia.

[66] This issue is important because DFID policy encourages in-country funding of UN agencies in middle-income countries and fragile states.

Figure 11. Planned Commitment to HIV and AIDS-related Projects/Programmes by Start Date Analysed by Bilateral/Multilateral (£m)



Partner Organisations

4.10 DFID supports a range of different partners. The most common[67] were international NGOs[68] (29% of projects), Ministries of Health (15%) and UN agencies (12%) (Figure 12, p30). Since 2000/1, the number of projects/programmes being managed by UN agencies has risen sharply. When comparing expenditure in 2003/4 and 2005/6, there have been increases not only for UN agencies, but also for National AIDS Councils. In 2003/4, the UK's largest expenditure on HIV and AIDS by partner type was to Ministries of Health (MOH), international NGOs and other multilaterals. By 2005/6, this had changed to Ministries of Health, National AIDS Councils and UN agencies (see Figure 13, p30).

[67] By number of projects/programmes

[68] This includes particularly INGOS with strong links with the UK, including 'British NGOs'.

Figure 12. Trends in Number of HIV and AIDS-related Projects/Programmes for Top Three Partners

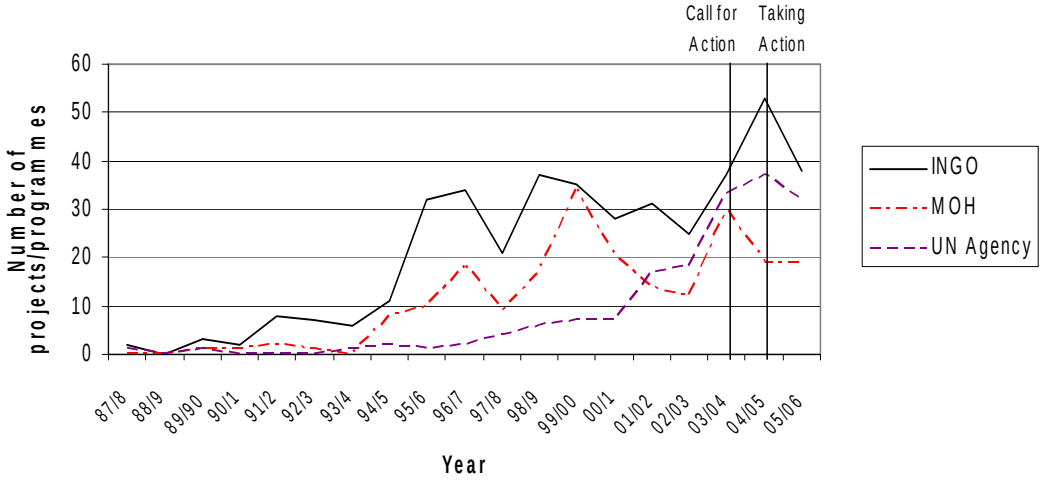
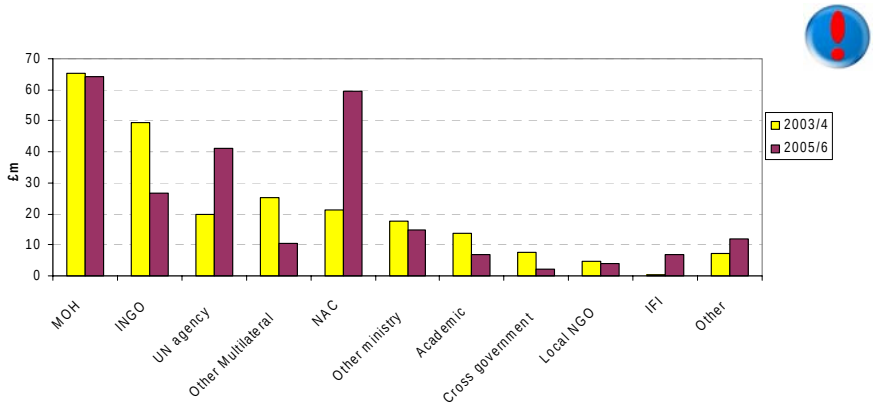


Figure 13. Comparison of Expenditure on HIV and AIDS-related Projects/Programmes among Partner Types in 2003/4 and 2004/5[69]

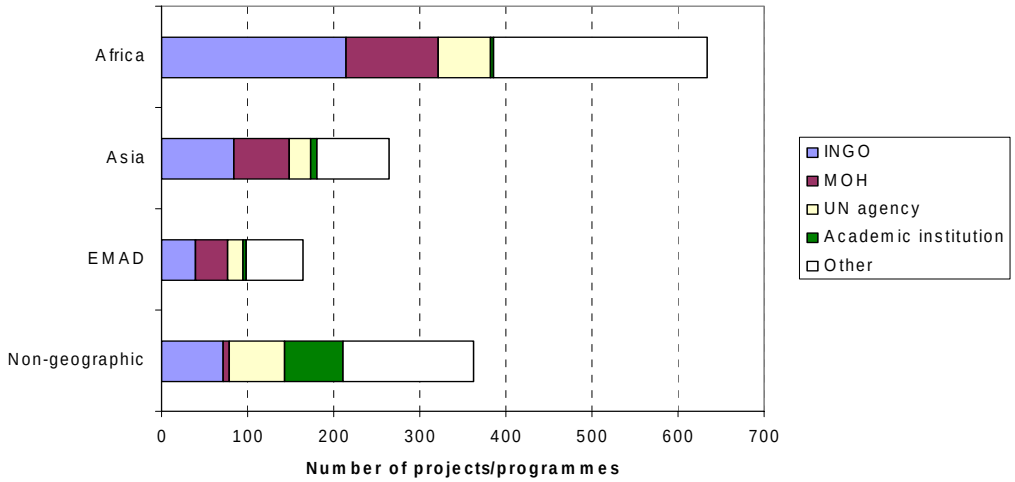


4.11 Figure 14 (p31) shows analysis of the spread of partner organisations across different regions supported by DFID. In all of them[70], the most common partners were international NGOs, MOH and UN agencies respectively. For non-geographic projects/programmes, the three most common partners were international NGOs, academic institutions and UN agencies respectively.

[69] Please note that the figures in this graph have been re-calculated to reflect DFID's new method for tracking AIDS spending (see section 3, Table 2, p10).

[70] Africa, Asia and EMAD

Figure 14. Spread of Types of Partners across Different Regions/DFID Divisions for HIV and AIDS-related Projects/Programmes



Focus of Work on HIV and AIDS[71]

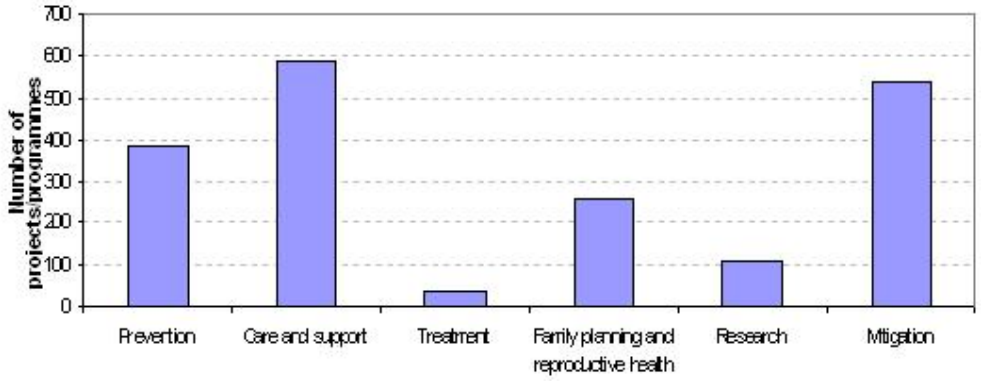
4.12 588 (41%) of the projects/programmes[72] in our dataset included some focus on care and support, 537 (38%) on impact mitigation, 387 (27%) on prevention, 261 (18%) on family planning (FP)/sexual and reproductive health (SRH), 109 (8%) on research and 37 (3%) on treatment[73] (see Figure 15, p32). The latter is made up of 37 projects/programmes that specifically mention treatment in the title or purpose. Other projects/programmes that include an emphasis on treatment may have been excluded if there is no mention of treatment in the project title or purpose. The number of projects/programmes with a focus on care/support and impact mitigation has risen since the mid-1990s, while the number of projects/programmes on FP/reproductive health has fallen.

[71] DFID has not previously been able to present a breakdown of the focus of its work on HIV and AIDS. This is because of the integrated way in which DFID funds HIV and AIDS activities, the way information is currently collected within DFID and the amount of work that is needed for analysis of this nature. The National Audit Office report did attempt an analysis of these issues (NAO, 2004, p 26). We faced particular challenges in seeking to do this analysis. These are described in detail on pages 17-19 of the working paper (SSS, 2006a).

[72] All projects/programmes were classified to at least one category.

[73] These figures do not add up to 100% as a project/programme could be classified to more than one category.

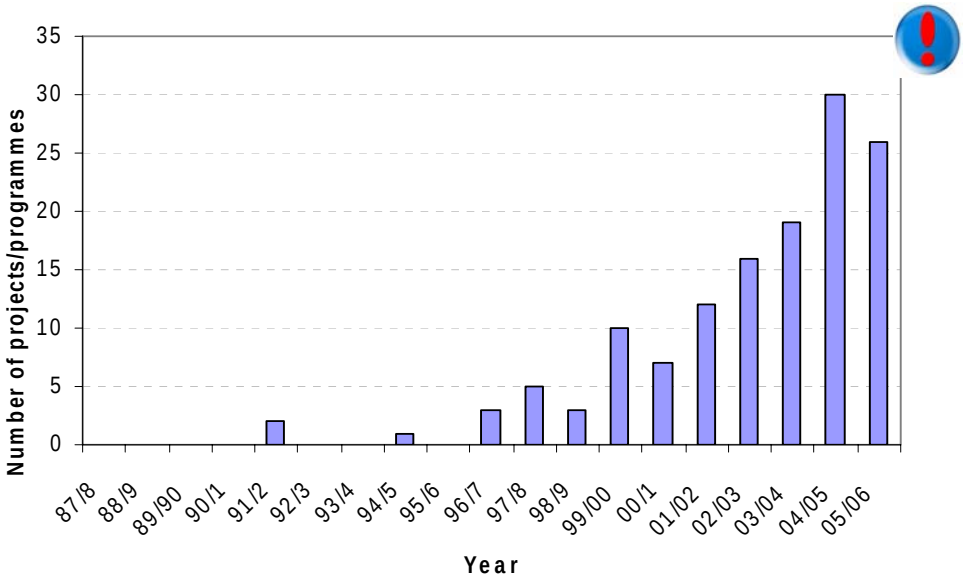
Figure 15. Number of HIV and AIDS-related Projects/Programmes which Include a Particular Focus



Policy Dialogue

4.13 134 projects/programmes (9%) were classified as having an element of policy dialogue. The number rose from 1999/2000 (see Figure 16). Of these, 42 (31%) were in Africa, 24 (18%) in Asia and 12 (9%) in Europe, Middle East and the Americas (EMAD). Fifty-six (42%) were in no geographic division. More detail of non-projectised work to strengthen political leadership is found in sections 3.13 to 3.18 (pgs14-15).

Figure 16. Number of HIV and AIDS-related Projects/Programmes with an Element of Policy Dialogue by Start Date



Building Monitoring and Evaluation (M&E) Capacity

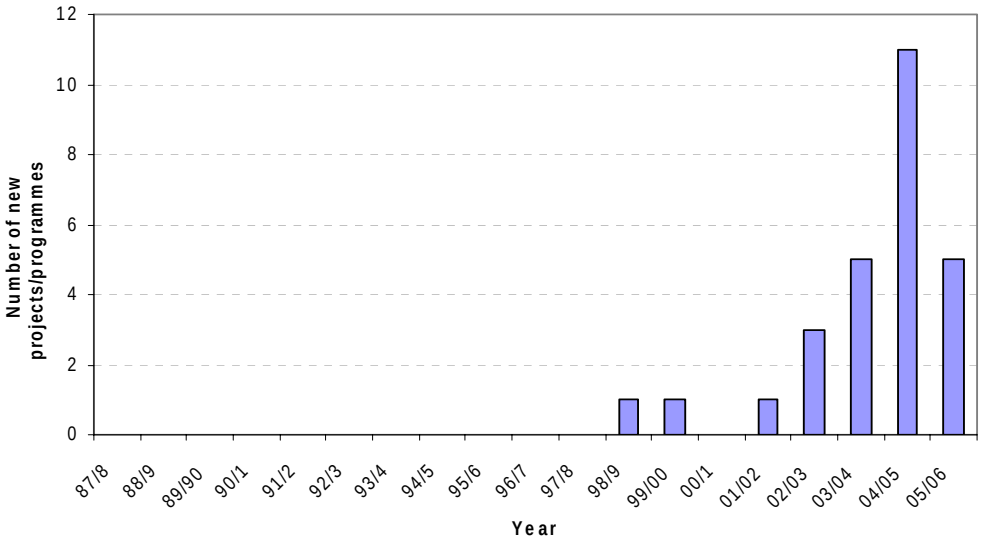
4.14 The capacity to effectively monitor and evaluate a national response to HIV and AIDS is an essential element of a country's response to the epidemic. Having one national M&E system for HIV and AIDS is a key element of the Three Ones. We identified 28 projects/programmes with a focus on building M&E capacity[74]. These mostly date from 2002/3 (see Figure 17). Of the 28, 12 were in Africa; 4 in Europe, Middle East and the Americas; 2 in Asia; and 9 were non-geographic projects/programmes. There are three main categories:

- Poverty monitoring, which includes strengthening poverty monitoring in Kenya, Mozambique and Tanzania; monitoring of humanitarian aid in Zimbabwe; and monitoring social change in Eastern and Southern Africa.

- Health monitoring, which includes support to WHO and the Health Metrics Network; monitoring of epidemic disease in Somalia; conducting a Demographic Health Survey in Zimbabwe[75]; health monitoring in Bangladesh; monitoring health systems performance and the work of the health systems resource centre.

- HIV and AIDS monitoring, which includes particularly support to UNAIDS both internationally and in a number of countries including Angola, Democratic Republic of Congo, Ethiopia, Somalia, Sudan, Ukraine and Russia.

Figure 17. Number of HIV and AIDS-related Projects/Programmes with Focus on M&E Capacity Development by Year of Start Date

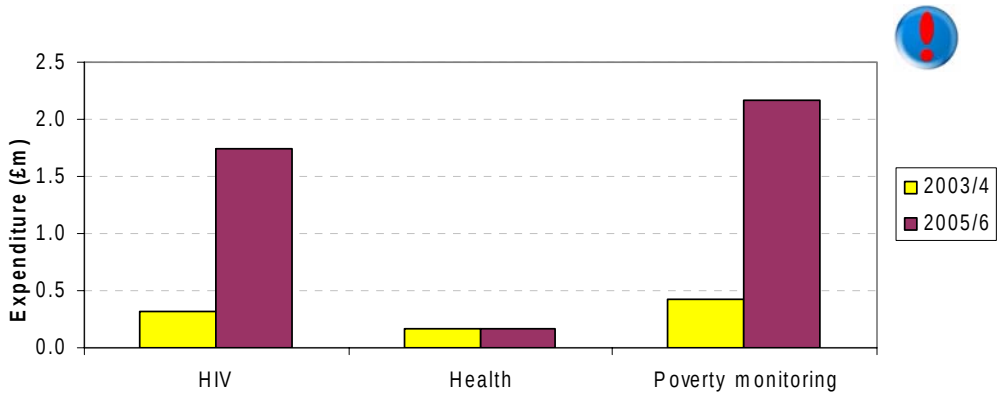


[74] It is likely that there could be other similar projects particularly in the areas of monitoring poverty and health. If these do not have PIMS markers for HIV/AIDS or reproductive health, we would not have identified them in this exercise.

[75] DFID has supported a number of other Demographic Health Surveys that were not picked up in this exercise. This is likely to be because they did not have a PIMS marker for HIV or reproductive health.

4.15 Financial commitment to this area of work has grown as seen in the expenditure figures for 2003/4 and 2005/6. Expenditure on relevant projects/programmes in 2005/6[76] was more than four times that of 2003/4. This change was particularly seen in the areas of HIV/AIDS and poverty monitoring (see Figure 18). Nevertheless, spending on M&E remains low. In 2005/6[77] spending on building M&E capacity accounted for just over £4 million or around 1% of total UK expenditure for HIV and AIDS, and spend on HIV/AIDS-specific M&E capacity building represented less than half of this.

Figure 18. Comparison of Expenditure on HIV and AIDS-related Projects/Programmes with Focus on M&E Capacity Development: 2003/4 and 2005/6



Projects/Programmes that are AIDS-specific Compared to Those that are Part of a Broader Enabling Action

4.16 Projects/programmes have been allocated into four categories – AIDS-specific, sexual and reproductive health activities, health activities and broader enabling actions. The number of projects/programmes is fairly evenly split between the four categories – AIDS-specific (26%), sexual and reproductive health (19%), health (27%) and enabling action (28%). The number of projects/programmes has risen in all categories since the late 1990s, apart from sexual and reproductive health, where the numbers have fallen. Expenditure between 2003/4 and 2005/6 remained largely static for broader enabling actions, fell for sexual and reproductive health projects/programmes and rose for both health and AIDS-specific activities (see Figure 19, p35). Regional distribution of these different types of projects/programmes is shown in Figure 20 (p35).

[76] To February

[77] To February

Figure 19. HIV and AIDS-related Projects/Programmes Expenditure in 2003/4 and 2005/6 Analysed According to How AIDS-Specific the Projects/Programmes Are

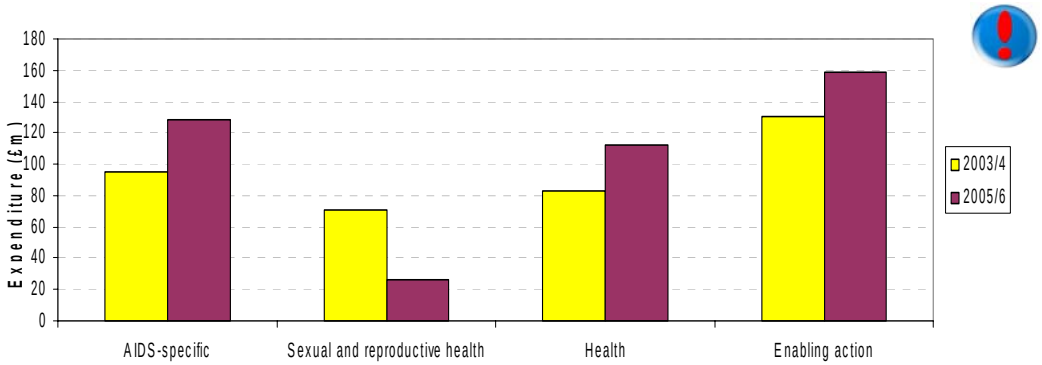
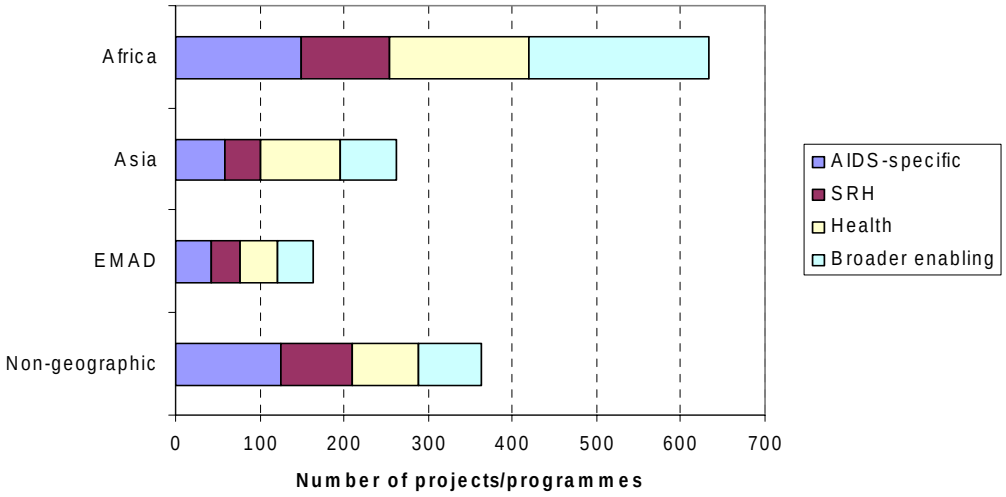


Figure 20. Spread of AIDS-specificity of HIV and AIDS-related Projects/ Programmes across Different Regions/DFID Divisions



Country by Country Analysis

4.17 Overall, the way DFID Country Assistance Plans address HIV and AIDS is appropriate for the type and stage of epidemic in particular countries (see section 5.12, p44 and Figure 24, p45).

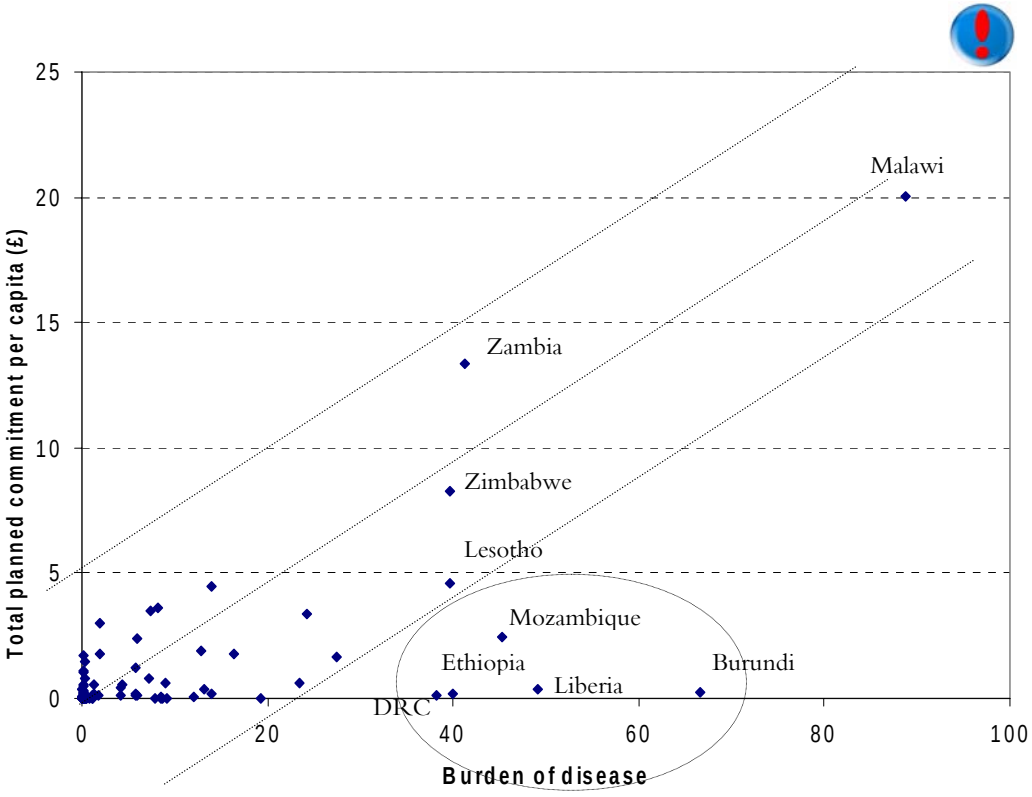
4.18 UK financial support to HIV and AIDS corresponds broadly to the burden of HIV disease in particular countries (see Figure 21, p36). However, it is difficult to interpret these findings fully because of limited information about funds needed by each country to respond effectively to HIV and AIDS or what funds are available from other sources[78]. There are particular challenges to making any

[78] Although with the increasing use of National AIDS Spending Assessments, there is probably more information on funds available than on resources needed.

assessments of this nature centrally, e.g. of multiple countries for purposes of comparison and prioritising resource allocation.

4.19 Some countries have a lower total planned bilateral commitment per capita than might be expected given their burden of disease (see Figure 21). These include Burundi, DRC, Ethiopia, Liberia and Mozambique. In some cases, these countries are receiving funds from UK sources excluded from the analysis, e.g. PRBS; receiving funds from UK sources through multilateral channels, e.g. the Global Fund; or receiving funds from non-UK sources.

Figure 21. Total Planned Bilateral Commitment for HIV and AIDS per Capita per Country Compared with Burden of Disease[79]

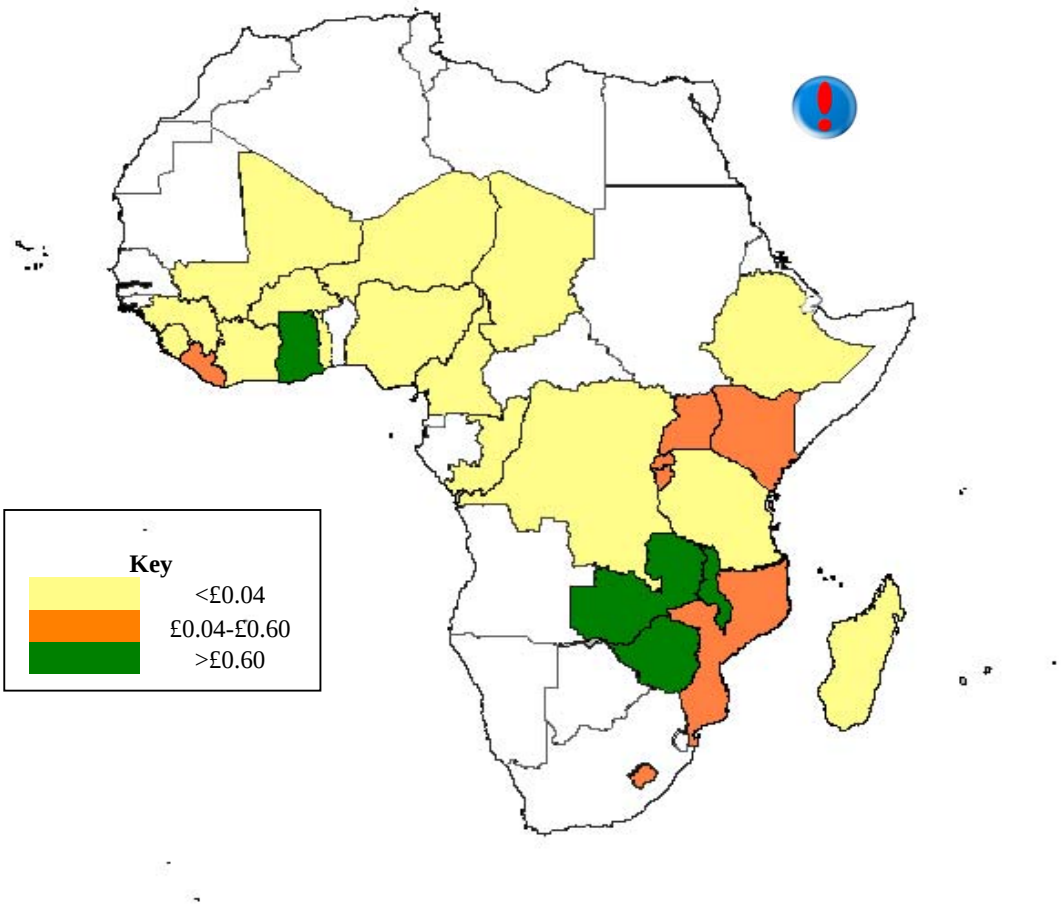


4.20 For countries with the highest composite index[80], there was a wide variation in bilateral expenditure on HIV and AIDS. The highest countries were Ghana, Malawi, Zambia and Zimbabwe. The lowest included Burkina Faso, Cameroon, Chad, Cote d'Ivoire, DRC and The Gambia (see Figure 22, p37).

[79] Figures for this graph have been re-calculated on the basis of DFID's new method for calculating AIDS spending (see section 3, Table 2 p10).

[80] i.e. poor countries with high burdens of HIV and AIDS

Figure 22. DFID Bilateral Expenditure (05/06) per Capita on HIV and AIDS in Poorest Countries of Africa with Highest Disease Burden



Implications for UK Government Information Systems

4.21 The information presented in this section was collected through a time-intensive, manual analysis of project/programme titles and their descriptions. DFID's current information systems do not systematically and rigorously collect data for many of the fields in question. Although the method was rigorously documented[81], it would not be possible using existing DFID information systems to generate this data in a systematic and reproducible way.

4.22 To address this, the UK Government needs to clarify which indicators it will track in the future and those which it will not. This issue is considered in more detail in Chapter 9 of this report (p122), including detailed proposals for

[81] Please see Annex 1 of the working paper for a detailed description of the method used (SSS, 2006a)

indicators for future monitoring. Information systems will need to be established or strengthened to ensure that the data required can be collected systematically.

4.23 If the proposed monitoring and evaluation system is accepted, it will have the following implications:

- DFID will provide a breakdown of the proportion of its funding to HIV and AIDS provided as bilateral and multilateral aid[82].
- DFID will be able to provide information on the amount of funding to HIV and AIDS going through particular aid instruments, such as sectoral and general budget support, and technical cooperation.
- DFID will report on the amount of funding provided to HIV and AIDS research, but it will not provide disaggregated figures for UK funding to prevention, care, treatment and mitigation[83]. Rather, it will seek to monitor country-produced coverage figures for key services[84] in PSA countries and the degree of financial support provided by the UK for AIDS in each country.
- DFID will not be able to provide a breakdown of funding through government and civil society[85].
- DFID will not be able to provide disaggregated figures for the proportion of spending on HIV and AIDS benefiting women, young people and other vulnerable groups. It will provide a figure for the amount of spending benefiting orphans and other children made vulnerable by HIV and AIDS. The monitoring and evaluation framework does contain some indicators that are reported in a disaggregated way for gender and age[86].
- DFID will be able to provide disaggregated spending figures for activities which have a 'principal' focus on HIV and AIDS, and those which have a 'significant' focus[87].

---

[82] Although currently financial support to multilateral agencies provided by country offices is counted as bilateral aid. If DFID wishes to track this amount, some changes would be needed to PRISM/ARIES. This might involved introducing a field for 'managing agency' and ensuring that it was filled in reliably

[83] There are two main reasons for this. First, the way the UK is increasingly providing its funding, e.g. as sectoral and general budget support, makes this difficult. Second, this kind of disaggregation risks undermining the UK's commitment to comprehensive and integrating programmes. A recent NAO report (NAO, 2006) attempted to analyse DFID's funding to civil society in general, not for HIV and AIDS specifically. Discussion of funding to civil society on HIV and AIDS is contained in a number of sections beginning with section 6.40, p70.

[84] Eg number of PLWHA on ART

[85] Although we attempted to do this (SSS, 2006a), there are significant problems because partner organisations are not always recorded for every project/programme; there may be more than one partner involved in an activity, especially in larger programmes; the current information system does not capture details about sub-recipients of funds; and there may be definitional problems over which organisations fall within civil society. A recent NAO report (NAO, 2006) attempted to analyse DFID's funding to civil society in general, not for HIV and AIDS specifically. Discussion of funding to civil society on HIV and AIDS is contained in a number of sections beginning with section 6.40, p70.

[86] For example, I4 on ART coverage which provides disaggregated figures for both women and children.

[87] Further work may be needed to determine the extent to which these categories map onto categories of 'AIDS-specific' activities and broader enabling actions

4.24 If DFID is to be required to report on some of these areas[88], such as disaggregating spending figures by programme focus, beneficiaries and/or implementing/managing agencies, there would need to be a major overhaul of DFID's information systems with the addition of a considerable number of additional fields. This is unlikely to be practical.

[88] This is expected by a number of stakeholders, including the International Development Committee and UK NGOs