6. *Taking Action* Implementation – Experience of Funding HIV and AIDS through "Country-led" Aid Instruments

In Brief

Question: What is the UK's experience with moving to "country-led" aid instruments regarding commitment and resources allocated to HIV and AIDS and the prioritisation of the response? What are the lessons on managing this?

The UK has championed the Paris Declaration on Aid Effectiveness and the use of country-led approaches to development. In particular, the UK has spearheaded the introduction of new aid instruments, such as general and sectoral budget support. Use of these is based on the belief that countries' poverty reduction strategies provide a sound basis for the provision of development assistance. However, HIV and AIDS are not always well reflected in poverty reduction strategies and country budgets.

Experience with poverty reduction budget support (PRBS) is at its early stages, although the evidence base on use of this instrument for funding sectors and cross-cutting issues is growing. While there is some positive experience of using PRBS to fund responses to HIV and AIDS, there is also some evidence that, where this has been done, insufficient priority has been given to HIV and AIDS. Some of the challenges in funding the response to HIV and AIDS through PRBS are shared with other sectors but some reflect specific challenges associated with the epidemic and the response to it.

A country's own priorities are at the heart of country-led approaches. However, there is a risk that countries may fail to prioritise HIV and AIDS until it is too late because of the long time lag between infection and effects, such as illness and death. Many countries with epidemics concentrated among particular vulnerable populations are failing to allocate sufficient resources to effective prevention activities among these populations. The UK has done a great deal and used a variety of mechanisms to influence priorities, ranging from demonstration harm reduction projects in Russia and China to high-level policy dialogue in DRC and Zambia.

There are concerns that funding to civil society organisations may be undermined by the shift to PRBS. This issue is particularly important because of the critical roles played by civil society organisations in the response to HIV and AIDS, roles that are not fully reflected in DFID's published documents on civil society, such as providing services to marginalised and neglected populations, such as sex workers, injecting drug users and men who have sex with men.

There are concerns among some DFID staff that central support for international agencies may be undermining 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 risks being undermined by direct, in-country funding to individual agencies. The Global Fund's principles commit it to country-led approaches. However, these are interpreted and implemented somewhat differently than by DFID

What is a "Country-led" Aid Instrument?

6.1 This section seeks to answer the question 'what is the UK's experience in moving to "country-led" aid instruments regarding commitment and resources allocated to HIV and AIDS and the prioritisation of the response?' This requires a common understanding of the term "country-led" aid instrument. The design document for this evaluation (DFID, 2005a) equates "country-led" aid instruments with poverty reduction strategies and general and sectoral budget support. However, a variety of aid instruments can be part of a country-led approach to poverty reduction[98].

6.2 The UK has been a strong supporter of country-led approaches to poverty reduction. Indeed, the implied tension between these approaches and central strategy is at the core of part of the objective of this evaluation[99]. DFID defines country-led approaches as 'where the partner country (including government and civil society[100]) takes the lead in formulating policies for its own development' (DFID, 2006i). A recent review of country-led approaches identified three main elements of the country-led approach paradigm[101] (Cox et al., 2006). Country-led approaches are characterised by:

- Support for country poverty reduction strategies and systems for planning, budgeting and accounting
- Aid instruments matched to country needs
- Harmonised approaches among donors
- More predictable aid flows
- Moves towards mutual accountability (Sharpe et al., 2005)

6.3 The UK's commitment to country-led approaches forms part of its overall commitment to improving aid effectiveness, as described in the Paris Declaration on Aid Effectiveness (High Level Forum, 2005). This declaration is structured around five partnership commitments – ownership, alignment, harmonisation, managing for results and mutual accountability – which encapsulate the principles of country-led approaches. The declaration also includes a number of indicators to be used to monitor implementation progress.

---

[98] For this reason, although this section is focused on general and budget support, as required by the evaluation design document, we do not use the term country-led aid instruments except in this introduction and in the title. We use the term country-led approach to describe the overall approach and the terms general and sectoral budget support when describing particular aid instruments

[99] In the design document (DFID, 2005a) this tension is expressed as follows. *"As a donor country we have things we wish to achieve, policies we would like implemented, spending targets we need to meet. How do we square those with letting countries choose priority policies, sectors and manage donors themselves?"*

[100] The inclusion of civil society in this definition is worthy of note because there are concerns that the country-led approach is resulting in too much emphasis on the state and government planning (Sharpe et al., 2005). This is particularly important in relation to HIV and AIDS where people living with HIV and AIDS and civil society organisations aspire to be included meaningfully in planning processes, such as developing the Poverty Reduction Strategy and the Medium Term Expenditure Framework (MTEF)

[101] These are the alignment of the international system with country plans and systems; building effective country leadership of the development agenda and the emergence of new rules of the game for international assistance.

6.4 Despite concerns that the drive for poverty reduction strategies originated in the conditionalities of international financial institutions, that the shift to country-led approaches has been largely donor-driven and that donor accountability requirements have resulted in setting up parallel monitoring systems, e.g. performance assessment frameworks (PAFs)[102], there is evidence of increasing country ownership of the approach, e.g. in Mozambique, Tanzania, Uganda and Vietnam (Cox et al., 2006).

6.5 Recently, DFID has issued guidance on use of aid instruments (DFID, 2006j). This recognises that different contexts require use of different aid instruments:

- In low-risk, aid-dependent, low-income countries, PRBS may be the most appropriate instrument, supported by policy dialogue and technical cooperation. Where risk is medium, PRBS might be combined with sector financial aid. In situations of higher risk, modifications of/alternatives to PRBS might be considered appropriate, including earmarked general or sector budget support, or projectised support through programme-based approaches.
- Conflict settings require special responses combining humanitarian aid, more developmental approaches, selective technical cooperation and non-aid support to peace building.
- Fragile states may require a range of different supporting mechanisms depending on the precise context, including whether the causes of fragility are related to lack of capacity or political will.

6.6 For countries that are less dependent on aid (see Box 11), governments may prefer donors to contribute through targeted projects, technical assistance, or sector support, rather than general budget support (Sharpe et al., 2005).

Box 11 China: A Distinctive Country-Led Approach

China is a very large, lower-middle-income country with a strong central government. All these factors contribute to a distinctive aid environment. There is little scope for general or sectoral budget support because official development assistance comprises such a small part of Chinese GNP (<0.07%). The Chinese Government exerts strong control over the provision of external aid, preferring bilateral projects from individual donors rather than pooled mechanisms. In this regard, the development agenda, in general, and the national AIDS response, in particular, is country-led, although there is limited scope for actors other than government, e.g. civil society, to play a role.

Health, Reproductive Health, HIV and AIDS in Poverty Reduction Strategies

6.7 As aid is increasingly delivered on the basis of a nationally-owned poverty reduction strategy, the content of these becomes more significant. Although there was an expectation that general budget support would result in a shift away from the more popular areas for donor support, e.g. health (Cox et al., 2006),

[102] For a more detailed review of experience of performance assessment frameworks in five countries, Benin, Ghana, Mozambique, Nicaragua and Tanzania, see Lawson et al., 2005b.

there is evidence that health is well-represented in poverty reduction strategies (DFID, 2005d). In a study of 21 countries[103] with poverty reduction strategies, health spending had risen in all countries although concern was expressed that these increases in absolute spending might be less significant when allowances were made for inflation and changes in exchange rate. In addition, health spending as a percentage of priority spending and/or GDP either remained static or fell in several countries. Where rises did occur, they were reported to be modest (WHO, 2004).

6.8 A further study of the same 21 countries concluded that there was a reasonable focus on population, reproductive health and adolescent health and development issues, although quality and scope varied widely. There was more focus on population and especially reproductive health issues and less on adolescent health and development (World Bank, 2004). However, a review of linkages between sexual and reproductive health, HIV and AIDS concluded that few poverty reduction strategies provide analysis of links between poverty, development, population, HIV and AIDS, or address linkages between SRH, HIV and AIDS in the health section (Druce et al., 2006).

6.9 A study of 22 countries[104] poverty reduction strategies concluded that the majority were weak on HIV and AIDS. Some of the weaknesses included undue focus on the health sector; inadequate consideration of gender issues; failure to link HIV and AIDS to macroeconomic issues; and weak budgeting for the HIV and AIDS response (UNAIDS et al., 2005).

6.10 Table 3 (p59) examines the extent to which poverty reduction strategies, or their equivalent, reflect HIV and AIDS in the seven countries included as case studies in this evaluation. Russia and Zimbabwe do not appear to have poverty reduction strategies. In China, there is little focus on HIV and AIDS and, in India, HIV and AIDS are covered only under health. In DRC, HIV and AIDS are treated as one of five pillars of the poverty reduction strategy. Ethiopia and Zambia are unusual in that both include details of financial resources needed for HIV and AIDS in their poverty reduction strategy. Box 12 (p59) contains additional examples of the extent to which HIV and AIDS are included in poverty reduction strategies and their accompanying financial frameworks.

6.11 These findings are significant. If HIV and AIDS are not adequately reflected in poverty reduction strategies, there is a risk that aid instruments based on these strategies, e.g. PRBS, will not address HIV and AIDS well.

[103] Albania, Bolivia, Burkina Faso, Ethiopia, Gambia, Guinea, Guyana, Honduras, Malawi, Mauritania, Mozambique, Nicaragua, Niger, Rwanda, Senegal, Tajikistan, Tanzania, Uganda, Vietnam, Yemen and Zambia

[104] 15 in Africa and 7 in Asia

Table 3. The Extent to which HIV and AIDS are reflected in Poverty Reduction Strategies[105]: Evaluation Country Case Studies

Country	Comment
China	China's approach to development is described in the 11th Five Year Plan. There is also a white paper on rural poverty reduction. The latter does not mention HIV and AIDS (UNAIDS et al, 2005)
DRC	DRC has recently completed a poverty reduction strategy based on a participatory poverty analysis, funded by DFID. The response to AIDS is one of five pillars in this strategy
Ethiopia	Ethiopia's PRSP contains a chapter on AIDS and treats it as a crosscutting issue. It is unusual among PRSPs in that it does include a broad breakdown of financial resources needed to respond to AIDS (UNAIDS et al., 2005)
India	India's approach to development is covered in its 10th Five Year Plan. This refers to HIV and AIDS within a chapter on health (UNAIDS et al., 2005)
Russia	Russia does not appear to have a poverty reduction strategy.
Zambia	Zambia's National Development Plan includes AIDS as a cross-cutting issue and includes an analysis of financial needs. However, it was incorporated at a late stage meaning that participation in the planning process was limited (UNAIDS et al., 2005)
Zimbabwe	Development policies are extremely controversial in Zimbabwe, e.g. on land reform. However, there is a strong degree of support for the proposed strategic framework on AIDS and the National Plan of Action for OVC

Box 12 Poverty Reduction Strategies, HIV and AIDS: Examples

Experience from **Uganda** (Butcher, 2003) highlights some of the processes required to mainstream HIV and AIDS into the country's poverty eradication action plan. However, even if HIV and AIDS are included in the poverty reduction strategy, they may not be reflected in financial frameworks. For example in Uganda, AIDS is peripheral to the MTEF and rarely reflected in budgets of other sectors (Lister et al., 2006).

An evaluation of general budget support in 7 countries concluded that the long-term effects of AIDS on development strategy and public expenditure had been neglected (IDD and Associates, 2006). A recent evaluation concluded that **Mozambique's** Action Plan for the Reduction of Absolute Poverty (PARPA) failed to take into account the effects of HIV and AIDS in assessing growth and MDG progress. In **Cambodia,** the Poverty Reduction Strategy does not define HIV and AIDS needs well and links poorly to the budget and donor funding.

A study of 21 sub-Saharan countries concluded that poverty reduction strategies paid 'little attention' to the situation of orphans and vulnerable children (World Bank and UNICEF, 2004).

Country Experiences of Funding Poverty Reduction Strategies

6.12 A key principle of country-led approaches is that funding should be provided on the basis of a country's own poverty reduction strategy. This section considers some country experiences of this. First, it looks briefly at country experiences of moving to country-led approaches, in general, and poverty reduction budget

[105] Or equivalent

support, in particular (see sections 6.13 and 6.14). Second, it examines available evidence of the effects that general budget support has had on a number of sectoral and cross-cutting issues (see sections 6.15 to 6.17). Third, it presents examples of experiences of funding the response to HIV and AIDS through PRBS (see sections 6.18 to 6.23).

Country-Led Approaches and PRBS in General

6.13 Progress towards country-led approaches is at an early stage and has been slow. An OECD study of harmonisation and alignment in 14 countries[106] concluded that only about 30% of the portfolio of projects was managed according to national procedures[107] (OECD/DAC, 2005b). A joint evaluation of general budget support in seven countries has just been published (IDD and Associates, 2006). Even in Tanzania, a leader in this area, only 35% of total aid was provided as general budget support in 2005 (Sharpe et al., 2005). Obstacles have included demands for short-term results in certain sectors; weakness of poverty reduction strategies in some countries; risks of putting aid through weak public financial systems; doubts about applicability of the approach in some countries[108]; and fears of overemphasising the role of the state (Sharpe et al., 2005)[109].

6.14 Opinions are divided as to whether transition should be rapid, to promote national action on critical issues of planning and budgeting, or more gradual, to minimise negative effects on delivery of services. Experience from Zambia emphasises the importance of managing the period of transition from one aid instrument to another and highlights transition issues to be addressed by national government, DFID and other donors (Miller, 2006).

PRBS, Sectors and Cross-cutting Issues[110]

6.15 DFID has recently produced a background note on evidence relating to the effects of PRBS on sectors and cross-cutting issues (DFID, 2006k). This concludes that PRBS has had positive effects on flows of funds, institutions and policies. There have also been positive outputs including expansion in health service utilisation and education service delivery. In relation to gender, HIV, AIDS and the environment, PRBS is commended as a useful, complementary instrument to other aid modalities.

---

[106] Bangladesh, Bolivia, Cambodia, Ethiopia, Fiji, Kyrgyz Republic, Morocco, Mozambique, Nicaragua, Niger, Senegal, Tanzania, Vietnam and Zambia

[107] Results were lowest for audit (28%) and monitoring and evaluation (28%) and highest for procurement (34%). Disbursement (32%) and reporting (30%) were in between.

[108] Eg fragile states or those that receive little aid

[109] UNAIDS identified a number of weaknesses in implementing poverty reduction strategies including limited country ownership; weak governmental capacity; lack of incentives for engagement; and overlap with existing plans (UNAIDS et al., 2005)

[110] Sectors include education; health; water and sanitation; and social protection. Cross-cutting issues include exclusion; HIV and AIDS; environment; democracy and human rights; and growth. Exclusion covers issues such as disability and gender.

6.16 However, in some cases, expansion has been accompanied by a reduction in the quality of services and inequitable distribution. Constraints to achieving positive outcomes on sectors and cross-cutting issues include:

- Insufficient finances for capital and recurrent costs
- Weak institutions for planning, budgeting and implementing
- Poor policies including political prioritisation and poor technical choices
- Few and expensive public goods
- Demand-side constraints with people lacking means, information and voice
- Allocation of external finances which does not support national priorities, plans and budgets

6.17 DFID argues that PRBS can address the first three of these constraints but is less effective in addressing the last three, which may be better addressed by other aid instruments, perhaps in combination with PRBS (DFID, 2006k).

Funding Responses to HIV and AIDS through PRBS

6.18 A number of countries such as Mozambique, Tanzania, Uganda and Vietnam are part-financing their response to HIV and AIDS through PRBS. Positive results have included improving coordination, creating forums for dialogue and making links across sectors. In Mozambique, this instrument is credited for helping AIDS to be seen as a cross-sectoral issue rather than being seen at the sectoral level only (IDD and Associates, 2006). It has also resulted in increased levels of on-budget funding for HIV and AIDS in Tanzania.

6.19 However, there have been problems in translating increased budgets into better delivery of services, in general, including those relating to HIV and AIDS. For example, in Tanzania, only 25% of budgeted funds were programmed and only 80% of programmed funds were absorbed. In Ghana, there is concern that donor funds delivered through budget support are being distanced from service delivery. In Mozambique, benefits for the response to HIV and AIDS have not been as great as might have been expected (see Box 13). A similar situation in Tanzania is reportedly due to weak sectoral commitment towards tackling HIV and AIDS (see Box 14, p62).

Box 13 Even 'Star Performers' have Struggled to Finance HIV and AIDS Services through Poverty Reduction Budget Support

Mozambique is a 'star performer' with poverty reduction budget support. Since 2004, the approach has been supported by fifteen donors resulting in a stronger focus on the national poverty reduction agenda; improved donor predictability; and reduced transaction costs. From 2000 to 2004, total ODA rose from US$877 million to US$1228 million, the proportion supplied through budget support rose from 3% to 19% and DFID's provision of budget support rose from around £10 million to over £30 million. Nevertheless, service delivery in all sectors has not yet improved significantly, including the national response to HIV and AIDS (Chapman et al., 2006).

6.20 A recent review of DFID country evaluations in 2005/6 concluded that the approach taken was focused on building government capacity to tackle poverty in the medium to long term, but that this was resulting in lower priority being

given to immediate support for services to alleviate poverty, leading to a risk of missing MDG targets (Barr and Barnett, 2006).

Box 14 UK has Supplemented PRBS with Other Instruments in Many Countries

Nine donors began budget support in **Ghana** in 2002. By 2006, general budget support accounted for 40% of donor aid, 10% of the government budget and 4% of GDP. DFID played a key role in establishing this. Nevertheless, donor funds have been distanced from service delivery. A recent evaluation concluded that health and education are better supported through sectoral funding until there is public sector reform and better public financial management. To date, DFID has funded HIV and AIDS in Ghana through projects. Results have been positive with 'reasonably effective performance' compared to 'performance stagnation' in the health sector (Azeem et al., 2006; Killick, 2005).

By 2004, fourteen donors were supporting poverty reduction budget support in **Tanzania**, providing 20% of the national budget. The government budget for HIV and AIDS rose from US$36 million in 2004-5 to US$382 million in 2006-7. However, only 25% of the budget was programmed and only 80% of programmed funds were absorbed. Problems noted included weak sectoral commitment to HIV and AIDS issues and limited impact of donor initiatives to foster political capacity (Lawson et al., 2005a; Daima Associates and ODI, 2005; Issa et al., 2005). DFID has provided additional support to Tanzania's response to HIV and AIDS, together with other donors, through a 'rapid funding envelope' for civil society and technical assistance to TACAIDS.

Uganda has received massive increases in aid flows since 1998 with much of this going through budget support since 2000. In 2005/6, half of DFID's £70 million support to Uganda was through PRBS. Other donors supporting PRBS include Germany, the World Bank, Africa Development Bank, Netherlands, Ireland, Sweden, Norway and the EU (DFID, 2006e). DFID is providing additional funding for the response to HIV and AIDS in five main ways. These include a partnership fund that benefits the Uganda AIDS Commission; pooled funding to UN agencies; basket funding to civil society; social marketing of condoms; and research funding through the London School of Hygiene and Tropical Medicine.

Poverty reduction budget support is at an early stage in **Zambia**. In 2004, fourteen partners agreed to 'Harmonisation in Practice' and, in 2005, four of these committed to provide budget support. Major challenges facing this approach include weak financial management between and within sectors. DFID and other donors have largely funded the national response to HIV and AIDS through projects/programmes, although some donors joined together in a joint funding agreement with the National AIDS Council (NAC). HIV and AIDS are now being treated as a separate sector because of the scale of the resources required, the number of organisations involved and the emergence of the NAC as a sectoral 'home' for the response (Drew and O'Connell, 2006).

6.21 Some of the challenges faced in funding the response to HIV and AIDS through PRBS are common to the use of/transition to PRBS, in general, and to effects on sectors and cross-cutting issues. For example, major weaknesses in public sector financial management systems, e.g. in Ghana, (Cox et al., 2006) make it difficult to fund anything through budget support, including the response to HIV and AIDS. Specific issues which apply to the response to HIV and AIDS are:

- The urgency of the need for an effective, scaled-up response.

- The relative newness and weakness of institutions for HIV and AIDS when compared to established sectoral ministries[111].
- The need for innovative and pilot approaches which are better funded through instruments other than PRBS (DFID, 2006k).
- The critical role played by civil society organisations in the response to HIV and AIDS (see section 6.40, p70).
- 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 and whose needs are not prioritised by governments.

6.22 In most settings, the national response to HIV and AIDS will require financial support through other aid instruments alongside PRBS. This is the approach that the UK has been following in many countries (see Box 14, p62). Such a 'twin-track' approach is also advocated in a review of DFID country evaluations conducted in 2005/6 where capacity building through budget support is supplemented by alternative means focused on the achievement of key lagging MDGs, including on HIV and AIDS (Barr and Barnett, 2006).

6.23 There are particular contexts where PRBS may not be an appropriate instrument for funding part of the national response to HIV and AIDS. These include:

- Countries, such as Rwanda, that have sufficient funds for their national response to HIV and AIDS from other sources (Purcell et al., 2006).
- Fragile states, such as Zimbabwe and Ethiopia (see Box 15), where governments are either unable or unwilling to deliver core functions[39].
- Countries with HIV epidemics concentrated in particular sub-populations[112] that lack a policy framework to respond effectively to epidemiological priorities. However, DFID's experience shows that instruments such as budget support[113] can be effective for funding national responses to HIV and AIDS if an appropriate policy framework is in place. Examples from different countries are presented in Box 16 (p64).

Box 15 Failures in Governance Mechanisms Mean Direct Budget Support is not Currently Feasible in Ethiopia

Donors began to shift towards budget support in **Ethiopia** from 2002. Positive factors for this shift included effective basic administration; relatively strong revenue collection; appropriate public service staffing levels and 'quite high' standards of fiscal/macroeconomic management. Barriers included a thin pool of trained and educated people and the lack of democratic traditions (DCI, 2004). Following contested elections and outbreaks of violence and unrest in 2005, DFID and other donors suspended direct budgetary support channelling support instead to protection of basic services (DFID, 2006m).

[111] This issue is also relevant for other cross-cutting issues

[112] Such as injecting drug users, sex workers and men who have sex with men

[113] Particularly 'sub-sectoral' budget support through National AIDS Councils or their equivalent.

Box 16 UK Support for National AIDS Responses in Countries with HIV Epidemics Concentrated among Vulnerable Populations

In **Cambodia**, DFID has been funding the response to HIV and AIDS through a 'sub-sectoral SWAp' through the Ministry of Health. The response is seen as effective, evidenced by declining HIV prevalence. A key success factor has been the strength of the National Centre for HIV/AIDS, Dermatology and STDs, which has benefited from capacity-building support from a number of donors. DFID has also provided funding to the BBC World Service Trust for work with mass media and to PSI for social marketing of condoms.

In **China**, DFID support has been used to pilot interventions among injecting drug users, sex workers and men who have sex with men, which have influenced both policy and practice. DFID is now planning to fund a programme jointly with the Global Fund.

In **India,** DFID initially provided funding for prevention work among vulnerable populations through pilot projects. These built both political commitment and an evidence base. Currently, DFID funds the response to HIV and AIDS in eight states through earmarked sectoral support. DFID is planning to provide unearmarked sub-sectoral support to the National AIDS Control Organisation and it is expected that these funds would be channelled to civil society organisations as well as government.

Budget support began in **Vietnam** in 2001. It is now in its fourth round of operation with funds totalling US$225 million, between 7.5-10% of official development assistance. A recent evaluation concluded that HIV and AIDS had been more successfully integrated into budget support than other crosscutting issues, such as gender. However, the main evidence of this was the development of an action plan from a 'public health' perspective rather than the more 'social' perspective previously pursued by the government (Bartholomew et al., 2006). The evaluation gives little detail of funding for the HIV and AIDS response through budget support or the degree of focus on the most vulnerable populations, such as injecting drug users and sex workers and their clients.

Country Experience of Prioritisation of the National Response to HIV and AIDS

6.24 In determining their own development priorities, countries need to decide whether HIV and AIDS are a priority in relation to other issues. They also need to decide on priorities within the national response to HIV and AIDS.

6.25 Many factors affect the degree to which countries prioritise the national response to HIV and AIDS. These include the type and severity of the epidemic, the personal views and experience of senior decision-makers, the existence and importance of competing priorities and the degree of influence of the international community in the country.

6.26 In general, public health approaches encourage countries to prioritise health issues which cause most death and illness. This approach is problematic with HIV and AIDS because of the relatively long period between infection and onset of illness. Countries which only make HIV a priority once it is causing significant illness risk responding too late. For this reason, it is important that countries collect information on levels of HIV infection and risk behaviours through a regular surveillance system. Because many epidemics are concentrated among particular vulnerable populations, this surveillance should not only

encompass the general population but also these sub-populations, particularly injecting drug users, sex workers, men who have sex with men and prisoners[114].

6.27 In theory, priorities within the national response to HIV and AIDS should be set through the development and implementation of a national AIDS strategic framework. However, a recent evaluation of World Bank assistance in 26 countries (Ainsworth et al., 2005) concluded that most national AIDS strategies do not cost or prioritise activities and that they were so similar that 'a generic package of HIV/AIDS areas of focus and interventions could have served just as well'.

6.28 Setting the right priorities is of critical importance. Making the right decisions means that money is put to best use. In an epidemic concentrated in a particular sub-population, prioritising responses which protect that sub-population can protect everyone. Conversely, making the wrong decisions means that money is wasted. Opportunities to control a concentrated epidemic may be missed resulting in many more people being infected.

What are the Barriers to Setting Appropriate Priorities for National Responses to HIV and AIDS?

6.29 Of particular concern are the findings of a recent review of 17 countries with a concentrated HIV epidemic (Sharma et al., 2005). This found that:

- Most countries lack adequate data for designing an appropriate response. Particular gaps are in prisons, how and where sex work happens and the shifting patterns of drug use.
- In most countries resource allocation is not appropriate for the country's epidemiology. Where resources are provided for prevention among the most vulnerable, levels of resources are so low that they are unlikely to make a difference. For example, in Ghana, the general population accounts for less than one quarter of all new HIV infections yet receives more than 99% of all funding for HIV and AIDS programmes. Sex workers account for three quarters of all new HIV infections but programmes focusing on the needs of sex workers receive less than 1% of all AIDS funding (Wilson, 2007).
- Where resources are provided, they are often not used on strategies known to be effective. In particular, coverage with needle-syringe exchange programmes and drug substitution therapy is not high enough in countries where the epidemic is spreading through injecting drug use.
- There is an overall sense 'that a neglect of concentrated epidemics will drive the overall prevalence over 1%, encouraging governments to reduce their interest in vulnerable populations and shift to the more comfortable general population strategies'.

6.30 Based on the country case studies conducted for this evaluation, the main barriers to effective priority setting for national responses to HIV and AIDS relate to the policy environment. In some countries, e.g. DRC, Ethiopia and

[114] Such forms of surveillance are termed 'second generation'

Zimbabwe, these derive from broader governance issues, in particular the willingness and/or capacity of government to provide the core functions of a state. In others, e.g. China and Russia, they relate to specific issues involved in responding to an AIDS epidemic concentrated among particular vulnerable sub-populations, e.g. injecting drug users. In countries that have an appropriate policy environment, e.g. Zambia, the main barriers to responding effectively to HIV and AIDS relate to capacity, including the ability to allocate and track finances and the lack of adequate human resources for health.

How has the UK Influenced Countries to Set Appropriate Priorities on HIV and AIDS[115]?

6.31 The World Bank's evaluation of its AIDS interventions (Ainsworth et al., 2005) identified a number of effective ways of building political commitment, which are relevant in this context. Examples of how these have been used by the UK to influence priorities on HIV and AIDS are presented in Table 4[116].

Table 4. UK Approaches to Influencing Country Priorities on HIV and AIDS

Mechanism	Example
Epidemiological and behavioral surveillance	DFID is supporting a demographic health survey in DRC. A survey of HIV prevalence among injecting drug users in Karachi was influential in setting priorities in Pakistan.
Pilot projects	UK support has been hugely influential in both China and Russia, in demonstrating the practicality of introducing effective prevention programmes for injecting drug users in those countries[117].
High level policy dialogue with public officials and key leaders...	
…by UK Government	Both DFID and the FCO have repeatedly raised the issue of sexual violence as a weapon of war in DRC. In Zambia, DFID and the FCO have exerted influence on relevant issues, such as, health user fees and prison conditions.
…acting with other donors	In Zambia, such dialogue is being done jointly with other donors, e.g. through the Joint Assistance Strategy in Zambia (JASZ). Similarly, the National Partnership Forum and joint review process allow donors to act together
Use of earmarked funds within an aid instrument	DFID previously provided earmarked funding to NACO in India. Now that an appropriate policy framework has been established, it is planning to provide unearmarked support in future.
Engaging civil society in advocacy	The UK has used this approach in many settings, e.g. in India and particularly where the space for more direct political dialogue is limited, e.g. Zimbabwe
Other	Examples of other methods used by the UK to exert influence include: • Supporting study tours of Chinese officials to observe HIV prevention activities for IDU in other countries • Supporting the production of technical briefings on targeted HIV prevention methods in China • Building the leadership capacity of important organisations in India, including NACO and SACS

[115] There is a broader question as to whether the UK as a donor should seek to exert such influence, particularly as such influence may be seen as 'distorting' national priorities. However, it is widely recognised that influence through policy dialogue needs to accompany provision of PRBS

[116] These examples are illustrative not comprehensive. They are drawn particularly from the seven country case studies conducted for this evaluation.

[117] Gains in Russia risk being lost because of the funding scale-back that accompanied the decision to close DFID's Russia office in 2007

Has the UK's Work with International Partners Supported Country-Led Approaches?

6.32 The UK has championed country-led approaches as a key component of increasing aid effectiveness. However, there are concerns among some DFID staff that increasing central funding of international organisations supports unaligned, 'vertical' programmes which have the potential to undermine approaches being supported by DFID country offices. This section seeks to examine evidence for these concerns.

6.33 The UK has been at the forefront of trying to influence the UN system to adopt country-led approaches, e.g. through active support for the introduction of the 'Three Ones' principles for effective national responses to HIV and AIDS. There is evidence that the UN is seeking to respond positively on this issue. The United Nations Development Group[118] has recognised the implications for the UN system of the Paris Declaration on Aid Effectiveness and particularly the development of new aid instruments, such as sectoral and general budget support[119]. Three priorities were identified including: putting national priorities at the centre of UN country programming; strengthening national capacities; and increasingly using and strengthening national systems (UNDG, 2005b). Particular areas of progress in 2005 included supporting poverty reduction strategies to be more focused on the Millennium Development Goals; strengthening the Resident Coordinator system; promoting greater coherence, coordination and harmonisation of policies; and improving coordination in post-conflict settings and after natural disasters (UNDG, 2006).

6.34 Much of the joint UN work done at country level has been related to HIV and AIDS. There has been a strong focus on developing a common UN HIV/AIDS implementation support plan[120]. At the international level, work that culminated in the current push for 'universal access' to HIV and AIDS services, emphasised the need for the development of country-led plans (UNGASS, 2006).

6.35 The UK provides funds to UN agencies in two main ways. First, multilateral funds are provided to various agencies as core funds and for particular purposes. Second, bilateral funds can be provided to UN agencies by country offices, and there is evidence of an increasing amount of money being allocated for HIV and AIDS activities in this way (see Figure 11, p29). DFID has provided funding to joint UN country HIV/AIDS plans, alone and together with other donors, in countries including Kenya, Lesotho and Uganda. Given the current structure of the UN, it would not seem reasonable to deny funding to individual agencies. Whether this is provided through multilateral or bilateral funds, however, measures need to be in place to ensure that agencies are following the agreed

[118] Established in 1997 to improve the effectiveness of the UN system at country level

[119] The role of the UN system in sectoral programmes has been considered by the UN Development Group (UNDG, 2005a). In that document, work on the role of the UN system in direct budget support was said to be ongoing.

[120] Other areas of focus have included the 'Three Ones' and issues relating to HIV and AIDS in the UN workplace

principles of the Paris Declaration on Aid Effectiveness, the recommendations of the GTT and proposals for UN reform.

6.36 There are particular concerns in relation to the Global Fund because in many countries it is seen as providing large amounts of money to unaligned, 'vertical' programmes[121]. The principles of the Global Fund include a commitment to base work on programmes that reflect national ownership and respect country-led formulation and implementation processes (Global Fund, 2006). Challenges to achieving these in practice have included:

- Weak national systems in recipient countries
- Global Fund systems[122] that have made integration more difficult
- The need to show results which makes sectoral funding mechanisms difficult for the Global Fund
- The Global Fund's own bureaucratic and often-changing reporting requirements (Radelet and Caines, 2005)

6.37 A recent review of the Global Fund's processes for proposal development and review (Wilkinson et al., 2006) included country ownership, donor harmonisation and alignment as one of four main focus areas. It concluded that the Global Fund's system of funding rounds encouraged the development of projects and increased transaction costs. It made a number of recommendations including the need for the Global Fund to develop guidelines for channelling resources through sectoral and general budget support.

6.38 There are examples of the Global Fund harmonising its efforts with others. For example, in Mali, the National AIDS Council acts as 'principal recipient' for funds from the World Bank and Africa Development Bank in addition to the Global Fund. In Mozambique, the Global Fund has funded through sectoral support to the health sector and is actively considering doing this in a number of other countries.

6.39 There are significant differences in the way DFID and the Global Fund view country-led approaches, summarised in Table 5.

Table 5. Approaches to Country-Led Approaches: DFID and the Global Fund

Issue	Global Fund	DFID
Committed to country-led approaches?	Yes – encapsulated in principles on which the Fund is established	Yes – champions these as part of commitment to Paris Declaration on Aid Effectiveness
Alignment with national priorities?	In principle yes. Applicant countries required to explain how proposed activities fit within national strategies	Yes, except in settings where priorities are considered inappropriate, e.g. in some fragile states
Harmonisation with other donors?	At one level, the Global Fund is a harmonised/pooled mechanism for donor countries. Although there are some	Yes, strong focus of DFID

[121] Other agencies are seen as acting in this way, e.g. the US Government and some private foundations. However, the Global Fund is different from these in that it is part-funded by the UK

[122] Such as the need for Country Coordinating Mechanisms and Local Fund Agents

Issue	Global Fund	DFID
	examples of the Global Fund joining pooled funding mechanisms, e.g. Mozambique, this is the exception rather than the rule currently. This may happen more in the future, although it will require countries to request such an approach in their proposal.	
Mutual accountability?	This is seen as a strong feature of the Global Fund with representatives of developing country governments and civil society participating in governance structures, e.g. the Board. The Global Fund has an open, transparent management style with a wide range of key documents published on the website.	It is unclear what practical mechanism DFID has for this. DFID is accountable to the UK Treasury for its Public Service Agreement, and in general terms to the UK parliament and electorate.
Results?	Another strong feature with the Global Fund committed to performance-based funding. The Fund has been involved in pioneering many of the recent initiatives on HIV/AIDS monitoring and evaluation, for example, in order to make this possible.	Not a strong feature of DFID's approach to date. For example, *Taking Action* does not have a clear monitoring and evaluation framework specifying the expected results[123].
Approach to policy dialogue	No in-country staff. Does not see its role as influencing countries. However, requires countries to follow best practice. Looks to partners, e.g. UNAIDS and WHO, to determine best practice.	Sees this as a key ingredient to successful use of some aid instruments, e.g. budget support. However, could be seen as a way of influencing country priorities, i.e. to fit UK agenda.
Response to weak national systems	Encourages development of new systems, e.g. Country Coordinating Mechanisms. Sees systems as broader than government alone.	Responds to weak national systems by trying to make them stronger. Strong commitment to working through existing systems, particularly those of government.
Key players in country-led approaches	Strongly committed to the idea of public-private partnerships. Insists strongly on involvement of civil society and private sector. Has policies and procedures to try to achieve this[124].	Seen as strongly focused on government. Sees limited role for civil society (DFID, 2006n). Some DFID staff use the terms country-led and government-led interchangeably.
Constraints to country-led approaches	1. The Global Fund's basic mandate is to support initiatives which make a difference on one of three diseases. It cannot fund activities which do not do this. 2. The mechanics for applying through rounds significantly limit the type of aid instruments that the Global Fund can use.	1. DFID has sometimes created the impression that country-led approaches are the same as using one particular aid instrument, e.g. PRBS. 2. British foreign policy may be stricter than Global Fund operating practices. For example, the Global Fund is willing, in principle, for the Zimbabwe Government to be a recipient of its funds

[123] With the exception of the spending target

[124] Probably stronger in terms of civil society than private sector

Funding for Civil Society[125,126]

6.40 Civil society organizations (CSOs) are concerned that as donors shift to PRBS, less funding will be available for their activities (SPW, 2006). This section examines some of the implications for funding of CSOs, particularly in relation to their role in the response to HIV and AIDS. First, it explores the importance of CSOs in the response. Second, it considers some of the effects on funding to CSOs of a shift to PRBS.

6.41 The case study conducted in Zambia for this evaluation (Drew and O'Connell, 2006) emphasises the important roles that CSOs have in relation to the national response to HIV and AIDS, in particular in providing services for hard to reach groups, e.g. sex workers, and in community-based responses, e.g. care and support for PLWHA. Although drawn from one country, this experience is illustrative of and relevant to experience in other countries (see Box 17 p71).

6.42 Given the contribution of CSOs to national responses to HIV and AIDS, what is the effect of a shift to aid instruments, such as PRBS on funding to these organisations? Categorisation of bilateral aid instruments distinguishes between funds provided to government, which is termed financial aid, and other forms of aid, which is termed technical cooperation. If aid is provided to a country as PRBS, CSOs could potentially receive funding in two distinct ways. The first would be for the national government to fund CSOs. The second would be for the donor to fund CSOs directly as a form of technical cooperation. There are examples of both of these approaches being used. For example, mission hospitals in some African countries have been funded from government budgets for many years and, more recently, community organisations have been funded by NACs through the World Bank MAP. Other countries, e.g. India, are beginning to fund civil society activities on HIV and AIDS from government budgets. However, this practice is not yet widespread, and there are concerns that some governments may be less willing to fund CSOs engaged in advocacy or empowerment activities than those engaged in provision of health or welfare services. There are many examples of situations where donors fund CSOs as a means of technical cooperation with government[127].

6.43 It is difficult to get accurate financial information on UK funding for civil society on international development, in general, and on HIV and AIDS, in particular

---

[125] In this report, civil society is defined broadly as it is in DFID's document on civil society and development (DFID, 2006n). This means it includes a number of groups in addition to NGOs, such as faith-based organisations.

[126] *Taking Action* (DFID, 2004a) contained a number of specific commitments in relation to faith-based organisations (FBOs) – to strengthen support to these organisations (p3), to support FBOs in creating a demand for better leadership and holding governments accountable (p28), to work with FBOs to strengthen the ability of communities to respond to and support families affected by AIDS to protect and care for their children (p49); to support FBOs in South Africa (p50); and to support the engagement of FBOs in addressing stigma and discrimination (p51). However, these commitments were not captured in the design documents for this evaluation (DFID, 2005a) so have not been specifically examined.

[127] For example, social marketing of condoms through organisations, such as Population Services International, and the civil society component of the STARZ programme in Zambia

(see section 5.24, p48). Although figures for direct funding of international civil society organisations are available[128], just under two thirds of all UK funding for CSOs is estimated to go through country programmes (NAO, 2006). DFID does not systematically monitor this[129]. DFID funding to international NGOs (INGOs) for HIV and AIDS appears to have reduced between 2003/4 and 2005/6 (see Figure 13, p30). At the same time, official figures show that DFID's funding to INGOs' HIV and AIDS activities through PPAs increased from £6.5m in 2003/4 to £11.7m in 2005/6[130]. However, there is some evidence that other sources of funding may be declining.

Box 17 Diverse Roles for Civil Society in Responding to HIV and AIDS: Lessons from Zambia

These roles include (DFID, 2006n) building voice and accountability and providing services and humanitarian assistance.

An example of an organisation that provides voice and accountability is Civil Society for Poverty Reduction, which is supported by DFID and which produced a civil society commentary on the National Development Plan. However, this role of civil society is relatively poorly-developed in the HIV and AIDS 'sector' in Zambia. Organisations of people living with HIV and AIDS, such as NZP+ have limited capacity.

Although Zambia is not a fragile state, civil society organisations are actively involved in providing HIV and AIDS services. These include activities that are difficult for government, such as work with sex workers; community-based activities, such as support programmes for orphans and vulnerable children; technical assistance in areas such as building NAC capacity; innovative activities, such as work done by Oxfam and Care in pioneering use of cash transfers as a means of social protection; emergency humanitarian aid; and filling gaps in government services, such as mission hospitals providing rural health services.

Although DFID views civil society largely as providers of services in fragile states, i.e. where governments either cannot or will not provide them (DFID, 2006n), experience in Zambia highlights the importance of civil society organisations in providing a wide range of HIV-related services in a relatively stable and well-functioning state and of identifying appropriate and efficient mechanisms for funding civil society organisations.

[128] Eg Civil Society Challenge Fund, Programme Partnership Agreements, Strategic Grant Agreements and Development Awareness Fund

[129] There would be considerable practical difficulties in monitoring this because, in some situations, civil society organisations are sub-recipients of funds provided by DFID to other agencies

[130] This apparent discrepancy can be explained because of differences in methods. First, figures calculated for this evaluation only included those PPAs with a PIMS marker for HIV or reproductive health. The official DFID method now includes all PPAs. Both methods used the same percentages to determine what percentage of PPA funding contributes to HIV and AIDS based on figures provided by NGOs. Second, figures calculated for this evaluation included funds provided to INGOs through instruments other than PPAs, e.g. CSCF and funds provided by country offices where main recipient appeared to be an INGO. Third, figures calculated for this evaluation for 2005/6 were to February only and thus were incomplete.

Concluding Comments

6.44 The UK's experience of using PRBS to finance national responses to HIV and AIDS is at an early stage. While PRBS has the potential to be a useful instrument in the response to AIDS, it currently needs to be supplemented with a mix of other instruments. One reason for this is that AIDS is often not adequately reflected in countries' poverty reduction strategies. In addition, the resource needs of the national response to HIV and AIDS are often poorly-reflected in the PRS's financial frameworks. National AIDS strategies also often fail to identify which elements of the AIDS response will be given priority. Many countries facing epidemics concentrated among particular groups have, for various reasons, failed to allocate sufficient resources to effective prevention measures focused on these sub-populations.

6.45 The UK has provided assistance to enable countries to prioritise their response to HIV and AIDS more effectively. Approaches used have included epidemiological studies in DRC, demonstration projects in China and Russia, engaging in high-level policy dialogue in Zambia and supporting civil society's influencing role in Zimbabwe.

6.46 There are concerns among some DFID staff as to whether support to some international organisations, e.g. the Global Fund, undermines the commitment to country-led approaches. A key issue is differing understanding of the nature of country-led approaches. The Global Fund could probably learn from DFID in terms of alignment and harmonisation. DFID could probably learn from the Global Fund in terms of supporting the role of civil society, mutual accountability and managing for results.

6.47 CSOs play critical roles in the response to HIV and AIDS. These roles include voice and accountability and provision of vital services that may be difficult for government to deliver effectively. Examples include innovative approaches and politically-sensitive services, such as harm reduction approaches for IDU. DFID and other donors need to ensure that adequate funds reach these organisations for provision of these services. Although this is beginning to happen, e.g. channelling funding to civil society through the Global Fund, there is a risk that too early reliance on this method of funding may increase bottlenecks. Effective mechanisms of direct funding to civil society still need to be identified and supported.