working paper

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

An Analysis of Trends in UK Government Funding and Activities

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EVALUATION WORKING PAPER 18

Interim Evaluation of *'Taking Action: The UK Government's Strategy for Tackling HIV and AIDS in the Developing World'*

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PREFACE

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

DFID's Evaluation Department (EvD) commissioned an interim evaluation of Taking Action in 2006 to respond to these concerns, and to generate lessons which will enable the UK government to improve its effectiveness. It will also lay the groundwork for a more systematic and detailed evaluation of the UK Government's strategy and activities in this area, planned for 2008/9. The evaluation is being carried out by independent consultants: a consortium between Social and Scientific Systems, Inc. (USA), the Institute of Education, University of London and the Mexico National Institute of Public Health. The process is managed by Julia Compton, John Murray and Jane Gardner in EvD. Further information and publications on the evaluation, including the specific evaluation questions being addressed, the composition of the steering group and frequently asked questions, can be found at: http://www.dfid.gov.uk/aboutdfid/performance/evaluation-news.asp

I am happy to introduce this working paper on 'Analysis of Trends in Funding and Activities related to HIV and AIDS', which is the first of three working papers to be produced for the evaluation. It concludes that UK support has increased significantly in a wide range of areas related to tackling HIV and AIDS. The paper also highlights the challenges in measuring spending on AIDS, for example in deciding how to apportion spending on broader actions such as strengthening health systems. It points out that these challenges are faced by all governments, donors, agencies and NGOs, and calls for a wide international debate on this topic.

It is important to understand, nevertheless, that this *is* a working paper and not the final evaluation report. The findings and conclusions in this paper are provisional and may be revised once further evidence has been considered. Readers who have views or evidence to contribute to the evaluation are welcome to contact the consultants via Jane Gardner, j-gardner@dfid.gov.uk

Nick York,
Head of Evaluation Department, DFID
30 June 2006

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This working paper has been prepared by an independent team from Social & Scientific Systems, Inc. and the Institute of Education.

The core team for the evaluation consists of Barbara Pillsbury, Karen Semkow, Roger Drew, Peter Aggleton and Ian Warwick. The team is very grateful to all those people who have provided support, information and comments. Particular support was provided by Susan Duberstein and Ariella Bock of Social & Scientific Systems, Inc. in extracting information from the CD version of PRISM.

The team was greatly assisted in preparing the first draft of this working paper by a number of DFID staff, including Julia Compton, John Murray, Jane Gardner, Sandra Baldwin, Phil Cockerill, Elaine Drennan, Kerstin Hinds, Sandra McAllister, Lesley Reid, Colette O'Neil and Heather McFedries, who supplied us with a Microsoft Access version of PRISM on CD-ROM. Information about other government departments was kindly supplied by Jonathan Bickley of the Department of Health, Mark Palmer of the MRC and Tamsin Rees of the Foreign and Commonwealth Office. Caroline Halmshaw of the International HIV/AIDS Alliance kindly provided information on enabling actions.

Our team would especially like to thank those who provided feedback on drafts of the working paper, including Robin Gorna, Sue Kinn, Sandra MacDonagh and Tim Waites. It also included Jenny Amery, Sandra Baldwin, Hans-Martin Boehmer, Julia Compton, Benedict David, Louisiana Lush, John Murray, Anne Philpott, Carolyn Sunners, Tamsin Rees and Madeline Church[1] who discussed this working paper at a meeting of the Evaluation Steering Group on 28th March 2006. Particular thanks are also due to Julia Compton, Phil Cockerill, Kerstin Hinds, Elaine Drennan and Peter Kerby for giving focused feedback on the methods used in this study in a methods working group meeting held on 27th April 2006. In addition, two members of DFID's Evaluation Department provided quality assurance comments on the final draft and Alasdair Swift provided assistance with using DevInfo to generate maps.

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

[1] Tamsin Rees is from the Foreign and Commonwealth Office and Madeleine Church is from the UK Consortium on AIDS and International Development. All others are DFID staff.

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GLOSSARY[2]

CAP	Country Assistance Plan
CSCF	Civil Society Challenge Fund
DAC	Development Assistance Committee
DCD	Development Cooperation Directorate
DCI	Irish Aid
DOH	Department of Health
DRC	Democratic Republic of Congo
DTI	Department of Trade and Industry
EMAD	Europe, Middle East and Americas Division
FA	Financial Aid
FCO	Foreign and Commonwealth Office
FP	Family Planning
GNI	Gross National Income
H/A	HIV/AIDS PIMS Marker
HSR	Health Sector Reform
IFFG	Investing for Future Generations
IOE	Institute of Education
ISP	Institutional Strategy Plan
MDG	Millennium Development Goal
MERG	Monitoring and Evaluation Reference Group
MIS	Management Information System
MOD	Ministry of Defence
MOH	Ministry of Health
NAO	National Audit Office
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
OVC	Orphans and Vulnerable Children
PAM	Poverty Aim Marker
PIMS	Policy Information Marker System
PPA	Programme Partnership Agreement
PQ	Parliamentary Question
PRBS	Poverty Reduction Budget Support
PRISM	Performance Reporting Information System for Management
PRSP	Poverty Reduction Strategy Paper
RAP	Regional Assistance Plan
RH	Reproductive Health
SRH	Sexual and Reproductive Health (also RSH)
SRSG	Statistical Reporting and Support Group
SSS	Social & Scientific Systems
SWAp	Sector Wide Approach
TA	Taking Action
TC	Technical Cooperation
TQA	Table of Questions and Approaches

Important Note: All relevant charts and figures have been marked with this symbol for data for 2005/6. As work was conducted in February 2006, information for this financial year is incomplete and should be interpreted with caution

[2] This is a summary glossary. A full glossary is available in Annex 12 (p 89).

EXECUTIVE SUMMARY

S1-S3 Introduction

S1 This is the first of three technical working papers for "The Interim Evaluation of '*Taking Action*: The UK[3] Strategy for Tackling HIV and AIDS in the Developing World.'" The aim of this paper is to analyse trends in UK Government funding and activities related to HIV and AIDS since *Taking Action* was adopted.

S2 This working paper is strongly focused on activities and spending in DFID, which is the lead department for *Taking Action*. However, available information from other government departments has been included (for example in sections 3.5-3.6, p5).

S3 It is important, when considering the findings and conclusions of this working paper, to understand the limitations of the methods followed. These are described in detail in Annex 1 (p53). In brief, a dataset of 1424 projects/programmes was identified from DFID's Performance Reporting Information System for Management (PRISM) using markers for HIV/AIDS and reproductive health, sector codes for orphans and vulnerable children and free text searching for HIV and related terms. The dataset covered the years 1987-2006. Much of the analysis was based on manual searching of a number of PRISM fields, particularly the project/programme title and description. Due to the limitations of the information system (see p34) and ongoing discussions about methods for tracking spending on HIV and AIDS (see p4), this working paper aims to identify broad trends rather than exact numbers.

S4-S7 Spending targets within *Taking Action*

S4 *Taking Action* contains several spending targets (see p4 for details) – for HIV and AIDS overall, for activities focused on orphans and other vulnerable children and for levels of support to certain international organisations, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund or GFATM), the Joint United Nations Programme on AIDS (UNAIDS) and the United Nations Population Fund (UNFPA).

S5 The basic systems for tracking progress towards the spending target for HIV and AIDS are in place in DFID. Some final work is currently being done on precise definitions and methods. It would have been helpful if this work had been completed prior to the target being set. Nevertheless, the systems and methods being used by DFID will interest others seeking to track spending on HIV and AIDS, for example, countries and other international agencies. Tracking such spending is not simple. For

[3] In general, we have given the full title for abbreviations in the text where we first use them. In the case of commonly-used abbreviations or omission, a summary glossary is provided at the start of the working paper. A full glossary is provided in Annex 12 (p89).

example, what activities can be considered as contributing to the response to HIV and AIDS? What proportion of finances can be counted from an activity that has a focus that is broader than HIV and AIDS alone, such as poverty reduction budget support? The approaches being taken by DFID are the product of detailed work and have been subject to intense scrutiny both within and outside DFID. As a result, DFID is well-placed to provide international leadership in this area.

S6 The system developed for tracking progress towards the spending target relating to orphans and vulnerable children (OVC) is not yet fully operational. It significantly underestimates spending in this area. Using a system based on project/programme markers for HIV, AIDS and reproductive health and free text searching the project/programme title and purpose for terms related to OVC, we identified 178 potentially relevant projects/programmes with spending in the first 11 months of 2005/6 of more than £60m. Information gathered from this exercise could help DFID better monitor how its work benefits orphans and vulnerable children.

S7 Finally, DFID is providing increasing support to a small number of international organisations that have pivotal roles in the global response to HIV and AIDS. These include the Global Fund, UNFPA and UNAIDS. For example, since the UK Government issued its Call for Action in December 2003, DFID core funding to UNAIDS has increased more than fivefold. The UK Government is on track to meet its *Taking Action* pledges to UNFPA and UNAIDS and will exceed its commitment in *Taking Action* to the Global Fund by more than threefold if it meets its latest pledges for 2006 and 2007. Based on a contribution of £51m to the Global Fund in 2005, the UK Government is already ahead of its *Taking Action* target for support to that institution.

S8-S18 Trends in UK Government support for the international response to HIV and AIDS

S8 Analysis of the project/programme dataset reveals:

- S9 *Aid Instrument* - 72% of projects/programmes were classified as technical cooperation. This correlates broadly with figures from DFID's Statistical Reporting and Support Group (SRSG), which show that annual expenditure through technical cooperation was 44-63% of bilateral expenditure on HIV and AIDS between 1997 and 2005. Technical cooperation is a general term used to describe the main alternative to financial aid, that is, rather than giving money directly to government, technical services are provided. Technical cooperation covers a wide range of activities, including provision of essential health services, pharmaceuticals, health products and equipment. There are identifiable trends of increasing financial support going through general[4] and sectoral budget support, which is in line with DFID's strategic shift towards country-

[4] Excluded from the financial analyses in this working paper.

led aid instruments. In addition, there is evidence of increasing support to the work of National AIDS Commissions, which is consistent with the 'Three Ones' strategy agreed by the international community in 2004.

- S10 *Policy Dialogue* - we also identified a sub-set of 135 projects/programmes that contain an element of policy dialogue. Projects/programmes in this area have grown significantly in number. However, this working paper probably significantly underestimates work of the UK government in this area as much of this is not 'projectised' and is therefore not captured on PRISM.

- S11 Although *bilateral funding* to countries remains the main funding mechanism, it is less dominant than in the late 1990s. Increasing amounts of money are going through multilateral channels, particularly since 2000. In addition, there are two sub-types of aid, currently classified as bilateral, which merit consideration. First, there are regional projects/programmes and secondly, there is in-country support to UN agencies and other multilaterals. This working paper shows an increase in recent years of in-country support to UN agencies, particularly the World Health Organisation (WHO), UNFPA, UNAIDS and the United Nations Children's Fund (UNICEF). Regional projects/programmes consist of true regional initiatives and grouped, multi-country projects/programmes.
- S12 *Partner agencies* – DFID supports projects/programmes managed by a range of partners. Most projects/programmes by number are managed by international NGOs, ministries of health and UN agencies. However, when analysed by value of planned commitments, most funds are going to projects/programmes managed by ministries of health and international NGOs. Also, we identified trends of increasing support to UN agencies and to National AIDS Commissions or their equivalent.
- S13 *Focus of HIV and AIDS work* – there are particular challenges in trying to determine the focus of HIV and AIDS work supported by DFID, because of the way DFID funds activities, the type of activities supported and the way in which information is gathered in this area. Consequently, we approached this task in two different ways. First, we allocated each project/programme to as many categories as seemed appropriate. Based on this, we estimate that 41% of projects/programmes contained some elements of care and support, 38% impact mitigation, 27% prevention, 8% research and 3% treatment. We also identified specific reproductive health projects/programmes (18%). The number of such projects/programmes is declining. The number of projects/programmes containing elements of care and support, and impact mitigation is increasing. Secondly, we analysed 376 projects/programmes specific to HIV and AIDS. Of these, we identified 120 (27%) that were largely focused on prevention and 23

(6.1%) focused on care and support. Twenty (5.3%) were judged to have a treatment element.

- S14 *Focus on vulnerable populations* – we identified projects/programmes which appear to have particular benefits for specific populations – women (23%), young people (8%), OVC (13%) and other vulnerable populations (12%). Support for projects/programmes benefiting young people, OVC and other vulnerable populations appears to be increasing. There is some evidence that expenditure on projects/programmes with particular benefits for women declined between 2003/4 and 2005/6, probably reflecting the reduction in specific projects/programmes focused on reproductive health. Analysis of gender markers for projects/programmes shows that the number of projects/programmes within our dataset with these markers has been steadily increasing.
- S15 *Broad or narrow focus* – we classified projects/programmes into four categories – AIDS-specific (26%), part of reproductive health project/programme (19%), part of health project/programme (27%) and part of a broader enabling activity (28%). Activities supported by DFID cover a broad range of areas, including in particular, important initiatives to create a more enabling environment. There are some definitional issues over what constitutes an enabling activity. We have begun to explore this issue based on work by the International HIV/AIDS Alliance, from which we identified five categories of enabling action, namely policy actions; resource mobilisation; actions to tackle stigma and discrimination; organisational development of structures and mainstreaming HIV and AIDS into broader development activities.
- S16 *Building monitoring and evaluation (M&E) capacity* – M&E is an essential component of an effective response to HIV and AIDS. We identified 28 projects/programmes, which have a focus on building M&E capacity. These have emerged particularly since 2003/4 and can be categorised as monitoring in three main areas – poverty reduction, health and HIV and AIDS. In particular, DFID has been supporting UNAIDS' role to strengthen national monitoring systems for HIV and AIDS as part of the 'Three Ones' approach. This support is in addition to the increased core support referred to earlier in this summary.
- S17 *Regional analysis*
    - Just under half of all projects/programmes were in Africa, one-fifth in Asia and 12% in Europe, Middle East and the Americas (EMAD). The remainder were non-geographic.
    - Aid instrument – technical cooperation is the most common aid instrument in all regions.
    - Partner-types – in all three geographic regions, the most common partners are international NGOs, ministries of health and UN agencies. For non-geographic

projects/programmes, academic institutions replace ministries of health as the second most common partner.
    - M&E capacity – one-third of these projects/programmes occur outside the three geographical divisions.
    - Vulnerable populations – Women are the most common 'vulnerable' population targeted by HIV-related projects/programmes in all regions. They are followed by OVC in Africa and other vulnerable populations in Asia.
    - AIDS-specificity – In Asia and EMAD, the most common group of projects/programmes were those focused on health (36% and 27% respectively). In Africa, the commonest group of projects/programmes is those providing broader enabling activities (34%) and for non-geographic projects/programmes it is those that are HIV and AIDS-specific (35%).

- S18 *Country by country analysis* – Levels of DFID bilateral financing correlate broadly with the burden of HIV and AIDS except in a few countries, e.g. Burundi, Democratic Republic of Congo (DRC), Lesotho, Liberia, Mozambique. The presence of other sources of financing (including UK budget support to government, UK support through multilaterals and funds from non-UK sources) may help to explain this.

S19 Trends in UK planning processes

S19 In addition to our review of DFID's Performance Reporting Information System for Management (PRISM), we reviewed all country assistance plans (CAPs), regional assistance plans (RAPs) and institutional strategy papers (ISPs) available to us. From these we conclude the following:

- The degree of focus of CAPs on HIV and AIDS seems to be sharper in countries with high adult HIV prevalence.
- ISPs were historically weak in this area but there has been marked and significant improvement in this area in recent ISPs, for example with the European Union (EU) and the UN Development Fund for Women (UNIFEM).

S20-S22 Discussion, conclusions and issues to consider

S20 We have structured our discussion and conclusions around the main question addressed by this working paper, namely to what extent the distribution of current UK-supported HIV and AIDS activities reflects the priorities laid out in *Taking Action*? These are illustrated diagrammatically in Figure 1 (pxiv).

S21 In summary, this working paper finds that the UK's spending and activities on HIV and AIDS are broadly in line with the priorities outlined in *Taking Action*. In particular, there is evidence that the UK:

- Will meet spending targets on HIV/AIDS[5] and OVC, and has contributed significantly increased funding to international organisations
- Has been a strong supporter of the international response to HIV and AIDS, including efforts to coordinate and harmonise responses, e.g. 'Three Ones' strategy
- Has supported a range of country programmes, focused strongly on integrated, coordinated and harmonised responses

S22 An area that may need more attention is monitoring and evaluating the activities supported by the UK government. This needs to go beyond simply tracking how much money the UK government is spending on HIV and AIDS to the broader picture of how the UK's contribution fits into responses and their financing in countries and globally. There may be need for special efforts to monitor activities in focus areas which are difficult to track, such as political leadership and long-term action.

[5] Assuming that spending is measured in the same way as anticipated when the target was set. If major changes are made in method, this could affect whether or not the target is met.

Figure 1: To what extent does the distribution of current UK-supported HIV and AIDS activities reflect the priorities laid out in Taking Action?

Closing the Funding Gap	• UK on track to reach HIV and AIDS spending target… but challenging to measure • Most support is still in form of technical cooperation projects/programmes • Some evidence of focus on women, young people and other vulnerable groups (this will be the focus of working paper 2) • System for tracking OVC spending target not fully operational but spending appears on track to reach target • Increased funding to key international institutions
Political Leadership	• Emergence of policy dialogue projects/programmes and non-projectised approaches • Focus on political leadership – a strength of many country assistance plans
International Response	• Continued support to multilateral organisations • Evidence of strengthened institutional strategy papers since *Taking Action* • Support to UNAIDS 'Three Ones' strategy in seven countries • Evidence of increasing use of UN agencies in-country • Relatively few projects/programmes identified as having a focus on access to treatment
National Programmes	• Country assistance plans that are relevant to in-country situation regarding HIV and AIDS • Wide range of partners including NGOs, government ministries and UN agencies • Small but increasing number of projects/programmes working through National AIDS Councils or equivalent • Support provided to wide range of projects/programmes including those specific to HIV/AIDS and broader initiatives on health and development • Evidence of reducing emphasis on specific reproductive health projects/programmes • Commitment to integrated response to HIV and AIDS, including a strong emphasis on prevention • Use of regional/multi-country projects/programmes in some settings • Broadly, country allocations appropriate for 'disease burden'. Questions of under-funded countries difficult to assess in the absence of accurate in-country data • Unclear systems for monitoring and evaluation – difficult to assess increases in scale
Long Term Action	• Little evidence of focus on sustainability, e.g. in country assistance plans • Focus on research, both specific to developing countries, financed by DFID, and more general research, financed through Department of Health
Strategy into Action	• Some actions from other government departments but challenging to measure • Higher profile for HIV and AIDS, not yet clear how this is affecting annual financial allocation • Monitoring system for *Taking Action* not yet fully established • DFID monitoring of progress currently strongly focused on spending target • Evidence of DFID support to build country monitoring and evaluation capacity

Based on the methods used in this working paper…

Key to colour codes

- This priority is strongly reflected in the overall distribution of UK-supported activities
- This priority is reflected in the overall distribution of UK-supported activities
- This priority could be more strongly reflected in the overall distribution of UK-supported activities

1. INTRODUCTION

1.1 This is working paper 1[6] for "The Interim Evaluation of '*Taking Action*: The UK Government's Strategy for Tackling HIV and AIDS in the Developing World.'" It documents a study, conducted by the Social & Scientific Systems, Inc. (SSS)/Institute of Education (IOE) evaluation team, which had as its main aim an analysis of trends in UK Government funding and activities related to HIV and AIDS (in particular the DFID portfolio) since *Taking Action* (2004-6) (DFID, 2005a).

1.2 The objective of the interim evaluation is to make recommendations in four main areas:

- To improve implementation and monitoring of the current strategy
- On how best to measure the success of the strategy, looking forward to the final evaluation of *Taking Action* in 2008/9
- For the UK Government's next steps on AIDS from 2008
- Regarding future UK (especially DFID) strategies on development issues (DFID/HLSP, 2005)

1.3 This working paper is the second product of the evaluation, following the inception report (SSS, 2006). It will also contribute to the final report of the evaluation and will inform other parts of the evaluation (DFID, 2005a).

1.4 Detailed requirements for this working paper are contained in the Table of Questions and Approaches (TQA) and in Annexes A and B of the evaluation design document (DFID/HLSP, 2005)[7]. These are also highlighted in specific terms of reference produced by the SSS/IOE team and agreed with DFID (SSS/IOE, 2006).

1.5 DFID is the lead department in implementing *Taking Action.* This working paper is strongly focused on DFID activities and spending. However, wherever possible, information from other government departments has been gathered and included.

[6] And working paper 18 in a series produced by DFID's Evaluation Department.
[7] In particular, the mapping study is explicitly referred to in TQA Q1.2, Q1.5 and Q1.6; in Annex A 1a, 1b, 1c, 3g5, 4b, 4b2, 5b and 6f2; and in Annex B1a.

2. METHODS

2.1 This technical working paper has been produced as a desk-based study of trends in UK Government funding and activities[8] related to HIV and AIDS since *Taking Action* came into effect in 2004. Although DFID leads on this strategy, information was also gathered from other government departments.

2.2 In particular, this working paper focuses on DFID activities and funds and uses DFID's Performance Reporting Information System for Management (PRISM) as its primary data source[9]. Four steps were followed:

- *preliminary data assessment*
- *data extraction from a CD-ROM containing an Access database of PRISM*[10]
- *manual filling of additional data fields*[11]
- *analysis of data*

2.3 This method identified a dataset of 1,424 projects/programmes from 1987 to 2006[12].

2.4 In addition, we made a rapid assessment of all Country Assistance Plans (CAPs), Regional Assistance Plans (RAPs) and Institutional Strategy Papers (ISPs) that we could identify (see Annex 2, p69). We also

[8] The terms 'activities' and 'projects' are used in different ways within DFID. In this context, 'activity' is being used as a way of describing units of DFID funding. This is how the term is used within AIDA. The term 'project' is used with the same meaning, e.g. in PRISM in the terms 'project title' and 'project purpose'. However, in DFID, the term 'project' is used in a number of different ways. Within DFID's MIS system, it is used as a sub-set of these units of funding. In this system project is defined as a finite activity with known start and end date (DFID, 2005c) as compared to a programme, which does not have these. In a discussion on types of aid instruments (Colenso, 2005), project is seen as one type of aid instrument but is not defined. Sectoral budget support is classified in the checklist in that document as 'project aid'. Following discussion with the methods working group, we agreed to use the term 'projects/programmes' wherever possible to refer to these units of funded activity.

[9] PRISM (Performance Reporting Information System for Management) is an electronic information system accessible from within DFID. It contains information about DFID-funded projects/programmes and links to related documents. Information from PRISM is also exported to AIDA, which is accessible online at http://aida.developmentgateway.org/. Projects/programmes on PRISM are coded to certain development themes, including HIV and AIDS and reproductive health, using a Policy Information Marker System (PIMS). These are referred to within DFID as PIMS markers. If a project/programme has a particular theme as its main focus, it is allocated a principal ('P') marker for that theme. However, if it has a significant effect in a thematic area, but is primarily focused on something else, it is allocated a significant ('S') marker for that theme.

[10] Dated February 2006.

[11] Much of the analysis in this report is based on manual review and analysis of project/programme titles and statements of purpose as the information required for many of the fields, e.g. partner type, vulnerable populations, focus of intervention etc. is not recorded systematically in PRISM.

[12] Up to February 2006.

reviewed a number of other relevant documents[13]. We also made contacts with a number of DFID staff and other government departments. However, because of time constraints and the fact that this working paper is part of a larger evaluation process, we did not perform an extensive literature review or conduct exhaustive interviews with DFID staff[14].

2.5 It is particularly important when considering the findings and conclusions of this study that the methods followed and their limitations be understood. For this reason, they are described in considerable detail in Annex 1 (p53).

[13] These are given as a list of references at the end of this report (p47). However, a comprehensive review of documents was beyond the scope of the mapping exercise.
[14] Although a number of interviews have been conducted and more are planned as part of the overall evaluation process.

3. PROGRESS TO SPENDING TARGETS

3.1 Targets in *Taking Action*

3.1 *Taking Action* (DFID, 2004) contains several spending targets, which are summarised in Table A of the Evaluation Design Document (DFID/HLSP, 2005). These were to increase funding for AIDS-related work and spend at least £1.5 billion over the next three years (from 2005-06 to 2007-08), to:

- Fund action that prioritises women, young people and vulnerable groups, and focuses on human rights
- Ensure that we spend at least £150 million on programmes to meet the needs of orphans and other children, particularly those in Africa, made vulnerable by HIV and AIDS
- Double funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund or GFATM) over the next three years, representing an increase of £77 million (US$140 million)
- Provide £36 million to the Joint United Nations Programme on AIDS (UNAIDS) over the next four years to support its global leadership
- Provide £80 million to the United Nations Population Fund (UNFPA) over the next four years to support its HIV prevention, sexual and reproductive health work with women

3.2-3.7 Measuring HIV and AIDS spending

3.2 Issues that have been raised concerning the way DFID tracks spending on HIV and AIDS (Janjua, 2003; NAO, 2004; Daly, 2005; ActionAid, 2005; International Development Committee, 2005; DFID, 2005b; Benn, 2005) [15] include:

- Absence of clear budget lines for HIV and AIDS and no single accurate record of HIV and AIDS expenditure
- Inclusion of activities not specific for HIV and AIDS, such as sexual and reproductive health, general budget support etc.
- Reliance on some types of what has been termed 'phantom aid', such as debt relief and technical assistance
- Absence of disaggregated figures, e.g. for types of services and degree of focus on most vulnerable groups

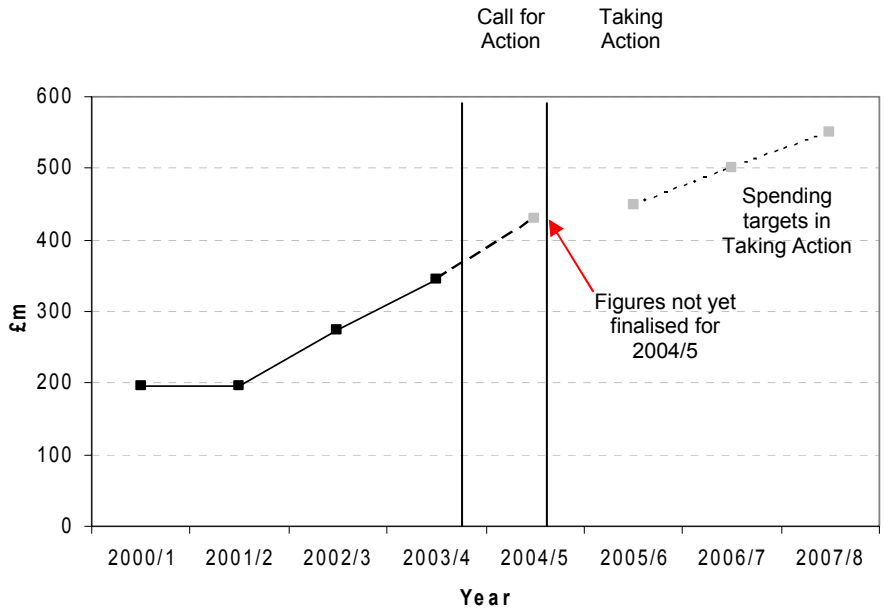
3.3 The method for tracking UK AIDS expenditure is still being revised to try to address these issues. As a result, figures for 2004/5 have not yet been finalised although it is of the order of £430m (see Figure 2, p5). Issues under discussion include how to deal with:

- Poverty reduction budget support (PRBS)
- Activities that have a significant but not principal focus on HIV and AIDS

[15] See Annex 4 (p73) for more detail.

- Programme partnership agreements, which provide strategic funding to non-government organisations (NGOs)
- Core funding to multilateral organisations whose work is not exclusively focused on HIV and AIDS
- The need for a system to provide accurate information whilst being simple to administer

Figure 2: Reported UK Government Spending on HIV and AIDS



3.4 Whatever method is adopted, it is likely to be left with some unresolved issues including:

- Undercounting of some expenditure, e.g. of spending by other government departments, research, gift aid (see points 3.5 and 3.6)
- Difficulties in comparing internationally with other bilateral agencies (see section 5, p29). However, this is not simply an issue of measurement but fundamental differences in approaches to funding HIV and AIDS. It is clearly easier to measure 'vertical' funding of HIV and AIDS programmes. However, this risks considerably underestimating the contribution made by an agency that funds mainly in a different way, e.g. DFID.

3.5 The system is not likely to include financial contributions from other government departments related to HIV and AIDS. For these, DFID collects financial data for official development assistance (ODA), but not disaggregated figures for HIV and AIDS. For example, the Foreign and Commonwealth Office (FCO) contributed £86.2m in ODA in 2004/5. This was broken down to international subscriptions (£7m); Chevening[16] (£12.2m); drugs control (£6.5m); justice and crime (£287,000); environment, sustainable development, human rights, democracy and good governance ((£11.8m) and administrative costs (£18.3m). The FCO also has an annual fund of £60,000 available to finance HIV and AIDS

[16] A system of scholarships provided through the Foreign and Commonwealth Office – see http://www.chevening.com/ for more details.

projects as part of its Global Opportunities Fund (FCO, 2005). Also, the UK government contributed around £40m as ODA through civil society organizations through the gift aid scheme[17] in 2004/5.

3.6 Like other donors, (OECD/UNAIDS, 2004; Kates, 2005), the UK government does not count funds for general HIV and AIDS research as benefiting low and middle income countries. However, such research could have significant benefits for such countries. The Department of Health (DOH) report (Bickley, 2005) that they allocate around £500m to National Health Service (NHS) trusts for health-related research. This is not disaggregated for HIV and AIDS, but this is a significant area of work. For example, the Chelsea and Westminster Healthcare NHS Trust reports spending more than 10% of its £3.2m allocation in 2004/5 on HIV and AIDS research. In addition, the DOH funds a programme on sexual health and HIV managed by the Medical Research Council (MRC) worth £8m and the Health Protection Agency conducts research on STIs.

3.7 The UK Government is not alone in facing challenges tracking spending on HIV and AIDS. These also affect low income countries, other donors and international organisations (UNAIDS, 2003; UNAIDS, 2005 and section 5, p29). As a result, there is an unprecedented opportunity for DFID to demonstrate global leadership in a field that is characterised by limited information and significant definitional challenges. To date, there has been little consultation outside of DFID about this method and resulting figures. It is hoped that with the publication of these, there will be broader discussion, which could benefit countries and organisations struggling with the same issues.

3.8-3.9 Progress against spending target for orphans and vulnerable children (OVC)

3.8 DFID is currently using a combined system of sector codes[18] and markers within a Policy Information Marker System (PIMS) to track progress towards the OVC spending target (DFID, 2005b). However, this system is not yet fully operational[19]. We identified 178

[17] A system of tax relief on money donated to UK charities.

[18] Sector codes allow parts of the expenditure of a project/programme to be allocated to particular sectors. There is a sector code for work which has an impact on orphans and vulnerable children. Coding a project to this sector does not necessarily mean that it is HIV-related. However, the 'OVC spending target' within *Taking Action* is clearly worded as a sub-set of the spending target for HIV and AIDS. As a result, the current methodology for tracking this requires a project/programme to have a PIMS marker for either reproductive health or HIV and AIDS, and a sector code for OVC in order for expenditure on that project/programme to be counted towards the OVC spending target.

[19] In February 2006, SRSG were able to identify three projects with both an OVC sector code and an HIV/AIDS PIMS marker (DFID, 2006a) with a total spend for FY 2005/6 of only £1.58m (£1.5m of that was for post-tsunami relief in India). SRSG identified a further seven projects with an OVC sector code but no HIV/AIDS PIMS marker but this only brought total spend to £2.56m. Problems are said to be related to implementation rather than method and include:

- Lack of understanding of how to apply PIMS markers and sector codes
- Lack of buy in to the importance of the system/philosophy of PIMS/sector markers/agreement of the methodologies which led to a reluctance to add appropriate markers

projects/programmes relevant to OVC (see Annex 1 for criteria, p53). Of these:

- Sixty-nine had documented expenditure for FY2003/4 worth £45.2m[20]
- Fifty-seven had documented expenditure[21] for FY2005/6[22] worth £61.3m[23] (see Figure 3, p8).

3.9 Our figures could be useful to DFID in different ways. First, the projects/programmes identified could be reviewed to see if they should have an OVC sector code allocated. Secondly, our method[24] could be used in the future as a method of quality control. Finally, our method raises a number of methodological issues. These include:

- Whether 100% of financing for an education project/programme should be considered as benefiting OVC
- What proportion of support to child-focused organisations should be apportioned to OVC[25]
- Whether spending on OVC should strictly be a sub-set of spending on HIV and AIDS. This is currently how it is viewed within *Taking Action* but raises issues about how OVC are defined, particularly in countries with lower rates of HIV infection and high rates of other causes of child vulnerability.

[20] These expenditure figures currently include all expenditure for these projects. This may need to be reviewed in the light of the new method for tracking AIDS spending (see section 3.2, p4). However, it is unclear if definitions of spending for OVC should be strictly limited to HIV and AIDS spending. For example, although perhaps UNICEF classifies only 9% of its spending as HIV and AIDS-related, it is likely that a larger proportion would be considered as benefiting OVC, perhaps 100%.

[21] Includes four with zero expenditure for 2005/6 as opposed to a blank.

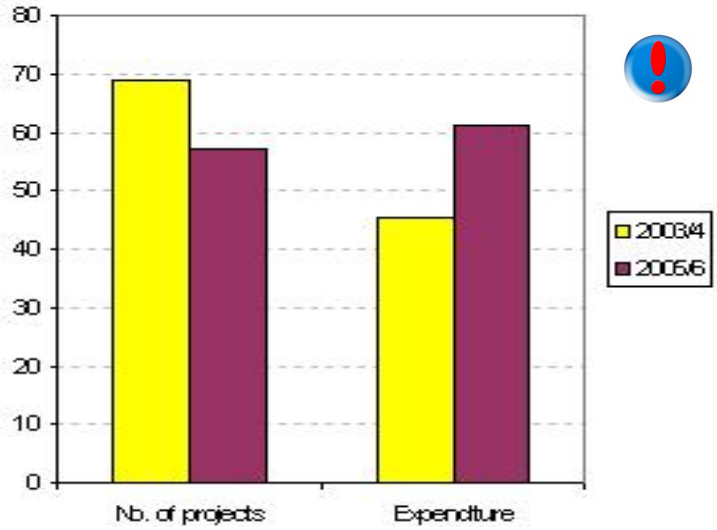
[22] To February 2006.

[23] If these figures are confirmed, it is assumed that the £150m target for spending on OVC applies to the financial years 2005/6 to 2007/8 and that spending would be uniform (i.e. £50m per year), this level of spending would be ahead of target.

[24] Of free text searching of project/programme title and purpose for keywords (see Annex 1, p53).

[25] It appears that current method would only allocate a proportion of funding to multilaterals, e.g. UNICEF, but would apportion all funding to international NGOs, e.g. Save the Children.

Figure 3: Number of projects/programmes and level of DFID-funding (£m) for activities related to orphans and vulnerable children in 2003/4 and 2005/6

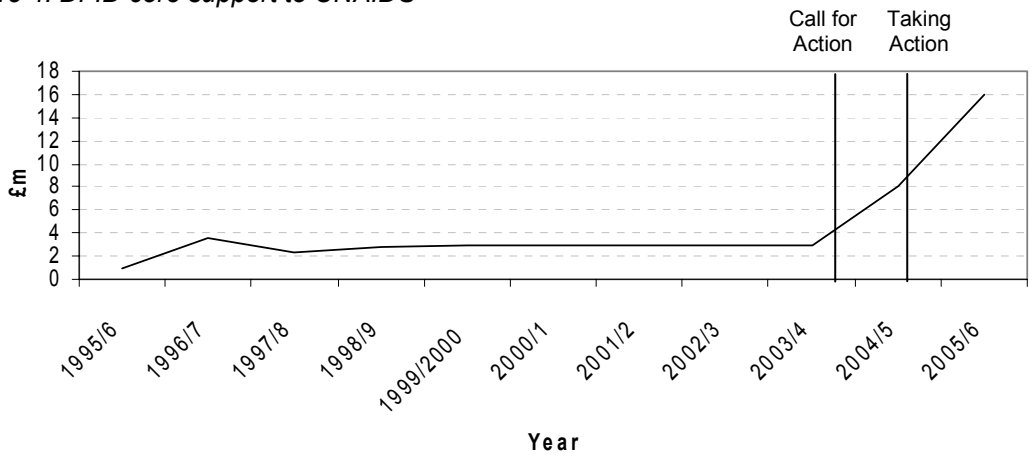


3.10-3.11 Progress against spending targets for international organisations

3.10 There has been a dramatic increase in core support to UNAIDS in line with the commitments in *Taking Action* (see Figure 4). In addition, support to UNFPA was £20m in both 2004/5 and 2005/6, which is also in line with the levels required by *Taking Action*[26].

3.11 *Taking Action* committed the UK to double its commitment to the Global Fund by contributing £77m over three years (see section 3.1, p4)[27]. In fact, the UK gave £51m to the Global Fund in 2005 and has pledged an additional £100m in each of the years 2006 and 2007 (Thomas, 2006). If these pledges are honoured, this would mean that the target in *Taking Action* would have been exceeded threefold.

Figure 4: DFID core support to UNAIDS



[26] This is a less significant increase than in the case of UNAIDS as core funding for UNFPA was £15m in 2001/2 and £18m in both 2002/3 and 2003/4. In addition DFID provided additional funds to UNFPA in 2003/4 (£25m) and 2004/5 (£10m) based on an EU request concerning reproductive health commodity security.

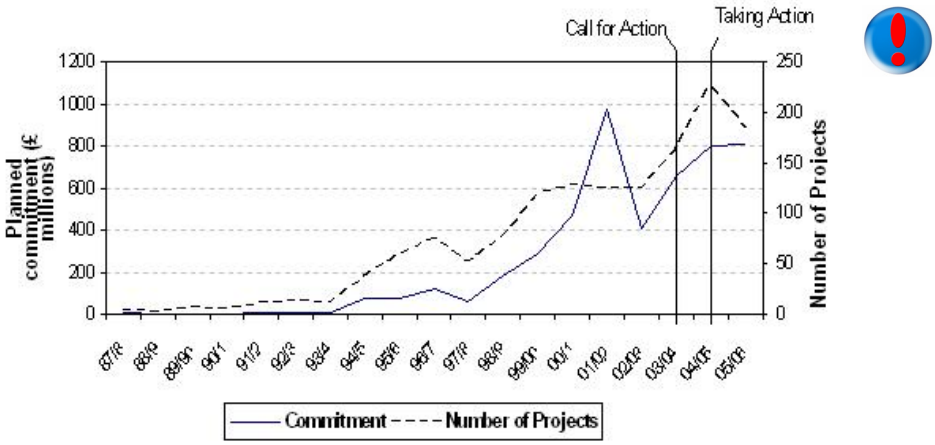
[27] At the time, this was interpreted that the UK had contributed £77m prior to this and would contribute a further similar sum over the next three years (ACTSA, 2004). As the Global Fund operates by calendar years, it can perhaps be assumed that this was referring to 2005-7.

4. DISTRIBUTION OF CURRENT UK-SUPPORTED HIV AND AIDS ACTIVITIES

4.1-4.2 Trends in number of projects/programmes and financial commitment

4.1 The number of HIV-related projects/programmes[28] fulfilling the selection criteria has been rising. Total new commitment per year[29] and average project/programme size has also risen (see Figure 5, below). All financial figures in this working paper exclude budget support[30] meaning that total commitment and spend on HIV and AIDS will in fact be higher than reported here[31]. These trends started well before *Taking Action* was developed but it seems that they have been reinforced since then. We also analysed projects/programmes in three groups on the basis of planned commitment – small (<£1m), medium (£1-10m), large (>£10m)[32]. Figure 6 (p10) presents this analysis. It shows a large increase in financial commitments related to large projects/programmes from 1999/2000.

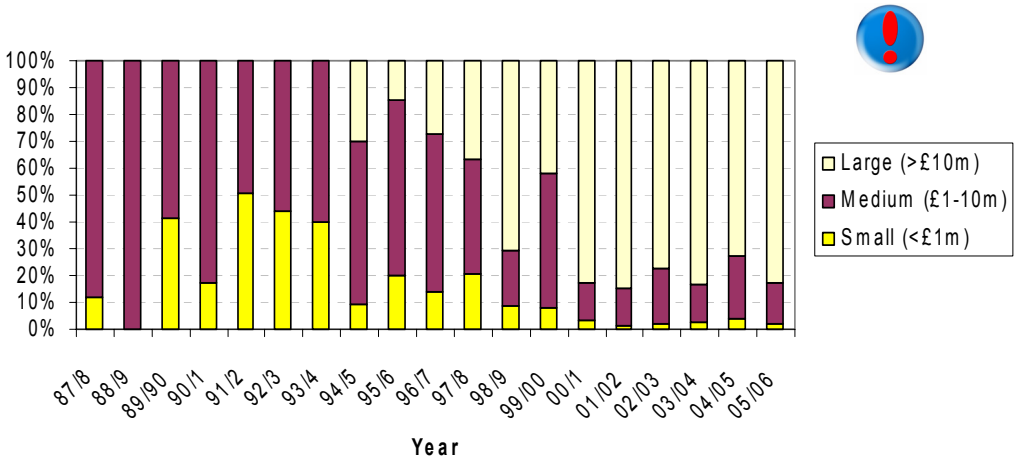
Figure 5: Trends in Number and Size of DFID Projects/Programmes Related to HIV and AIDS: 1987-2006[33]



[28] That is projects/programmes meeting the selection criteria specified in Annex 1 (p53).
[29] That is the total financial commitment made to a project/programme at the time that it starts. This may be for several years and is one reason why figures for this are much higher than the expenditure figures reported earlier in this report – see sections 3.2-3.8.
[30] For example, these figures exclude a planned commitment of £1.38b made to 17 projects/programmes we coded as 'budget support'. This was suggested by the methods working group to make our analysis as comparable as possible to the approach being taken by DFID, described in sections 3.2-3.7 (p4-p6). All these projects/programmes were included in our dataset, i.e. they have a PIMS marker for either HIV/AIDS or reproductive health.
[31] Note that figures for 2005/6 were not yet complete at the time the data was extracted.
[32] For the purpose of this analysis, the 17 "budget support" projects/programmes were included.
[33] The large peak of commitment in 2001/2 occurred because a number of large multi-year projects/programmes were begun 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.

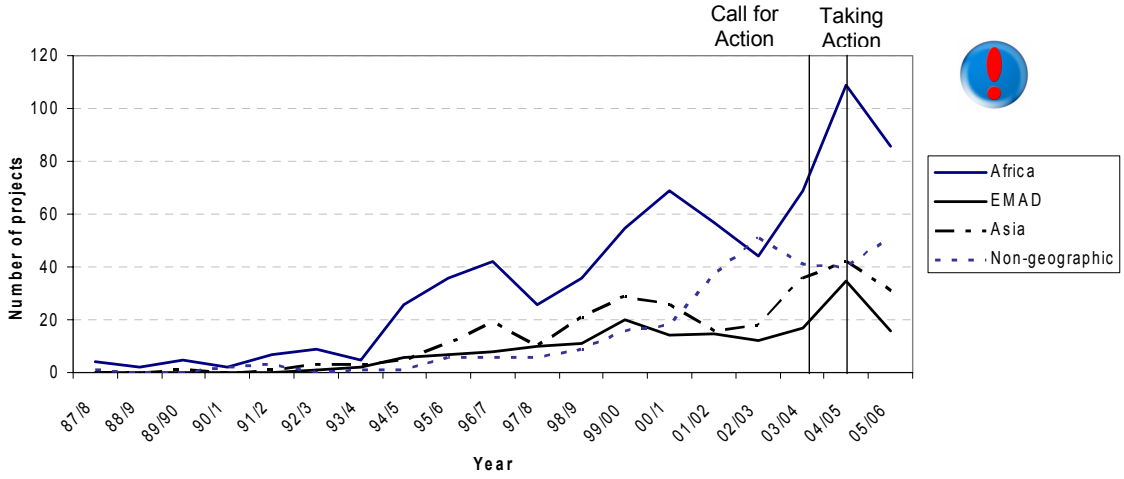
Distribution of Current UK Supported HIV and AIDS Activities

Figure 6: Planned financial commitment to new HIV and AIDS-related projects/programmes of different sizes



4.2 We also conducted a regional analysis of projects/programmes. About half (48%) were in Africa, about one fifth in Asia (19%) and 12% in Europe, Middles East and the Americas (EMAD)[34]. The remaining 20% were non-geographic. Figure 7 shows the regional trend over time with the largest growth being seen in projects/programmes in Africa followed by non-geographic support.

Figure 7: Regional analysis of number of new HIV and AIDS-related projects/programmes 1987-2006

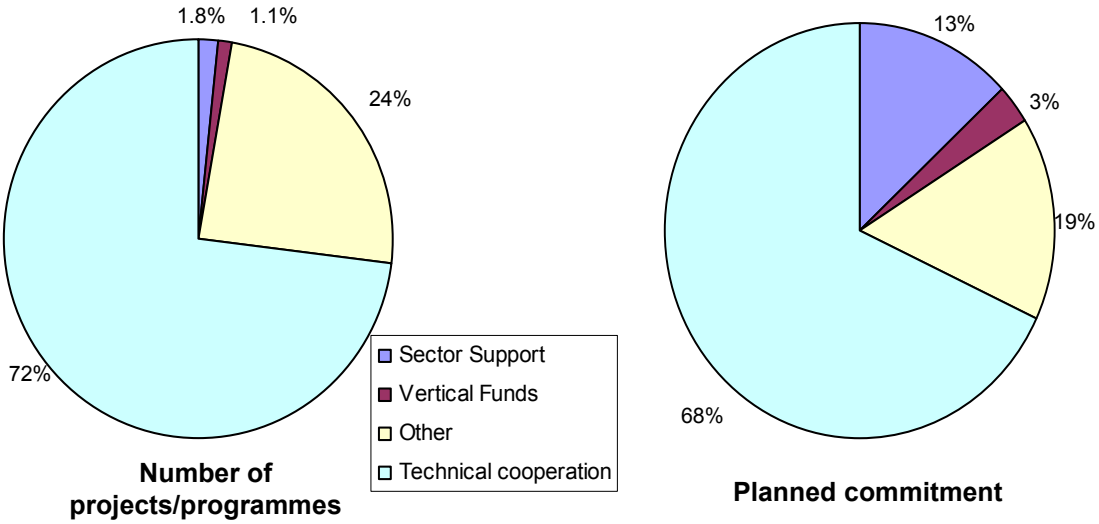


[34] DFID currently operates according to a Public Service Agreement for 2005-8. The 6th target within that is to ensure that the proportion of DFID's bilateral programme going to low-income countries is at least 90% (see DFID, 2005d). This is known within DFID as the '90/10 target' and means that EMAD, 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.

4.3-4.7 Analysis by aid instrument[35]

4.3 Based on our analysis, 72%[36] (1027/1424) of the projects/programmes in our dataset fall into the category of technical cooperation (see Figure 8). This is higher than the figure of 25% for DFID as a whole (DFID, 2006b).

Figure 8: Percentage of HIV and AIDS-related projects/programmes by aid instruments (by number and planned commitment)



4.4 As part of the production of this working paper, DFID's Statistical Reporting and Support Group (SRSG) analysed bilateral expenditure on HIV and AIDS from 1997 to 2005 by aid instrument. This is shown graphically in Figure 9 (p12). Despite the differences in method and period covered (see Annex 1, p53), the figures we obtained (68% for 1987 to 2006) for planned financial commitment for technical cooperation are broadly comparable to expenditure figures supplied by SRSG, i.e. that 44-63% of bilateral expenditure on HIV and AIDS between 1997 to 2005 was spent through technical cooperation.

4.5 The term technical cooperation is applied to all projects/programmes that are not financial aid, i.e. direct government to government financing. Consequently, a wide range of services fall within this category. A rapid review of 200 technical cooperation projects/programmes revealed that

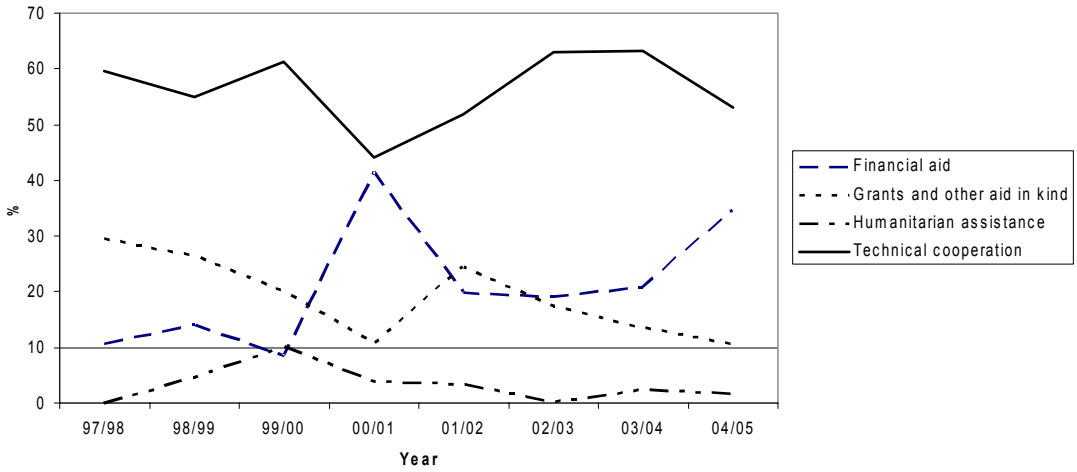
[35] We faced a challenge when trying to analyse our dataset by aid instrument. There is currently no uniformly agreed classification of aid instruments within DFID (Colenso, 2005; DFID 2006b; Foster and Leavy, 2001 – summarised in Annex 7 (p79). Although work is ongoing to try to develop this as part of the work of the Aid Effectiveness Team, there are significant challenges because of the different ways such definitions are used. However, some form of definitions will be needed, not least for annual reporting under the terms of the International Development (Reporting and Transparency) Bill. The way we have defined aid instruments is covered in detail in Annex 1 (p53). We have compared there with how projects might have been classified had we followed the checklist for classification of aid types produced in December 2005 (Colenso, 2005).

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

they contained elements[37] of:

- Service delivery (104) including projects/programmes in the following fields – family planning, reproductive health, TB, general health services and HIV-related activities
- Supply of pharmaceuticals, health products and equipment (27) including contraceptives, condoms, reagents
- Research (21) including surveys, evaluation, 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)
- Infrastructure (3)
- Pilot projects (2)
- Sustainable financing (1)

Figure 9: Figures for DFID bilateral expenditure on HIV and AIDS from 1997-2005 by aid instrument (Source: SRSG)

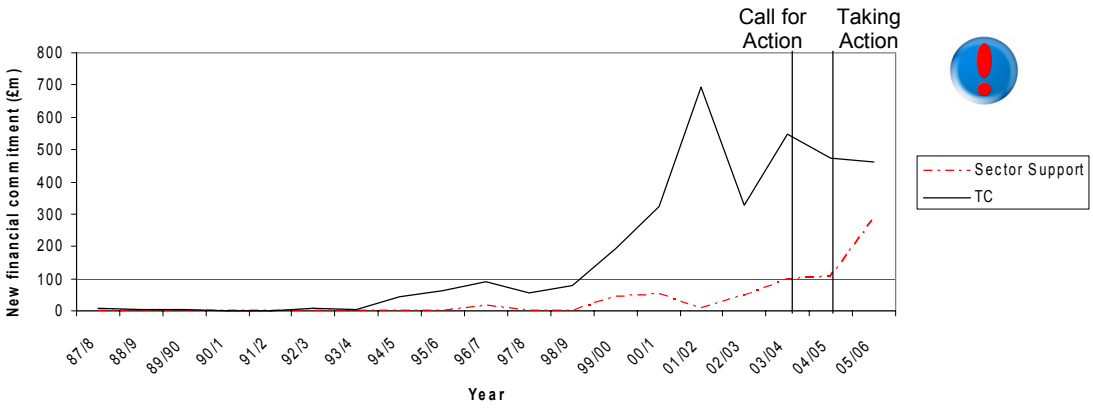


4.6 Of the 28% of projects/programmes not classified as technical cooperation, we classified half as projects[38] with the remainder spread across different categories including sector support[39] (1.7%) and vertical funds[40] (1%). When looking at the projects/programmes by value of commitment, a slightly different picture emerges. Technical cooperation

[37] Each project/programme was classified in as many categories as seemed appropriate.
[38] 'Projects' constitute 14% of our dataset by number but only 1% of total planned commitment. (Please note that the term project is being used here as an aid instrument and refers mainly to small projects funded through NGOs, e.g. Civil Society Challenge Fund (CSCF) – see Annex 1 (p53) and Footnote 8 for more detail).
[39] Mainly health and education.
[40] These are disease-specific funds, including support to National AIDS Commissions (NACs).

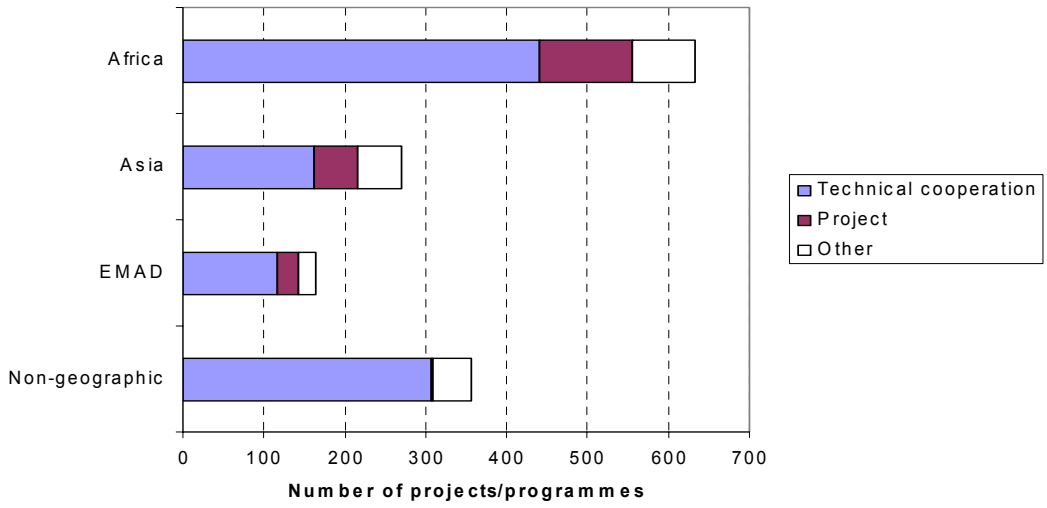
remains the largest category (68%), but sector support (13%) occupies a larger percentage by value. The new financial commitments made through sector support have been rising since 2001/2 while the amount being committed to technical cooperation has remained largely the same (see Figure 10). Although these trends may be apparent over the long-term, there is little discernible change in patterns of expenditure analysed by aid instrument between 2003/4 and 2005/6[41].

Figure 10: New financial commitment to HIV and AIDS-related projects/programmes (£m) by year of start date according to main aid instruments



4.7 We analysed how different aid instruments are used within different regions by DFID (see Figure 11). In all regions technical cooperation is the most commonly used aid instrument for HIV and AIDS 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.

Figure 11: Spread of use of aid instruments across different regions/DFID divisions for HIV and AIDS-related projects/programmes

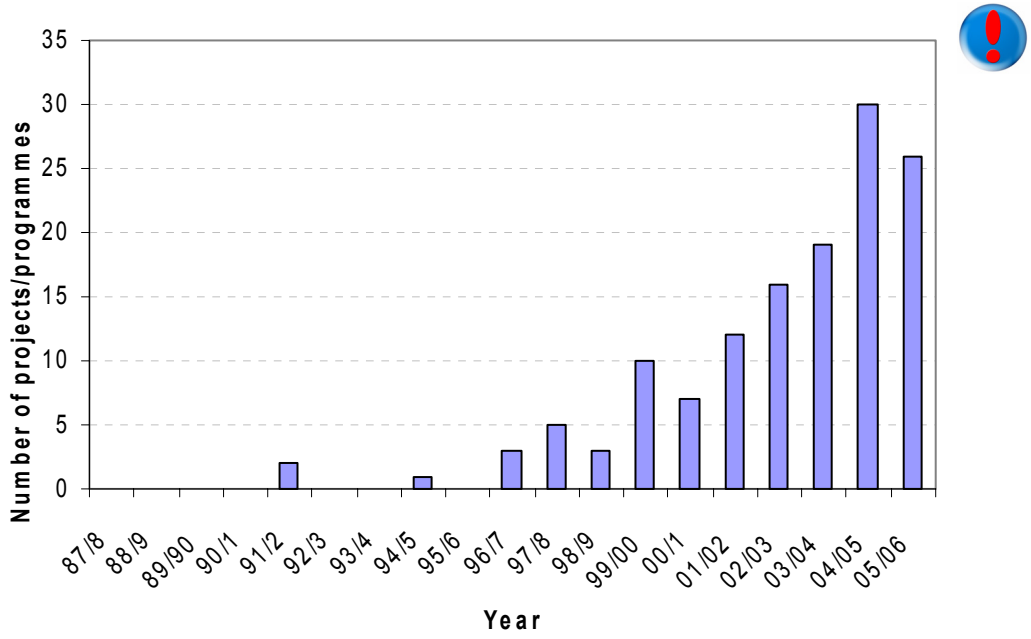


[41] Spending changes as a result of new policy are likely to be seen first in new financial commitments and only later in expenditure figures as much expenditure is occurring on the basis of historic decisions.

4.8 Policy dialogue

4.8 We classified a total of 134 projects/programmes (9%) as having an element of policy dialogue. The number of projects/programmes falling into this category has steadily risen from 1999/2000 (see Figure 12). Of these projects/programmes, 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. In addition, we reviewed a large number of Country Assistance Plans. One of their strengths was the focus placed on promoting national political leadership on HIV and AIDS (see section 6.1, p32). However, the method pursued for this working paper would not capture activities in this area, and this is a significant focus of work for both DFID and the Foreign and Commonwealth Office (FCO). FCO report that they have a focus on political influencing regarding HIV and AIDS both globally[42] and in individual countries. For example, following the UNGASS high-level meeting in June 2006, they will be conducting an informal review of processes within the FCO that contributed to that meeting.

Figure 12: Number of HIV and AIDS-related projects/programmes with an element of policy dialogue by start date



4.9 Pooling funds in country

4.9 One of the aims of the mapping study was to spot countries in which the issue of pooling of funding for the national response to HIV and AIDS is an important issue. This is needed particularly for the country case studies that are planned as part of this evaluation. This was done by identifying countries in three categories – those with a project/programme in the dataset characterised as budget support; those with a project/programme in the dataset characterised as sector support;

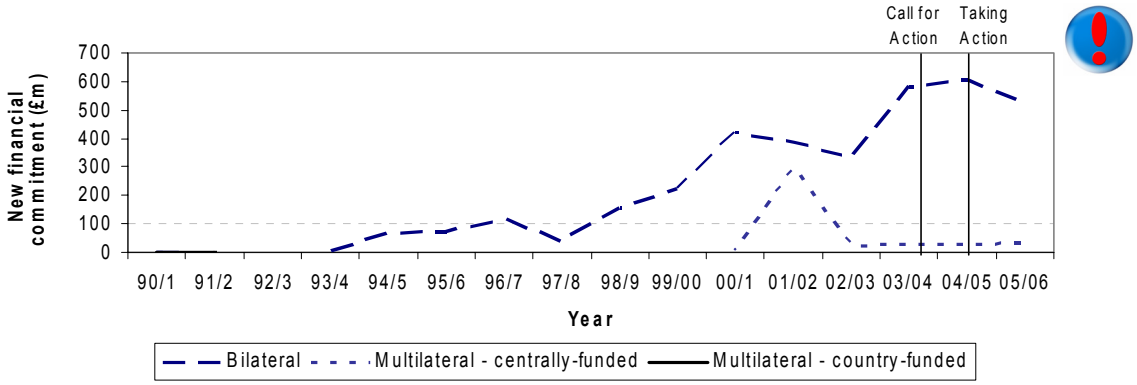
[42] For example, through the UK mission to the United Nations.

and those who identified donor coordination on HIV and AIDS as an issue in their CAP. Results are presented in Annex 9 (p84). Proposed case study countries[43] are highlighted in that Annex in yellow[44].

4.10 Bilateral or multilateral

4.10 When analysing whether a project/programme was bilateral or multilateral, we also identified in-country projects/programmes being managed by the multilaterals and a number of other projects/programmes[45] (see Annex 1 for detailed method). We classified 65% as bilateral, 20% as other, 8% as multilateral (centrally-funded) and 7% as multilateral (country-funded). There has been a steady increase of projects/programmes of all types. However, the spread has changed with less dominance of bilateral HIV and AIDS related projects/programmes than compared with the mid-90s. When looking at financial values of projects/programmes[46], the most striking trend is the increased finances being committed through multilateral agencies at country level. Again this trend is clearer when looking at new commitments (see Figure 13). A rapid analysis of these 104 projects/programmes shows that most are being managed by WHO (27), UNAIDS (15), UNICEF (15) and UNFPA (9). These projects/programmes are seen across each of DFID's three regional divisions, Africa, Asia and EMAD[47].

Figure 13: Planned commitments to HIV and AIDS-related projects/programmes by start date analysed by bilateral/multilateral (£millions)



4.11-4.12 Partner organisations

4.11 Analysis of partners (see Annex 1 for method, p53) showed a wide spread of organisations managing projects/programmes with DFID support. The most common three[48] were international NGOs[49] (INGOs) (29% of projects) (see Figure 14, p16), Ministries of Health (MOH) (15%) and UN agencies (12%). When analysed by financial commitment, the

[43] Five of seven are included (exceptions are Russia and Zimbabwe).
[44] Appears shaded when printed in black and white.
[45] Largely regional initiatives.
[46] With 17 budget support projects/programmes excluded.
[47] In roughly equal proportions across the three divisions.
[48] By number of projects.
[49] This includes particularly INGOS with strong links with the UK, including 'British NGOs'.

largest recipients are MOH (33%) and INGOs (14%). 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 Commissions (see Figure 15).

Figure 14: Trends in number of HIV and AIDS-related projects/programmes for top three partners

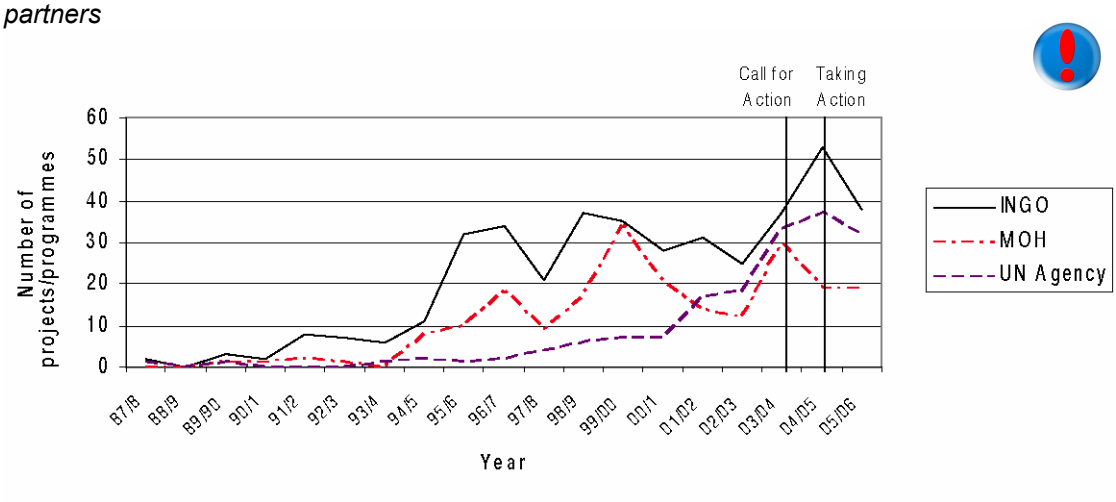
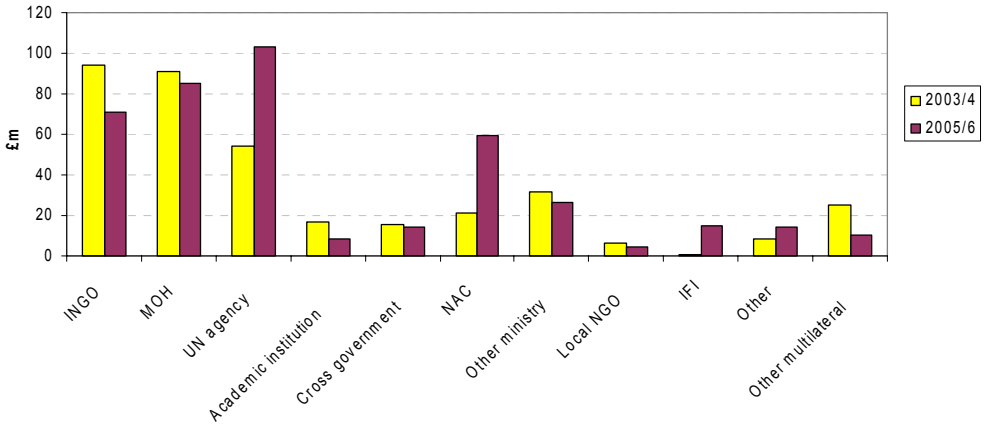


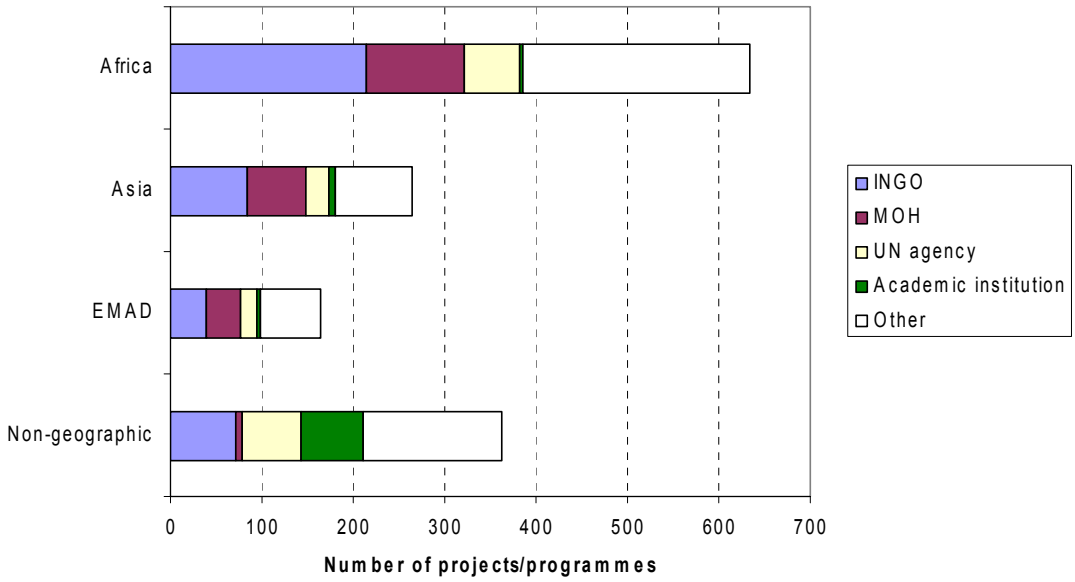
Figure 15: Comparison of expenditure on HIV and AIDS-related projects/programmes among partner types in 2003/4 and 2005/6



4.12 We analysed the spread of partner organisations across different regions supported by DFID (see Figure 16, p17). In all of them[50], the most common partners were INGOs, MOH and UN agencies respectively. For non-geographic projects/programmes, the three most common partners were INGOs, academic institutions and UN agencies respectively.

[50] Africa, Asia and EMAD.

Figure 16: Spread of types of partners across different regions/DFID divisions for HIV and AIDS related projects/programmes



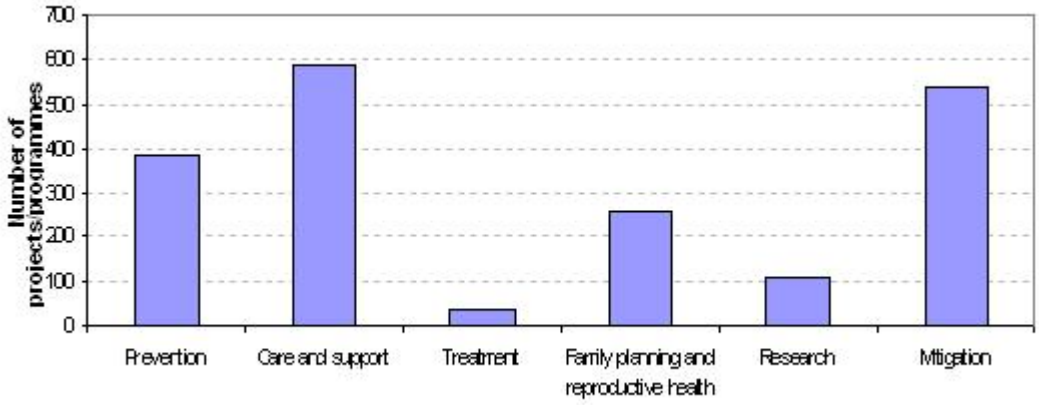
4.13-4.16 Focus of work on HIV and AIDS[51]

4.13 Based on the method described in Annex 1 (p53), we recorded that 588 (41%) of the projects/programmes[52] 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[53] and 37 (3%) on treatment[54] (see Figure 17, p18)[55]. The number of projects/programmes with a focus on care/support and impact mitigation has risen, while the number of projects/programmes on FP/RH has declined. There are relatively few projects/programmes for either research or treatment.

[51] Despite requests for this information, 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 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).
[52] All projects/programmes were classified to one category or the other.
[53] This represents 109/1424 projects/programmes from 1987-2006.
[54] This is made up of 37 projects/programmes which specifically mention treatment in the project/programme 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 title or purpose.
[55] These figures do not add up to 100% as a project/programme could be classified to more than one category.

Distribution of Current UK Supported HIV and AIDS Activities

Figure 17: Number of HIV and AIDS-related projects/programmes which include a particular focus



4.14 As noted in the methods section (see Annex 1, p53), we faced considerable difficulties in analysing this field due to the way DFID funds HIV and AIDS activities, the absence of an agreed method for doing this and the absence of available information from PRISM. Following the circulation of the draft working paper, concerns were raised about this data field from individual DFID staff members, and at meetings of the steering group and the methods group. These concerns included:

- The view that DFID should not be seeking to analyse this kind of information because it runs contrary to the way in which DFID funds activities and its principles of trying to promote an integrated, harmonised approach to responding to HIV and AIDS
- Problems with the methods being used, for example, an activity funded through sectoral support would be classified as care and support but would be classified as mitigation if funded through budget support
- Problems when seeking to allocate financial amounts to particular fields because there is currently no way of allocating part of funding of a project/programme to a particular focus, i.e. it is 'all or nothing'

4.15 Based on this feedback, an alternative approach was tried, which only identified projects/programmes with a specific focus on HIV prevention, care and support for people affected by HIV and AIDS and/or AIDS treatment. These were identified from a sub-set of 376 projects/programmes, which had previously been identified as 'AIDS-specific' (see section 4.22-4.26). Of these, 120 (32%) were judged to be focused on HIV prevention and 23 (6.1%) on care and support[56]. The majority (233 – 62%) were either general/integrated activities or did not specify. Of these 376 projects/programmes, a total of 20 (5.3%) refer specifically to treatment for AIDS.

4.16 Based on figures supplied by DFID's Central Research Department (CRD, 2006), there were 16 health and education research projects/programmes with expenditure related to HIV and AIDS in

[56] Including home-based care, activities for PLWHA and palliative care.

2005/6[57]. These were reported to have an expenditure of just over £20m in 2005/6[58]. There are plans to further expand these activities including commissioning two AIDS-specific research programme consortia.

4.17-4.18 Building monitoring and evaluation (M&E) capacity

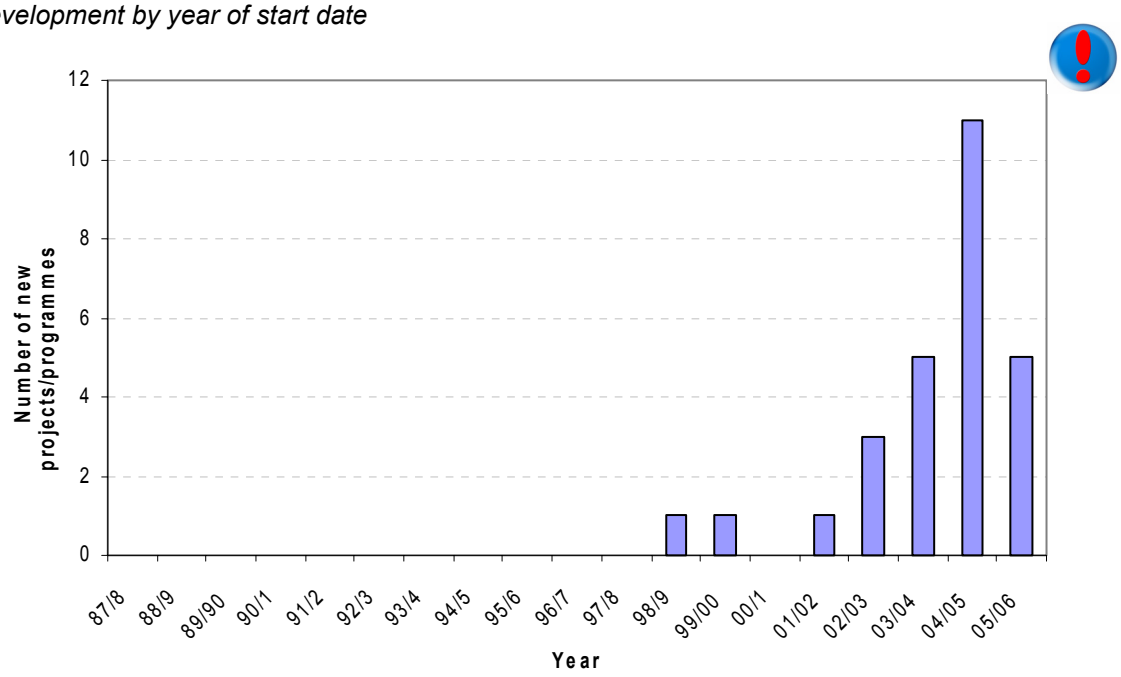
4.17 The capacity to effectively monitor and evaluate a national response to HIV and AIDS is an essential element of a country's response to the epidemic. Having one national M&E system for HIV and AIDS is part of UNAIDS' Three Ones strategy. We identified 28 projects/programmes, which had a focus on building M&E capacity (see Annex 8, p81).[59] These mostly date from 2003/4 (see Figure 18, p20). 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[60], 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[61], which includes support to WHO and Health Metrics Network; monitoring of epidemic disease in Somalia; conducting a Demographic Health Survey (DHS) in Zimbabwe; health monitoring in Bangladesh; monitoring health systems performance and the work of the health systems resource centre
- HIV and AIDS monitoring[62], which includes particularly support to UNAIDS both internationally and in a number of countries including Angola, Ethiopia, Somalia, Sudan, Democratic Republic of Congo (DRC), Ukraine and Russia

[57] This is lower than the number of research projects/programmes classified by us as focused on research with expenditure in 2005/6 (35). This is probably because our dataset was not limited to health and education research. Comparison of the datasets shows that of the 16 projects/programmes in the CRD dataset, 12 are also in ours, 1 is not and in the case of 3 it is not possible to be sure as MIS codes were not included in the CRD spreadsheet.
[58] This includes large grants to research into vaccines (£8m) and microbicides (two grants totalling £7.1m). In the case of 4 projects/programmes, only a proportion of the funding has been counted as relevant to HIV. If all funding was included, this would raise the figure by a further £3.44m.
[59] 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.
[60] 22% by number; 27% by commitment.
[61] 30% by number; 32% by commitment.
[62] 47% by number; 41% by commitment.

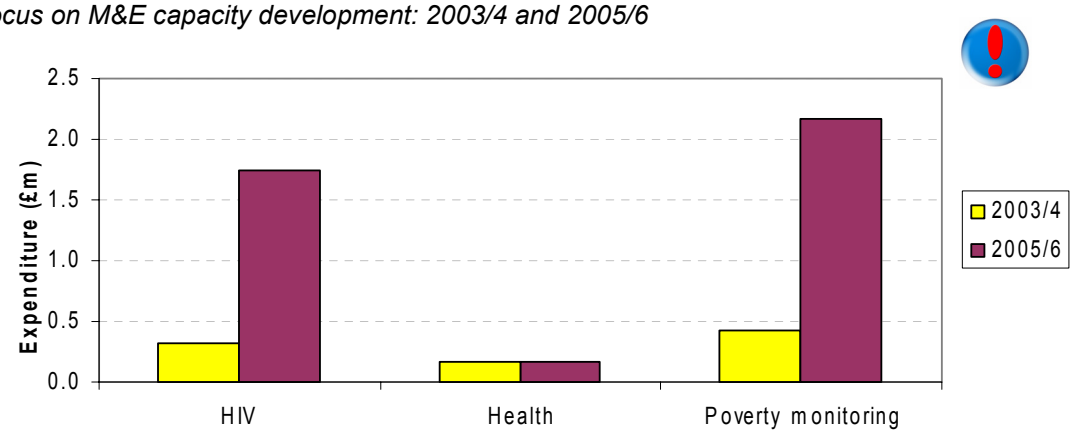
Distribution of Current UK Supported HIV and AIDS Activities

Figure 18: Number of HIV and AIDS-related projects/programmes with focus on M&E capacity development by year of start date



4.18 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 has been to date more than four times that of 2003/4. This change was particularly seen in the areas of HIV/AIDS and poverty monitoring (see Figure 19). Nevertheless, spending on monitoring and evaluation remains low. For example, this working paper finds that in 2005/6[63] spending on building monitoring and evaluation capacity accounted for only just over £4m, which is less than 1% of targeted UK expenditure for HIV and AIDS in 2005/6.

Figure 19: Comparison of expenditure on HIV and AIDS-related projects/programmes with focus on M&E capacity development: 2003/4 and 2005/6



[63] To February.

4.19-4.21 Vulnerable populations

4.19 *Taking Action* has a particular focus on women, young people, OVC and other vulnerable groups. This evaluation will devote the second of three working papers to these groups. As part of this mapping exercise, we identified[64] projects/programmes with a particular focus on women (329), young people (109), OVC (178) and other vulnerable groups (175). We identified 805 projects/programmes, which had no identifiable focus on any vulnerable group. Analysis of number of projects/programmes and size of financial commitment shows that there has been an increase in both in relation to other vulnerable groups. This can also be seen when looking at expenditure in 2003/4 and 2005/6. There were increased amounts spent on young people, OVC and other vulnerable groups, but the amount spent on projects/programmes marked as relevant to women was reduced (see Figure 20, p22).

4.20 PRISM also contains markers for gender. We examined how these had been used in the projects/programmes within our dataset. In total, 333 of the projects/programmes have gender markers (301 'S' and 32 'P'[9]). Although this total is similar to the number we classified as relevant to women (329), there is little overlap between the two groups. Only 86 projects/programmes were classified by us as relevant to women and have a gender marker. We carried out a preliminary assessment of the reasons for this difference by examining the types of projects/ programmes assigned a gender marker and those classified by us as related to women[65]. There are a very wide variety of projects/ programmes with a gender marker. Health projects/ programmes, in general, and reproductive health projects/programmes, in particular, seemed more likely to be classified by us as relevant to women than to receive a gender marker. The number of projects/programmes with a gender marker has been steadily rising (see Figure 21, p22).

[64] See Annex 1 (p53) for detailed method.

[65] This was conducted by a different team member from the lead author. One of the possibilities considered was that the lead author had 'missed' some projects/programmes which should have been included as relevant to women. Although this was the case in about 10 projects/programmes, this would make little material difference to the degree of overlap between these two approaches.

Figure 20: Comparison of expenditure on HIV and AIDS-related projects/programmes with a focus on vulnerable groups in 2003/4 and 2005/6

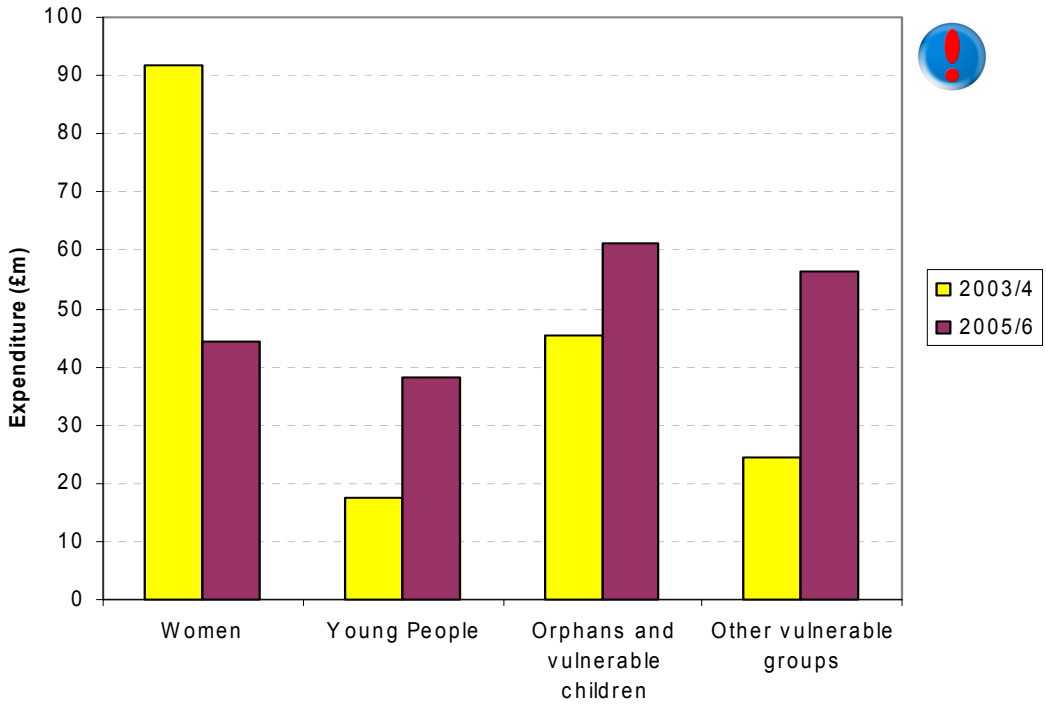
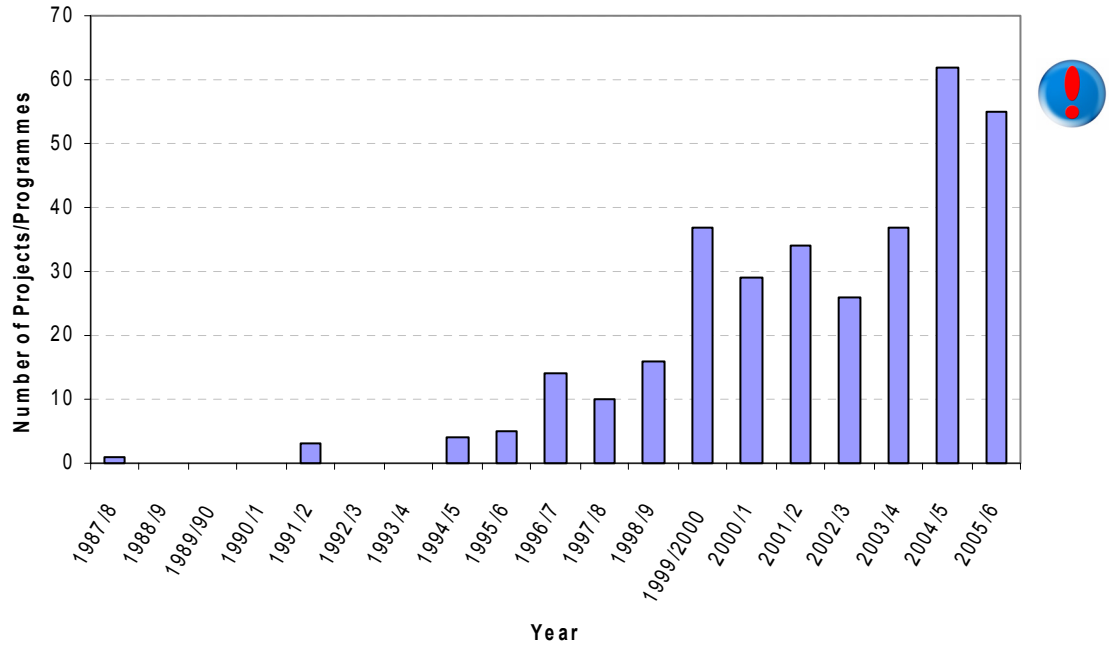
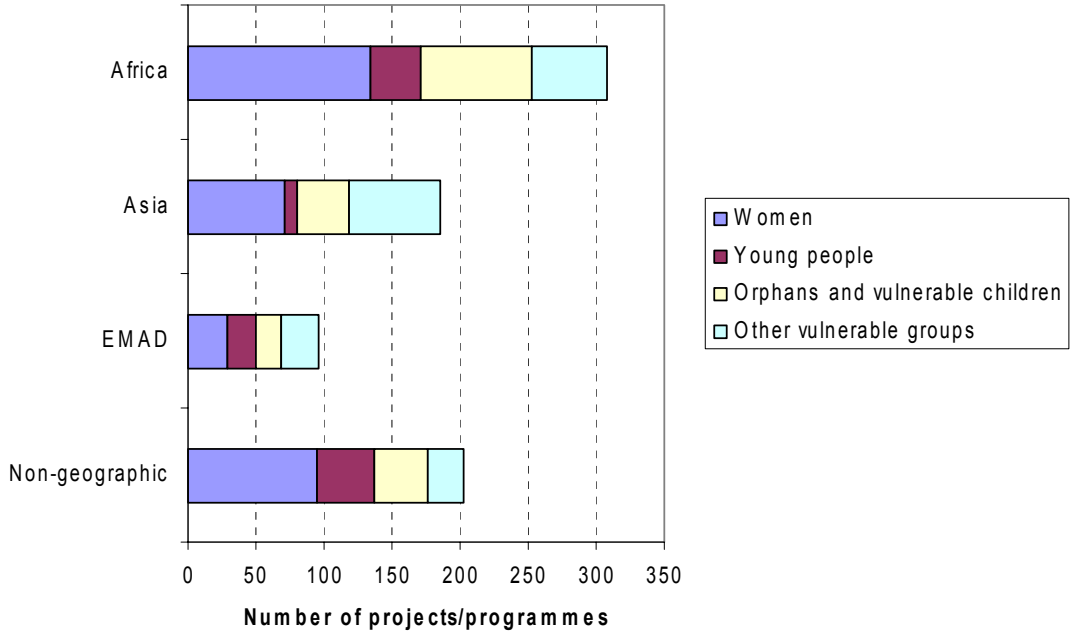


Figure 21: Number of HIV and AIDS-related projects/programmes in the dataset with a gender marker in the Policy Information Marker System (PIMS)



4.21 We also examined how projects/programmes focused on particular vulnerable groups were spread across regions. From our data, it appears that projects/programmes focused on women are strongly represented in all regions. Projects/programmes focused on orphans and vulnerable children are particularly strongly represented in Africa and projects/programmes focused on other vulnerable groups in Asia (see Figure 22, p23).

Figure 22: Spread of focus on particular vulnerable groups across different regions/DFID divisions for HIV/AIDS-related projects/programmes[66]



4.22-4.26 Projects/programmes that are AIDS-specific compared to those that are part of a broader enabling action

4.22 We faced a challenge when seeking to classify projects/programmes into whether they were AIDS-specific or part of a broader enabling action because we did not have clear definitions of these various categories. We divided projects/programmes into four[67] categories based on criteria presented in Annex 1 (p53) – AIDS-specific, sexual and reproductive health activities, health activities and broader enabling actions. We identified 396 projects/programmes (28%) that met our criteria for 'enabling actions'. We then tried to split these into sub-categories based on five categories identified from the literature (International HIV/AIDS Alliance, 2004). These categories are:

- Policy actions[68]
- Resource mobilisation
- Actions to tackle stigma and discrimination, including a focus on human rights, particularly of vulnerable populations
- Organisational development of structures, both governmental and in civil society
- Mainstreaming HIV and AIDS into other development activities (see Figure 23, p24)

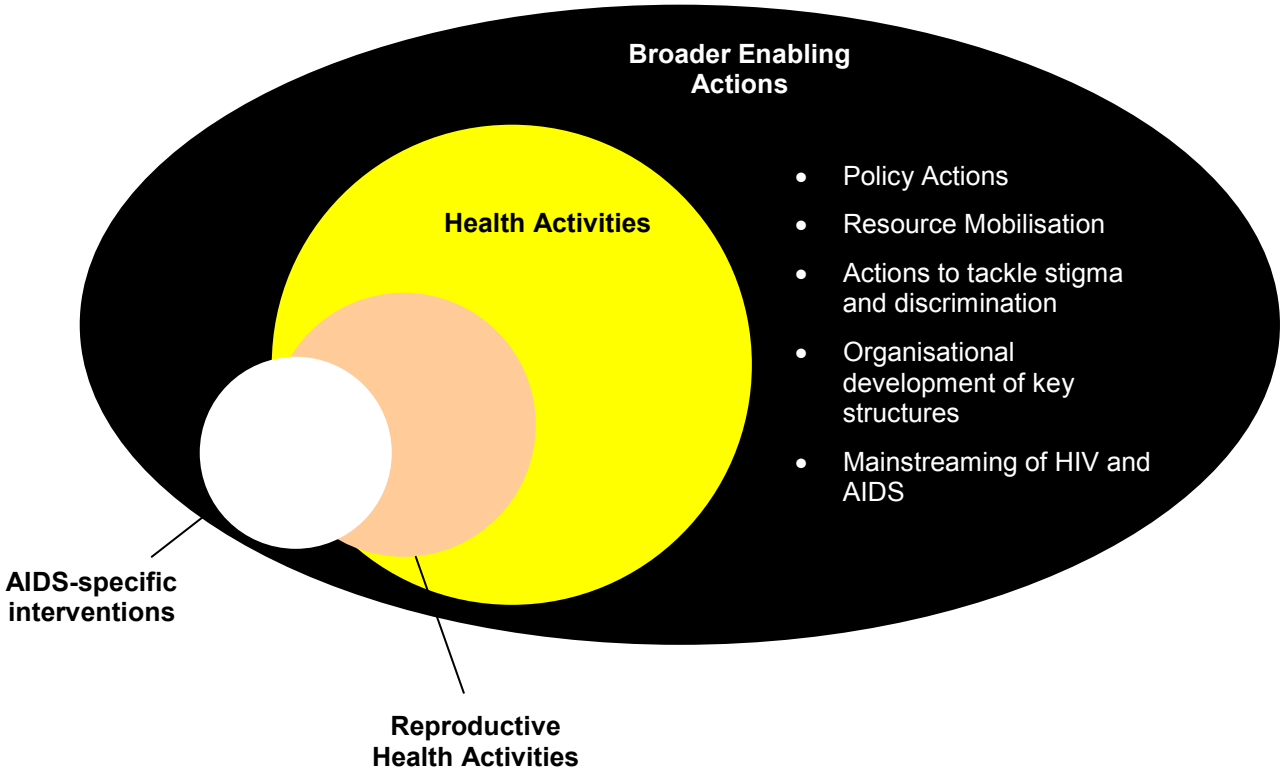
[66] Excludes 805 projects/programmes with no specific focus on any particular vulnerable group.
[67] Initially, we had five categories but we merged AIDS-specific (partial) with AIDS-specific (total) as we had only 18 projects/programmes in the former category. These are listed in Annex 13, p93.
[68] Includes enacting existing policies, filling policy gaps, and reforming obsolete or restrictive policies.

Distribution of Current UK Supported HIV and AIDS Activities

4.23 We conducted a rapid assessment of 50 projects/programmes[69] in our 'enabling action' category. Of these, we identified 1 as focused on policies, 0 on resource mobilization, 6 on stigma and discrimination, 1 on organisational development and 41 on mainstreaming HIV into development.

4.24 In addition, PRISM has a Poverty Aim Marker (PAM) called 'enabling action'. Our dataset contains 415 occurrences of this marker (29%). We analysed the degree of overlap between our definition of an enabling action and the PAM marker. 205 projects/programmes had both, 210 had the PAM marker but were not classified by us as an enabling action and 192 were classified as an enabling action by us but did not have a PAM marker[70].

Figure 23: Narrow and broad approaches to responding to HIV and AIDS



4.25 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%) (see Figure 24, p25). However, when analysed by new financial commitment, more funds are allocated to enabling actions (46%) and less to AIDS-specific (19%) and sexual and reproductive health (8%). The number of projects/ programmes has risen in all categories since the late 90s, apart from

[69] The first 50 in our list of these projects/programmes.
[70] This issue was discussed at the Methods Working Group meeting in April 2006. As the PAM marker for enabling action is focused on enabling actions relating to poverty, in general, and not HIV and AIDS in particular, it is not perhaps surprising that there is limited overlap between these two approaches.

sexual and reproductive health, where the numbers have reduced. A similar picture is seen for financial commitments with an even more striking increase in relation to enabling actions. 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 25).

Figure 24: Distribution of HIV and AIDS-related projects/programmes regarding how AIDS-specific they are: 1987-2006

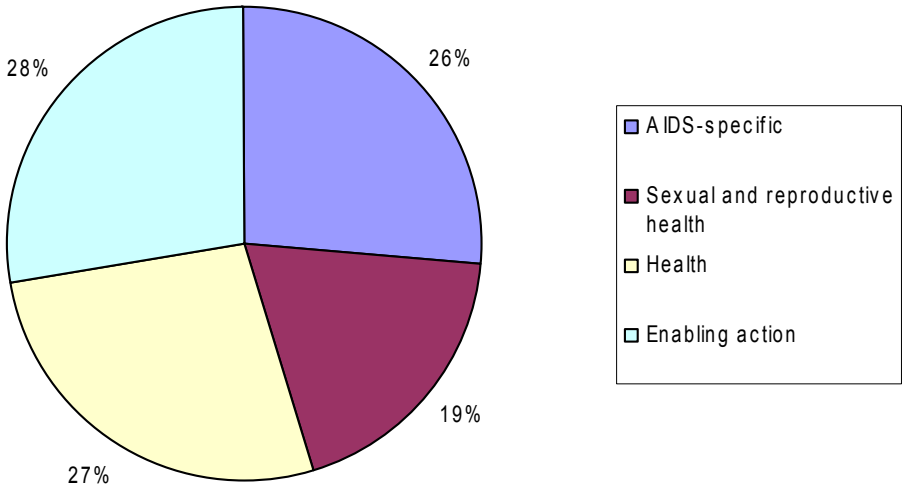
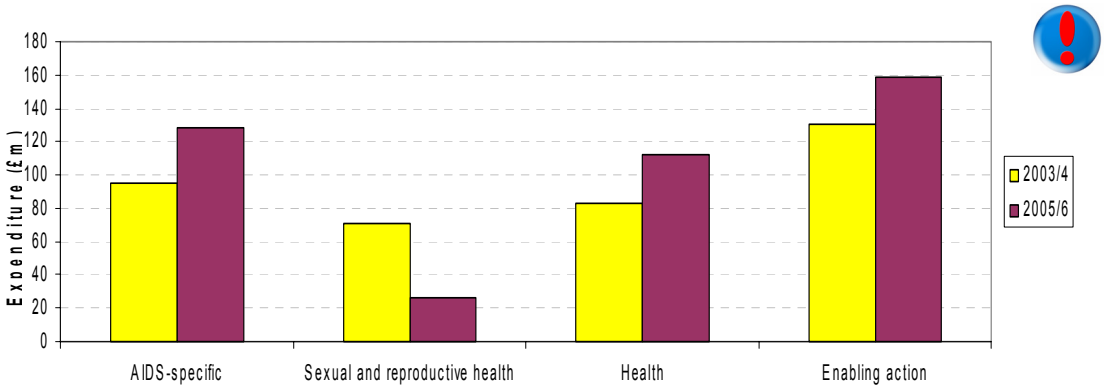


Figure 25: HIV and AIDS-related project/programme expenditure in 2003/4 and 2005/6 analysed according to how AIDS-specific the projects/programmes are

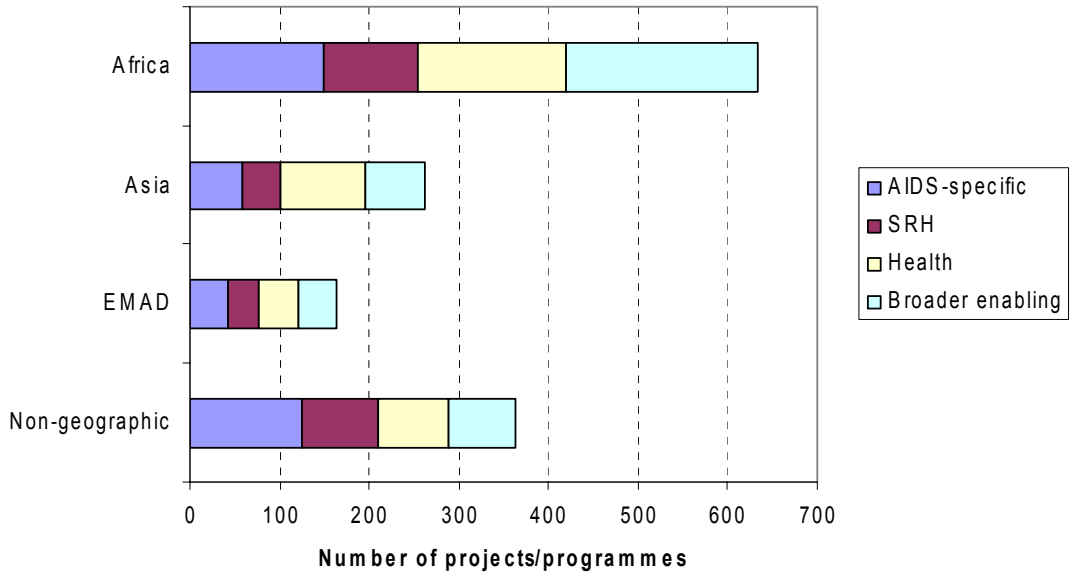


4.26 We examined how these different types of projects/programmes were spread across regions. The distribution was as follows:

- Africa – broader enabling (34%), health (26%), AIDS-specific (24%) and sexual and reproductive health (17%)
- Asia – health (36%), broader enabling (25%), AIDS-specific (22%) and sexual and reproductive health (16%)
- EMAD – health (27%), AIDS-specific (26%), broader enabling (26%), sexual and reproductive health (21%)

- Non-geographic – AIDS-specific (35%), sexual and reproductive health (23%), health (22%) and broader enabling action (20%) (see Figure 26)

Figure 26: Spread of AIDS-specificity of HIV and AIDS-related projects/programmes across different regions/DFID divisions



4.27-4.28 Country by country analysis

4.27 Finally, information has been collected for each country represented in the dataset (see Annex 14, p95). Information collected included:

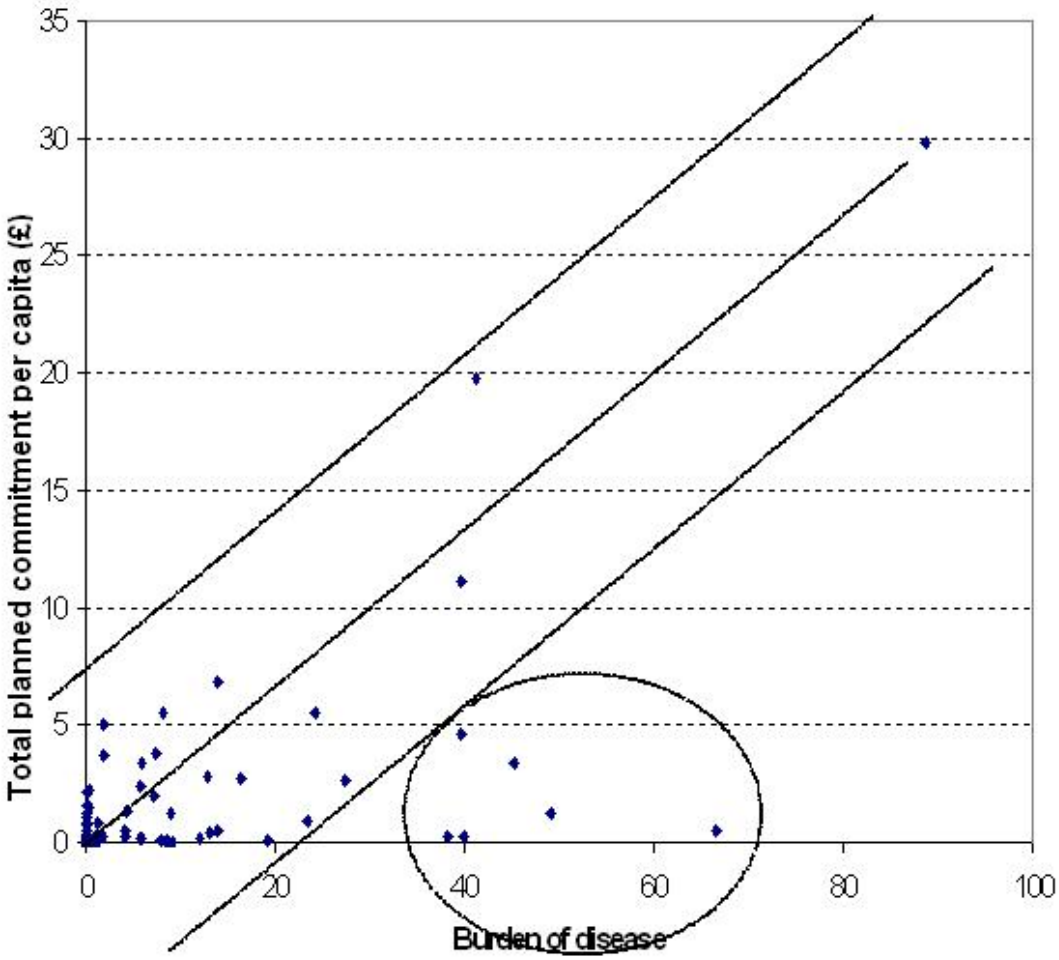
- Number of projects/programmes in the dataset
- Number of new projects/programmes in 2005/6
- Total planned financial commitment[71]
- Project/programme expenditure in 2005/6[72]
- Population[73]
- Adult HIV prevalence[74]
- Gross National Income (GNI) per capita[75]
- Burden of disease and composite index[76]

4.28 We generated a number of graphs and maps analysing information about our dataset against parameters, such as burden of disease and composite index (see Figures 27-28, p27-p28). Findings from these graphs include:

[71] Excluding PRBS.
[72] To date that data was extracted, i.e. February 2006.
[73] This information was mostly taken from WHO or UNAIDS website. It allowed comparison of commitment and expenditure between countries on a per capita basis.
[74] From UNAIDS website.
[75] From the World Bank website.
[76] These are both calculated using methods that have been used by the Global Fund for prioritizing its own resource allocations. More details are provided in Annex 14 (p95).

- Some countries have a lower total planned bilateral commitment per capita than might be expected given their burden of disease. These include Burundi, DRC, Ethiopia, Lesotho, Liberia and Mozambique (see Figure 27)
- For countries with the highest composite index[77] (8), there was a wide variation in bilateral expenditure on HIV and AIDS. The highest countries were Zambia, Malawi, Zimbabwe, Ghana and Uganda. The lowest were Burkina Faso, Cameroon, Chad, Congo, Cote d'Ivoire, The Gambia, and Guiana (see Figure 28, p28)

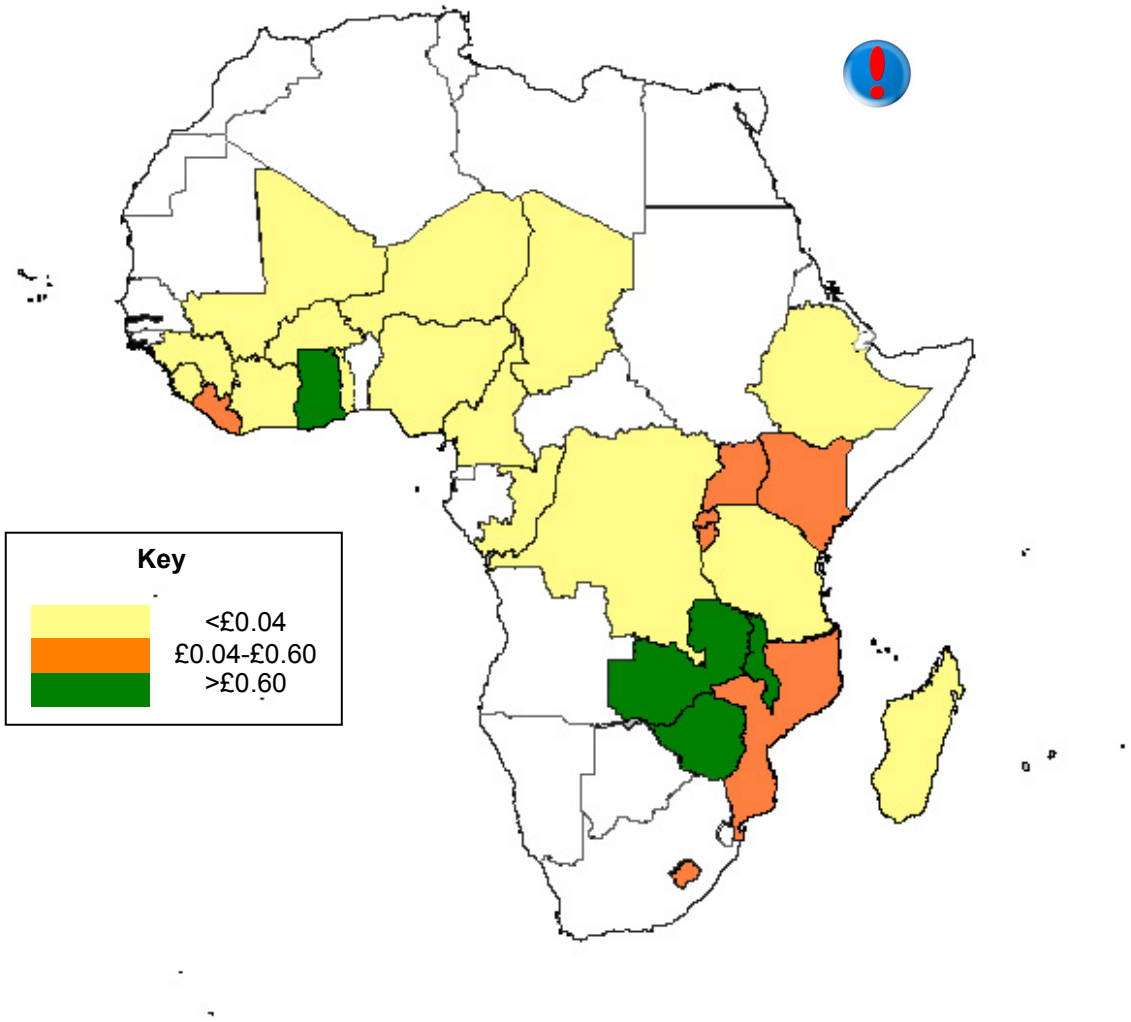
Figure 27: Total planned bilateral commitment for HIV and AIDS per capita per country compared with burden of disease



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

Distribution of Current UK Supported HIV and AIDS Activities

Figure 28: DFID bilateral expenditure[78] (05/06) per capita on HIV and AIDS in poorest countries of Africa with highest disease burden[79]



[78] Excluding through poverty reduction budget support and centrally-funded commitments through multilaterals and the Global Fund.
[79] All the countries highlighted get the maximum score of 8 for the burden of disease and composite indices used by the Global Fund[227]. Countries not shown either have no data available or have a score <8 (see Annex 14, p95).

5. THE INTERNATIONAL CONTEXT[80]

5.1 Table 1 (and Figure 29, p30) shows that the UK is the second largest funder of the international response to HIV and AIDS after the United States. However, because of differences in the way donor countries provide and track funding to work on HIV and AIDS, these figures are not truly comparable. The main difference is whether countries include only activities specific to HIV and AIDS or also broader activities[187]. Counting only activities specific to HIV and AIDS significantly reduces the apparent funding of countries, like the UK, who finance HIV and AIDS activities as part of broader mechanisms, such as sectoral support and poverty reduction budget support.

Table 1: International Context of Spending[81] on HIV and AIDS (US$ millions[82])

Country	2000	2001			
UK	117.4	106.1	77.4	408	596.1
Australia	32.3	26.4	10.7	39	N/A
Canada	43.8	36.6	50.9	93.8	189.2
France	22.2	19.3	22.4	36.3	138.7
Germany	16.8	29.0	32.0	133.7	124.4
Ireland	0.3	4.3	25.6	44.9	N/A
Japan	15.6	17.2	13.3	95	146.7
Netherlands	33.1	48.7	78.9	82	N/A
Norway	26.5	44.8	16.1	50.8	N/A
United States	329.3	582.7	787.8	838.3	1630.1
EC	28.6	24.0	55.2	93.2	277.2

5.2 The ways countries finance the international HIV and AIDS response need to be considered when seeking to track global resource flows. Yet, reports of spending largely overlook the aid instrument used. UNAIDS (UNAIDS, 2004) does distinguish between bilateral and multilateral funds. A recent report (Kates, 2005) breaks funds down into grants, loans, commodities and technical cooperation. It also analyses the split between bilateral funds and Global Fund contribution for a selected number of donors (see Figure 30, p30). In 2004:

- US funding to the Global Fund ($275m) made up 17% of its total HIV and AIDS financing
- France provided more than 80% of its total HIV and AIDS financing through the Global Fund
- UK financing to the Global Fund constituted only 6% of its total HIV and AIDS financing

[80] The terms of reference for this evaluation require the production of a table of UK expenditure on HIV and AIDS by aid instrument that is set in the international context. We encountered considerable difficulties in doing this (see Annex 1, p67).
[81] Commitments unless otherwise noted.
[82] Please note that these figures are in US$ not £.
[83] Figures for 2000-2002 from OECD/UNAIDS, 2004.
[84] From UNAIDS, 2003 – this report also compares disbursements and budget – UK was only country where projected disbursements were higher than budgeted.
[85] From Kates, 2005.

Figure 29: International context of spending on HIV and AIDS[86]

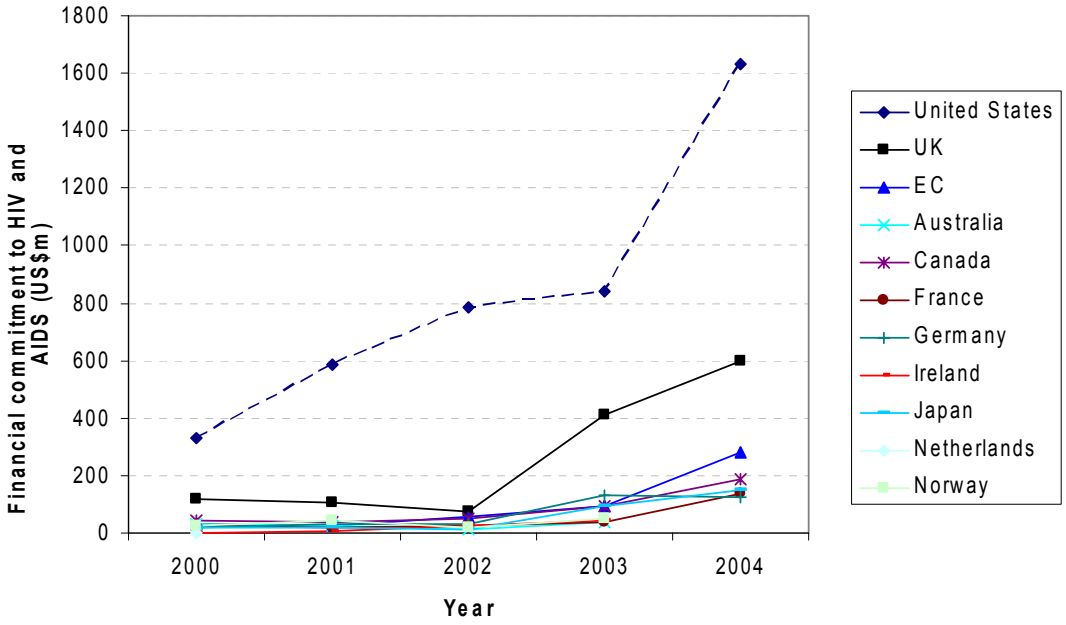
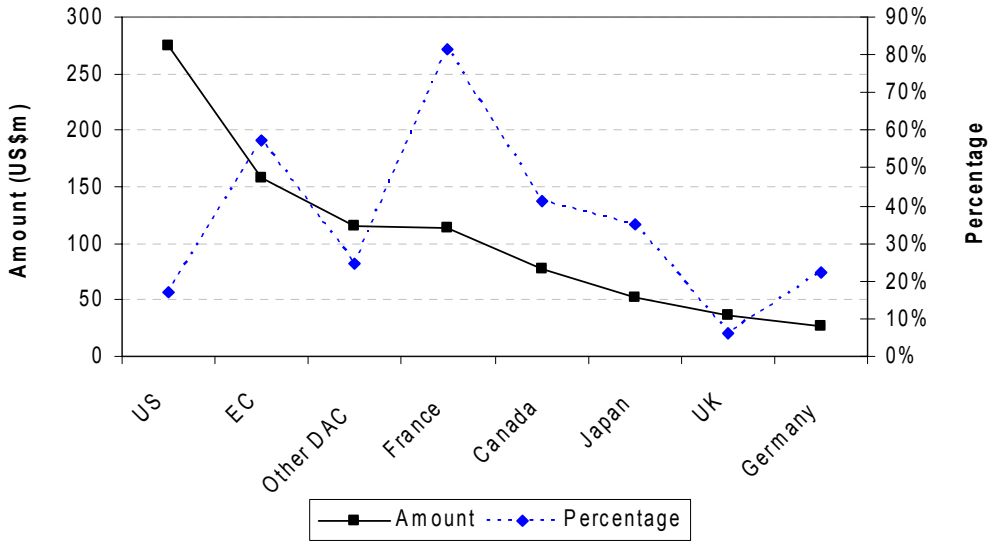


Figure 30: Amount and percentage of selected countries HIV and AIDS funding distributed through the Global Fund in 2004 (figures from Kates, 2005)



5.3 Another author (Lule, 2004) analysed different countries' allocations[87] to population assistance as to whether or not it was delivered through bilateral aid, multilateral aid or NGOs. The UK had the third highest proportion of bilateral aid (>60%)[88] for population assistance. Other countries used other mechanisms proportionately more, e.g. support to

[86] Based on data in table 1, p29.
[87] 2002 figures.
[88] Behind the EU (>90%) and Germany (70%).

NGOs (USA, France, Spain[89]) and support to multilateral agencies (e.g. Finland, Norway, Sweden, Denmark, Ireland[90]).

5.4 A number of countries/agencies have recently reviewed their activities[91] on HIV and AIDS. These included Irish Aid (Scott, 2005), World Bank (Ainsworth et al., 2005),and SIDA (Vogel et al., 2005).

5.5 Knowing the extent of finances available globally to respond to HIV and AIDS, and the contribution of individual donors, may be of some value. However, it is more important to know what finances are available in each country and how funds from a particular donor fit into that picture. Unfortunately, to date, this information has been largely absent. Now that clear guidance is available to measure this[92] (UNAIDS, 2005) the situation should improve. This year's high level meeting to review progress five years after the UN General Assembly Special Session (UNGASS) on AIDS provides an opportunity to review this.

[89] Based on figures in Lule, 2004 these three countries all put more than 60% of their population assistance in 2002 through NGOs as compared to just over 10% in the case of the UK.

[90] Based on figures in Lule, 2004 these countries all put more than 40% of their population assistance through multilateral channels, and this was more than 70% in the case of Finland. This compares with a figure of around 20% for the UK.

[91] In the case of SIDA, it was specifically a review of progress against their strategy.

[92] Through either national AIDS accounts as part of national health accounts or as a stand-alone process. To date, most experience with national AIDS accounts has been in Latin America and the Caribbean.

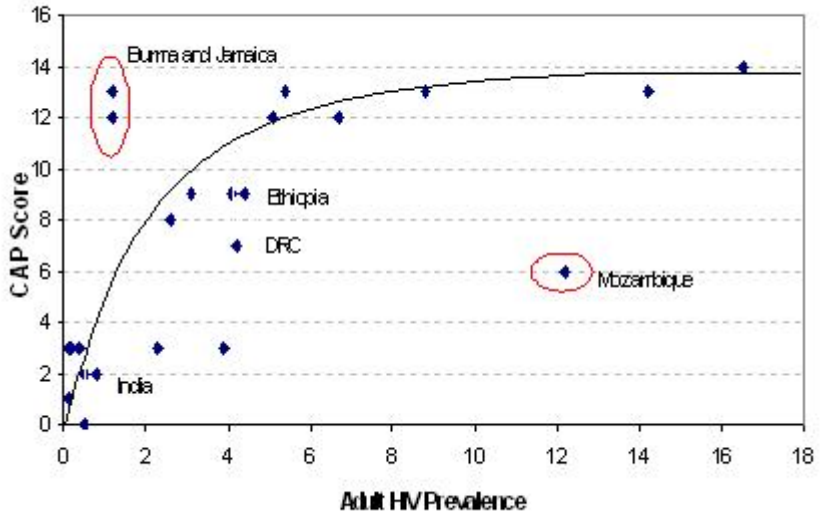
6. ANALYSIS OF DFID PLANS[93]

6.1 In order to get an initial picture of the nature of DFID's programmes on HIV and AIDS, we reviewed all country assistance plans (CAPs)[94], regional assistance plans (RAPs) and institutional strategy papers (ISPs) available to us (see Annex 2, p69)[95]. We developed a simple scoring system for assessing the adequacy of these plans (see Annex 1, p53). Simple analysis of these scores against date of introducing CAP failed to show any trend (see Annex 10, p85)[96]. However, we gained the impression that the degree of detail on HIV and AIDS in the CAP depended on the extent to which HIV and AIDS were perceived as a problem in a country. We decided to test this by plotting CAP score against adult HIV prevalence[97]. This confirmed our impression (see Figure 31). We then identified three 'outliers'[98]. Analysis of these three outliers would support a hypothesis that the quality of CAPs relating to HIV and AIDS programming is improving. CAPs were strongest in the following areas – linking HIV and AIDS to the Millennium Development Goals (MDGs) (19)[99]; recognising broader causes and effects of AIDS (17); promoting a comprehensive approach to HIV and AIDS (14); recognition of vulnerable groups (13); need for donor coordination (12); need for national political leadership (11); and role of National AIDS Commission (11)[100]. Weaker areas included M&E capacity development (3); sustainability (1); and assessing national financing[101] (1) and gaps (1) for HIV and AIDS.

6.2 Particular concerns have been raised previously about the adequacy of institutional strategy papers (ISPs) in respect to HIV and AIDS (NAO, 2004). It appears that there has been marked improvement here. Prior to adopting *Taking Action*, many[102] ISPs did not mention HIV or AIDS at all. However, since *Taking Action,* all ISPs reviewed refer to HIV and AIDS (see box 1, p33).

[93] Time constraints did not permit analysis of plans of other government departments to be included in the terms of reference for this working paper.
[94] Including Change Impact Monitoring Tables (CIMTs) where included in the CAP, e.g. Jamaica.
[95] This section is based on a textual analysis of CAPs, RAPs and ISPs and does not consider expenditure data at this stage.
[96] Although it may be possible to identify some trends when looking at disaggregated data by region.
[97] Obtained for each country from UNAIDS website.
[98] Mozambique, Jamaica and Burma – marked with red circle in Figure 31. Mozambique has a low score compared to HIV prevalence and Jamaica and Burma both have high scores.
[99] Figures show number of CAPs referring to this issue.
[100] Or equivalent.
[101] Several CAPs address the issue of coordinating donor finance. However, this issue refers to tracking national level expenditure on HIV and AIDS, e.g. through the use of a National HIV/AIDS Account as recommended by UNAIDS for UNGASS reporting (see section 5.4, p31).
[102] NAO record this as 8 out of 14. In our analysis, we record it as 10 out of 13.

Figure 31: 'CAP score' compared with adult HIV prevalence (%)



Box 1: Highlights from CAPs, RAPs and ISPs on HIV and AIDS

Burma's CAP contains a very detailed description of DFID financial resources related to HIV and AIDS as Annex 1;

Jamaica's CAP contains a detailed box (p.6) examining excluded groups in the country. It includes discussion of homophobia in relation to HIV and AIDS;

Kenya (p.20), Jamaica (p.10), Angola (p11) and Zambia (p9) all include detailed tables mapping the roles of other donors in HIV and AIDS financing in their CAPs. The Caribbean RAP contains a similar review as Annex 1 (p.13);

Kenya's CAP (p.5) includes an analysis of how HIV and AIDS are related to the issue of food insecurity. Zambia's CAP contains a detailed discussion of this issue (box1, p.4);

Relatively few CAPs refer to the importance of HIV and AIDS monitoring and evaluation. Those that do include Zambia (in a table on objective 4) and Nigeria (p11);

The RAP for Latin America (pp.3-5) and Kenya's CAP (pp.4-6) contain particularly detailed analysis of the links between HIV, AIDS and poverty;

The previous ISP between DFID and the EC made no mention of HIV or AIDS. The new one contains a box (p4) which describes the EC's Programme for Action on HIV and AIDS including a commitment by DFID to cooperate to ensure that this programme is monitored and evaluated; The ISP with the World Bank contains a similar box (p9).

Several of the new ISPs refer specifically to *TA*, for example, the ISPs with OHCHR (pp.3,4) and UNAIDS (pp.1,5,7,10);

The ISP with OHCHR describes how funding for HIV and AIDS will be evaluated (p.5); Similarly, the ISP with UNAIDS identifies ways in which progress will be monitored using a number of objectives and indicators (pp.7-10);

The ISP with UNAIDS contains a detailed box describing how other UK government departments will be involved (p.12) with UNAIDS;

Previously, the ISP with UNIFEM contained no reference to HIV and AIDS. The new ISP covers issues of HIV and AIDS in some detail including consideration of how HIV, AIDS and poverty are interlinked; issues relating to HIV, AIDS and the Millennium Development Goals (MDGs); ways in which UNIFEM will work to achieve its priority goal relating to HIV, AIDS and women; and recognition of UNIFEM's global leadership role on gender equality.

7. ADEQUACY OF UK GOVERNMENT INFORMATION SYSTEMS

7.1 We were asked to comment on the adequacy of the UK government's information systems to monitor the implementation of *Taking Action*[103]. DFID accounts for over 90% of spending covered by this policy and has information systems in place, which contain a great deal of the information required. DFID staff are well-aware of the limitations of these systems and steps are being taken to improve them[104].

7.2 Other government departments do not have specific tracking systems covering HIV and AIDS, and therefore this study was able to include very little information on their specific contribution. Much of the nature of the work done by other government departments is difficult to measure, either because it does not consist of discrete, projectised activities, such as the work on policy dialogue done by the Foreign and Commonwealth Office; or is not specific to tackling HIV and AIDS in developing countries, such as general AIDS research funded by the Department of Health, or work on international patent law by the Department of Trade and Industry.

7.3 The basic systems for tracking progress towards the HIV/AIDS spending target appear to be in place within DFID (DFID, 2005b) although some final work is currently being done on precise definitions and methods. These have been subjected to intense external scrutiny (Janjua, 2003; NAO, 2004; Daly, 2005) and, as a result, there is an unprecedented opportunity for DFID to demonstrate global leadership in a field that is characterised by extremely limited information and significant definitional challenges[105].

7.4 Similarly, there is a system for tracking the spending target for activities relating to OVC. This combines sector codes and markers from PIMS. However, the system of sector coding projects/ programmes that are

[103] TQA 1.6.

[104] E.g. with the planned introduction of an Activities Reporting and Information E-System (ARIES) in early 2007. In addition, much of the discussion at the Methods Working Group meeting in April 2006 was focused on how the experience of this evaluation can be used to strengthen information systems in future. Please see 'issues to consider' section for further details (p45).

[105] These issues are covered elsewhere in this report but include whether to record expenditure, which has a primary focus on HIV and AIDS only; how to treat expenditure on STIs, SRH and health more broadly; how to treat multilateral aid and debt relief; and thresholds for inclusion.

related to OVC is not yet fully operational[106]. DFID staff have many ideas for strengthening this system[107].

7.5 PRISM contains a wealth of information. However, there are significant challenges regarding its use. These include:

- Some of the fields where information is wanted are not currently coded in PRISM, e.g. focus of activity or target population. However, these challenges are not unique to DFID or PRISM (see p6). For example, the fields of aid instrument and AIDS-specific/enabling action are difficult to complete because of a lack of clear and shared international definitions of terms
- Although PRISM contains a huge amount of information, some parts are incomplete, for example, sector codes for OVC, partner information etc. In addition, information is not always entered consistently, e.g. PIMS markers for condom-related projects/programmes (see Annex 1, p67 including Table 5, Annex 1, p67). However, there is evidence from the analysis that many of these issues are historical and that there has been improvement over time
- Issues regarding quality control over information entered into PRISM. The work being done by the Global AIDS Policy Team in this regard is widely praised within DFID as a good model of how this can be done and there is evidence that this has improved since this was introduced

7.6 In addition to PRISM, there are other information systems within DFID but it is not always clear how completely these link together. For example, not all country assistance plans available on the DFID website were available on INSIGHT and vice versa. It seems that these two sites are uploaded by separate, unlinked processes.

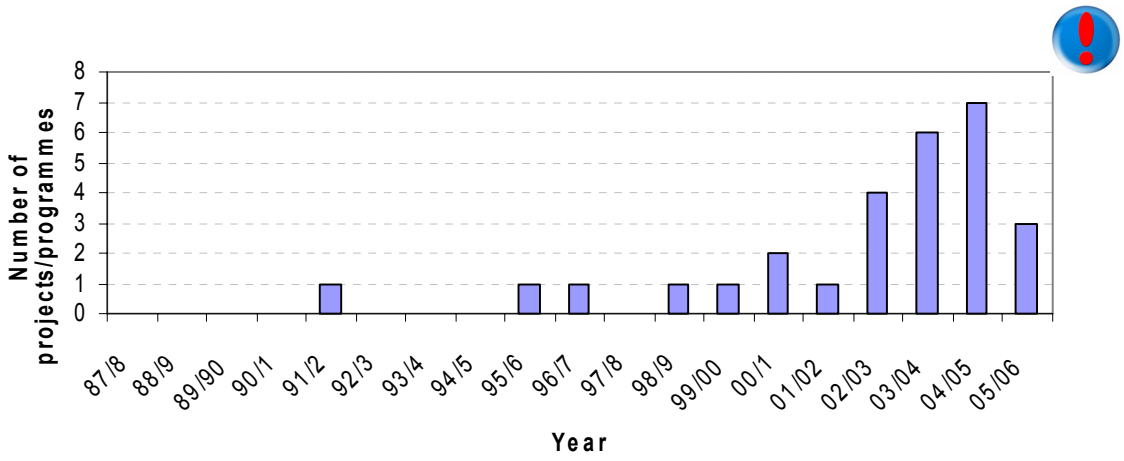
[106] Currently only three projects/programmes have both OVC sector code and an HIV/AIDS PIMS marker. This contrasts with 178 projects/programmes in our dataset which we identified as OVC-related (see Annex 1, p53 for methodology).
[107] These include training on importance of sector coding; reclassification of OVC sector codes based on the work of this evaluation; and/or introduction of a keyword system in ARIES.

8. OTHER ISSUES

8.1-8.2 HIV, AIDS, food security and social transfers

8.1 We identified 28 projects/programmes within our dataset related to food security (see Annex 1, p53 for method and Annex 11, p86 for list of projects). Almost all of these are in Africa (23 – 82%). Of the 28, we identified nine related to general development; three related to agriculture; nine relating to food distribution[108]; and seven related to policy, surveillance or research. There has been an increase in the number of these projects/programmes (Figure 32) and the financial commitment to them since 2001/2, although it appears that this dipped in 2005/6[109]. Expenditure on projects/programmes in our dataset related to food security was £16.3m in 2003/4 and £9.1m in 2005/6.

Figure 32: Number of HIV and AIDS projects/programmes related to food security



8.2 Strongly linked to the issue of food security is the issue of social transfers (Chapman, 2006[110]). DFID has a database of 40 social assistance projects/programmes (DFID, undated), which gives details of the category of social assistance, including cash transfers. There is some overlap between these and the 28 food security projects/ programmes, with seven appearing in both datasets[111]. These social transfer projects/programmes are more spread across regions[112] with 23 in Africa (58%), ten in Asia (25%) and seven in EMAD (18%).

[108] Including to particularly vulnerable people such as PLWHA and street children.
[109] Although figures for 2005/6 are not complete (see Glossary, (pvii) and Annex 1, (p53) for explanation).
[110] This paper focuses on social transfers related to health and education. However, Chapter 2 (pp. 4-6) provides a concise overview of issues relating to social transfers in general.
[111] This is based on comparison of country, title and purpose as the social assistance database does not include MIS codes.
[112] Than the projects/programmes identified as related to food security in our dataset.

9. DISCUSSION

9.1-9.2 Does the overall distribution of UK-supported activities reflect the priorities laid out in *Taking Action*?

9.1 This section is structured around the main question that this working paper was expected to answer, that is *does the overall distribution of UK-supported activities reflect the priorities laid out in Taking Action? Taking Action* (UK Government, 2004) has six main priorities and each of these will be considered in turn. Figure 1 (pxiv) summarises this discussion diagrammatically.

9.2 As a result of the method followed, the fact that DFID is the lead department in this field and the significant difficulties in obtaining data from other government departments, this discussion section is strongly focused on DFID activities and spending.

9.3-9.7 Closing the funding gap

9.3 DFID is in the process of finalising the methods it will use for tracking spending on HIV and AIDS. So, figures for 2004/5 are not yet definitively available. Preliminary figures of £430m indicate that the UK is on track to meet the HIV and AIDS spending target in *Taking Action.* However, this does assume that the method used will be fairly close to the one anticipated when the strategy was developed. It also highlights the problems that occur if targets are set before establishing clearly agreed methods for tracking progress towards meeting them.

9.4 The UK's financial contribution to the response to HIV and AIDS in developing countries is provided through a wide range of aid instruments (see sections 4.3-4.7, p11-13). In particular, technical cooperation accounted for 72% of all projects/programmes we identified and has accounted for 44-63% of annual bilateral expenditure on HIV and AIDS from 1997 to 2005. This technical cooperation supplements funds provided as financial aid and includes a wide range of activities, including provision of essential services, pharmaceuticals, health products and equipment (see section 4.5).

9.5 *Taking Action* has a strong focus on services for women, young people and other vulnerable groups. It is difficult to determine the extent to which UK-supported activities currently reflect this focus because this information is not routinely collected by DFID's management information systems. We have attempted to collect information in this area (see sections 4.19-4.21, p21-22) and this will be the main focus of a subsequent working paper in this evaluation. There is evidence of increasing levels of expenditure on activities focused on young people, OVC and other vulnerable groups between 2003/4 and 2005/6. The apparent reduction in funding to activities focused on women is probably due to a reduction in the number of specific reproductive health

projects/programmes, as these are either absorbed into broader health initiatives or re-labelled as HIV/AIDS programmes. Based on the use of a gender marker in PIMS, it appears that the number of projects/programmes with a principal or significant focus on gender is increasing (see Figure 21, p22).

9.6 Unlike the system for tracking the main spending target on HIV and AIDS the system for tracking the spending target for orphans and vulnerable children is not yet fully operational, largely because very few projects/programmes have been allocated a sector code for OVC. As a result, the current system significantly underestimates spending in this area, e.g. only £1.5m in 2005/6 as of February 2006. We identified a total of 178 projects/programmes which we considered to be relevant to OVC. These accounted for expenditure of £45.2m in 2003/4 and £61.3m in 2005/6 (see sections 3.8-3.9, p6-7).

9.7 *Taking Action* committed the UK government to provide increasing support to a number of international organisations, such as UNAIDS, UNFPA and the Global Fund. The UK is on track to meet its commitments to UNFPA and UNAIDS (see section 3.13, p8; Figure 4, p8) and will exceed threefold its commitment to the Global Fund if it meets its latest pledges for 2006 and 2007. The UK has taken a leading role in seeking to ensure replenishment of the Global Fund.

9.8-9.9 Political leadership

9.8 This exercise probably significantly underestimates work of the UK government in relation to stimulating political leadership as much of this is not 'projectised' and is therefore not captured in PRISM. Nevertheless, we were able to identify a total of 134 projects/programmes, which contained an element of policy dialogue (see section 4.8, p14). The number of these projects/programmes has increased over time (see Figure 12, p14) and includes activities in particular countries and at an international level, e.g. support to UNAIDS 'Three Ones' initiative and high level fora to review progress to health-related millennium development goals.

9.9 In addition, one of the strengths identified in our review of country assistance plans (CAPs) was their focus on the importance of supporting and developing national political leadership in relation to the response to HIV and AIDS (see section 6.1, p32).

9.10-9.14 International response

9.10 As mentioned earlier, DFID has maintained and increased its level of financial support to multilateral organisations, such as UNAIDS.

9.11 DFID's relationship with these bodies is described in a series of institutional strategy papers (ISPs). Previously, many of these were silent on issues relating to HIV and AIDS. However, this situation has improved

with all new ISPs mentioning HIV and AIDS, including targets to be achieved and specific reference to *Taking Action* (see section 6.2, p32).

9.12 In addition to supporting UNAIDS internationally, DFID has also been supporting its 'Three Ones' initiative in particular countries, e.g. Angola, Ethiopia, Somalia, Sudan, DRC, Ukraine and Russia. This appears to be a good example of initiatives to increase harmonisation.

9.13 This practice is not limited to UNAIDS only. There is also evidence of increasing support to UN agencies at country level (see Figures 14 and 15, p16), although it is unclear whether this is for the provision of technical knowledge or for the direct implementation of services. Currently, DFID's routine management information systems do not allow this information to be tracked as these projects/programmes are simply treated as a form of bilateral aid.

9.14 The UK has been actively involved in global initiatives to make antiretroviral therapy more widely available, for example by providing funds to the Global Fund, by financing WHO's 'Three by Five' initiative and by supporting a UNICEF forum relating to treatment of children. However, it is unclear how this is being translated into action in countries. DFID's management information system does not routinely record information on whether projects/programmes are providing ARVs and we were only able to identify 20 projects/programmes specific to HIV and AIDS, which referred to treatment of people with HIV and AIDS (see section 4.15, p18).

9.15-9.23 National programmes

9.15 DFID is strongly focused on bilateral support to countries and this is captured in this review of projects and programmes. DFID activities in a particular country are guided by a country assistance plan (CAP). Our review of these (see section 6, p32) shows that these are broadly appropriate for their country context and that they have improved over time (see Figure 31, p33). There are some areas where these could be stronger, including capacity development of HIV and AIDS monitoring and evaluation systems, focusing on sustainability and assessing national financing.

9.16 Although DFID's systems do not routinely capture information on the types of partners managing projects/programmes, it appears that DFID is working through a wide range of partner types, including particularly international NGOs, ministries of health and UN agencies (see Figure 14, p16).

9.17 Although the number of projects/programmes supported through National AIDS Councils is relatively small, it appears to be increasing (see Figure 15, p16).

Discussion

9.18 DFID supports a wide range of different types of projects/programmes related to HIV and AIDS. While these include specific interventions, they also particularly include broader initiatives focused on health and economic development (see sections 4.22-4.26, p23-26).

9.19 There is evidence of a declining number of specific projects/programmes for reproductive health (see Figure 25, p25). Possible explanations are that some of these projects/programmes are being re-labelled as HIV and AIDS activities or that they have been absorbed into broader health sector activities. This finding is supported by other literature (e.g. Druce et al., 2006), which has documented that other elements of reproductive health are being 'crowded out by the drive to fighting AIDS' (van Dalen and Reuser, 2005a) and that increased levels of funding for HIV and AIDS are not being seen in other areas of reproductive health (Lule, 2004; van Dalen and Reuser, 2005b)[113].

9.20 DFID is strongly committed to supporting integrated responses to HIV and AIDS, which incorporate elements of prevention, care and support, treatment and impact mitigation. Currently, information on the type of activities within a project/programme is not routinely collected by DFID's management information system. However, this working paper shows that of projects/programmes specific to HIV/AIDS, most (62%) are of this nature. Of projects/programmes with a specific focus, most relate to prevention (120) with relatively fewer focused solely on care and support (23) (see section 4.15, p18).

9.21 In some settings DFID provides support on a regional basis (see section 4.10, p15). Two distinct types of regional projects/programmes can be identified. The first may be considered a number of country-specific initiatives grouped together on a regional basis while the second is a true regional initiative. The former is simply a way of providing small levels of financial support to a number of countries with minimal transaction costs[114], while the latter is additional to global and country initiatives. There is need to be clear that such regional programmes add value and fit with activities at both global and country level[115]. A review of Irish Aid's response to HIV and AIDS (Scott, 2005) concluded that a major strategic challenge facing its regional programme was a failure to distinguish between these two types of initiative. Many of the activities were considered multi-country initiatives with little added value.

9.22 We sought to assess the extent to which the spread of DFID-supported projects/programmes across countries is appropriate. Broadly, the allocation of bilateral financial resources (see Figure 27, p27) seems

[113] For more details see Annex 4, p73.
[114] For example, SIDA's regional office in Lusaka also manages support to HIV and AIDS activities in middle-income countries in Southern Africa, in which SIDA no longer maintains an aid programme.
[115] For example, the review of Irish Aid (Scott, 2005) concluded that 'although the regional programme was meant to complement Irish Aid's responses at these levels, in practice it has largely worked in parallel to them.

appropriate for the level of disease burden in particular countries. However, there are some countries where the level of financial resources seems low for the level of disease burden. Possible explanations are that:

- DFID is providing its financial resources to the response to HIV and AIDS through other bilateral channels, such as poverty reduction budget support in Mozambique
- DFID is providing financial resources to countries through multilateral channels, such as the Global Fund
- Countries are receiving sufficient financial resources from other sources, e.g. Haiti
- There are considerable logistical barriers to increasing support, e.g. DRC, Liberia, Burundi

Nevertheless, there are very wide variations between levels of finance per capita provided by DFID to countries with similar levels of poverty and HIV/AIDS disease burden (see Figure 28, p.28).

9.23 Currently, there is no clear system for how DFID will monitor improvement in national programmes in the countries that it supports, although it is perhaps implied that this will be done through national monitoring and evaluation systems. To date, these have been quite weak and it will be important to review how far these have developed when reports for the 'post-UNGASS' review in June 2006 become available. Currently, it seems difficult for DFID to know the extent to which countries it is supporting are managing to scale up effective elements of a national response to HIV and AIDS. It is perhaps worth noting the limitations of countries' own strategies and plans for prioritising interventions that were documented in a recent review of World Bank experience (Ainsworth et al., 2005).

9.24-9.25 Long term action

9.24 It is difficult to assess the degree to which projects/programmes are focused on long term issues, such as sustaining services, through an exercise of this nature. Nevertheless, it did not emerge as a major focus in many. For example, in our review of CAPs (see section 6, p32) we only identified one that discussed the issue of sustainability in relation to HIV/AIDS services. Given that these plans are intended to guide DFID activities in a particular country, it might be expected that they would place strong and explicit emphasis on long-term action, given its prominence in *Taking Action*. This currently does not appear to be the case.

9.25 One of the ways in which the UK government is supporting long-term action is through research. This includes specific projects/programmes for developing countries financed by DFID (see Figure 17, p18) and through more general research financed by the Department of Health. Specific research supported by DFID includes work on both vaccines

and microbicides. Currently, the Department of Health has no system to identify how much of the general health research is focused on HIV and AIDS.

9.26-9.30 Strategy into action

9.26 *Taking Action* is a cross-Whitehall strategy and there has been strong commitment to it from a number of government departments. However, it has proved difficult to collect evidence of activities from other government departments. This may be because the nature of those activities is difficult to quantify. Where activities have been reported, e.g. by the FCO, DOH, they are not disaggregated for HIV and AIDS.

9.27 It appears that *Taking Action* has resulted in a much higher profile for HIV and AIDS within the UK government, in general, and within DFID, in particular. However, the exact effects of that raised profile, and particularly its effects on spending decisions are not yet clear.

9.28 One major challenge facing anyone who wishes to track the extent to which *Taking Action* has been translated from strategy into action is the absence of an agreed monitoring and evaluation framework for this. Developing such a framework will be the focus of the third working paper of this evaluation. Recent reviews of HIV and AIDS activities of Irish Aid, World Bank and SIDA all documented significant weaknesses in monitoring and evaluation systems (Scott, 2005; Ainsworth et al., 2005; Vogel et al., 2005).

9.29 Currently, the main focus of DFID's monitoring of *Taking Action* is on the spending target for HIV and AIDS. This may be because it is relatively tangible and thus lends itself to measurement. However, in the absence of clear methods to measure other elements of *Taking Action*, there is a significant risk of *Taking Action* being interpreted by some as only a spending target.

9.30 We identified a number of projects/programmes that include a focus on building monitoring and evaluation capacity internationally and in particular countries (see sections 4.17-4.18, p19-20). These are in a number of areas including poverty monitoring, health monitoring and HIV/AIDS monitoring. There is evidence that these projects/programmes are increasing (see Figure 18, p20).

10. CONCLUSIONS

10.1 Introduction

10.1 The following conclusions can be drawn from this working paper. They are illustrated in Figure 1 (pxiv).

10.2 Closing the funding gap

10.2 Initial indications are that the UK government is on track to meet the spending targets laid out in *Taking Action*. However, significant methodological challenges remain, particularly in relation to tracking spending on HIV and AIDS overall, and on OVC, and these have resulted in delays in publishing final DFID spending figures for 2004/5. The UK is on track to meet its target of support to international institutions, e.g. UNFPA, UNAIDS, and will significantly exceed them in some cases, e.g. the Global Fund, if current trends continue and latest pledges are fulfilled. Although UK spending on HIV and AIDS is through a variety of aid instruments, the largest single aid instrument used remains technical cooperation, accounting for 44-63% of annual bilateral expenditure on HIV and AIDS from 1997 to 2005.

This priority is strongly reflected in the overall distribution of UK-supported activities

10.3 Political leadership

10.3 Findings of this working paper confirm the emergence of policy dialogue as an aid instrument being increasingly used by the UK government in relation to HIV and AIDS. This is the case both internationally and in particular countries. However, there are major challenges in trying to set targets and monitor progress with such instruments.

This priority is reflected in the overall distribution of UK-supported activities

10.4 International response

10.4 This working paper reveals evidence of the UK's strong support to the international response and HIV and AIDS. This includes:

- Increased financial support to key institutions
- Stronger and more explicit focus on HIV and AIDS in institutional strategy papers
- Support to 'Three Ones' initiative globally and in particular countries
- Increasing use of UN agencies in-country
- Support to global initiatives to make treatment more widely available

This priority is strongly reflected in the overall distribution of UK-supported activities

10.5 National programmes

10.5 The UK government works in country through a range of partners, including international NGOs, ministries of health and UN agencies. Increasing support is being given through National AIDS Councils. The UK supports different types of projects/programmes related to HIV and AIDS, particularly integrated approaches and those focused on health and economic development. UK support to specific projects/programmes for reproductive health is reducing, perhaps as these are absorbed into sectoral programmes on health. Based on our review of country assistance plans and financial commitments, we conclude that UK support for HIV and AIDS is broadly appropriate to country context. Nevertheless, there are some countries where the level of financial resources provided by the UK for HIV and AIDS is low for the level of disease burden. Explanations for this include use of other aid instruments, significant funds from other donors or severe logistical barriers. To date, the UK government has no agreed system for tracking improvement in national HIV and AIDS responses in the countries it supports, although this is being reviewed as part of this evaluation.

This priority is strongly reflected in the overall distribution of UK-supported activities

10.6 Long term action

10.6 It is difficult in this working paper to draw conclusions about the UK government's delivery on its commitment to long-term action on HIV and AIDS. There is some evidence of this, for example, through support to HIV and AIDS research, both through DFID and the Department of Health. However, currently the Department of Health has no system for quantifying this support. In addition, DFID country assistance plans do not appear to emphasise strongly enough the focus on long-term action and sustainability explicit in *Taking Action*.

This priority could be more strongly reflected in the overall distribution of UK-supported activities

10.7 Strategy into action

10.7 Although *Taking Action* is a cross-Whitehall strategy and there has been strong commitment to it from a number of government departments, most of the activities and spending documented have been through DFID. This may be because it is the lead agency in this field and because activities of other government departments are difficult to quantify. Nevertheless, having such a strategy has raised the profile of HIV and AIDS both within DFID and across the UK government. The UK government has demonstrated support to developing HIV and AIDS monitoring and evaluation capacity internationally and in particular countries. Nevertheless, there is a need to develop a broad monitoring and evaluation system for tracking progress against *Taking Action*. To date the main focus of tracking *Taking Action* has been on whether or not the spending target has been met.

This priority is reflected in the overall distribution of UK-supported activities

11. ISSUES TO CONSIDER

11.1 Introduction

11.1 This is the first of three working papers for the interim evaluation of *Taking Action*. It is premature to make a large number of recommendations. However, some preliminary issues to consider are presented here. They are structured in two sections, the first around improving implementation of *Taking Action* and a second section relating to improving UK government information systems.

11.2-11.5 Improving implementation of *Taking Action*

11.2 DFID needs to rapidly finalise the method it will use for tracking spending on HIV and AIDS and publish and publicise figures for 2004/5 with the intention of stimulating discussion and dialogue about the methods used. These discussions should include INGOs, other government departments and international organisations. Many of these organisations face similar challenges in what is a complex area.

11.3 There is a mismatch between the increasing support through UN agencies by DFID country offices and the UK's strategic position on appropriate roles for UN agencies (DFID, 2006d). Perhaps this issue needs to be reviewed between DFID's various divisions.

11.4 Regional divisions could usefully review the countries, which appear to receive lower levels of DFID bilateral funding in relation to their burden of HIV and AIDS, to identify reasons for this (see section 9.22, p40) and to determine whether action is needed.

11.5 There is a pressing need for DFID to know how the effectiveness of national HIV/AIDS programmes is to be monitored, as it moves increasingly towards funding through country-led aid instruments. This issue will be reviewed in detail as part of Working Paper 3 of this evaluation and will consider the outcomes of the UNGASS review process in June 2006.

11.6-11.14 DFID information systems

11.6 The system of tracking OVC spending needs to be implemented. Projects/programmes identified in this working paper as relevant to OVC should be reviewed to see which of them should be allocated an OVC sector code. There is also need to clarify and inform staff about which kind of projects/programmes should be given OVC sector codes.

11.7 Consideration needs to be given to ways of tracking projects/ programmes and other initiatives, which focus on promoting political leadership. This might be done by tracking projects/programmes with a focus on policy dialogue through the management information system or through greater use of the country assistance plans.

Issues to Consider

11.8 Periodic word searches could be introduced as part of the quality assurance system for coding within PRISM and other parts of the management information system. Such searches could be carried out by Corporate Strategy Group monthly and/or Global AIDS Policy Team quarterly. Word search checks could be built into new systems, e.g. ARIES.

11.9 Heads of departments could conduct quality spot checks on information on new projects, perhaps one to three per quarter. This would include PIMS markers and sector codes. Cabinets and/or internal audit could follow the same procedure.

11.10 Other possible initiatives to improve quality of information in systems might include:

- Preparing a brief for country heads
- Training programme managers and finance officers
- Developing an e-module on coding and markers
- Workshop for PIMS monitors
- Improve written guidance on PIMS markers, e.g. in the project cycle management handbook
- Individual 'spotlight' issues, these might be produced by Corporate Strategy Group for general issues and Global AIDS Policy Team for issues relating to HIV and AIDS

11.11 DFID should continue to work closely with international bodies on harmonising approaches to tracking spending on HIV and AIDS, such as:

- Monitoring and Evaluation Reference Group (MERG) annual meeting
- DAC although processes may be slow as the work plan is fully scheduled for some time in the future
- UNGASS review meeting scheduled for June
- UNAIDS

11.12 It may be helpful to review whether the split of P and S markers within PRISM is helpful and to find ways of increasing the use of sector codes.

11.13 Consideration should be given to not applying PIMS markers to PRBS because the nature of this aid instrument is that it cuts across all themes.

11.14 It would be helpful to create a fixed record of source data at the time a dataset is extracted. Currently, it is not possible to go back to verify the data used for calculating the spending on HIV and AIDS because the version of PRISM that was used has been updated since the time that the date was extracted.

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ANNEX 1: DETAILED METHODOLOGY

Method in Brief

This annex describes in detail the method we followed to produce this working paper. The most important features are summarised here:

1. **Stages:** We conducted work in four stages:
    - preliminary data assessment, consisting of gaining familiarity with PRISM and related systems
    - data extraction, from a CD containing data from PRISM
    - manual filling of data fields – as most of the fields we were required to analyse are not contained within PRISM, we had to collect the information manually, mostly from the project title and purpose
    - data analysis, using three variables – number of projects/programmes, new financial commitment per year and expenditure in 2003/4 and 2005/6
2. **Dataset:** Our dataset contained 1,424 projects/programmes which had either
    - a PIMS marker for either reproductive health or HIV/AIDS
    - a sector code for orphans and vulnerable children
    - HIV or related word in project title or purpose
3. **Comparability with official figures:** We worked closely with SRSG to try to ensure that our figures are comparable with official figures. However, this proved difficult because the method to be used was not finalised by the time we concluded work on this paper. Particular features of our approach were:
    - all projects/programmes in our dataset were identified from PRISM, primarily using PIMS markers for HIV/AIDS and reproductive health
    - support to Iraq and Afghanistan was included
    - including projects/programmes identified by free text searching for HIV and related terms (see Annex 3, p81)
    - including projects/programmes with an OVC sector code
    - including projects/programmes with a start date in 2005/6
4. **Limitations:** The most significant limitations of this working paper are:
    - subjectivity of field allocation – this was minimised by one person doing the work and rigorous documentation of approaches followed
    - limitations of the accuracy of information in PRISM
    - incomplete financial information for 2005/6, i.e. to February 2006

Annex 1: Detailed Methodology

Preliminary data assessment

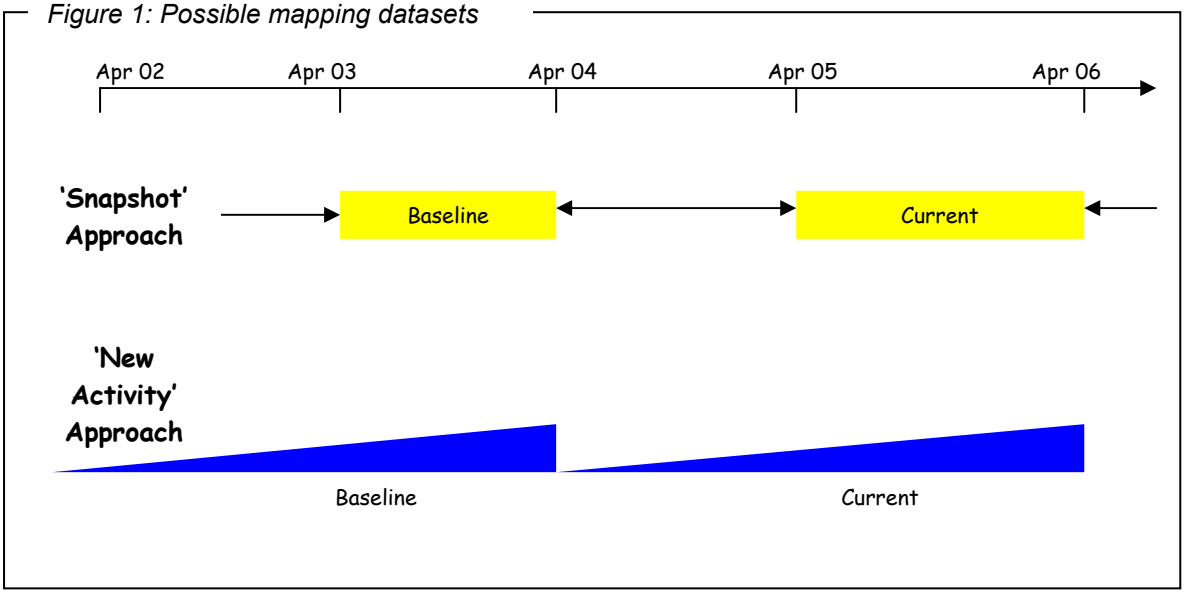
During a short visit to the DFID offices in East Kilbride, two members of the team conducted preliminary searches of PRISM to gain familiarity with the data available. This was combined with discussions with a number of members of DFID staff concerning the task ahead and issues relating to use of PRISM.

An early task was to define the datasets that would be used for comparison purposes to try to identify trends. In order to do this, a number of things had to be defined:

- *Criteria for inclusion* – projects/programmes were included if they had 'P' or 'S' PIMS markers for reproductive health or HIV/AIDS[117], or mention of HIV or related term in project/programme title or purpose[118].
- *Time period* – in the end, with improved accessibility to the data as a result of being provided with PRISM data in an Access database on CD, all projects/programmes meeting the criteria for inclusion were identified. However, when access to the data looked as if it would be more limited[119], two more limited approaches were considered (see Figure 1 and Table 1). This was important because a list of 'snapshot' projects/programmes was generated during the preliminary data assessment phase, which proved critical during the data extraction phase when checking for data completeness (see below). For this reason, the process is described in some detail here:

Initially, two main approaches to time period were considered (see Figure 1). Relative merits of these two approaches are considered in Table 1 (p55).

Figure 1: Possible mapping datasets



[117] Either H/A or HIV marker.
[118] Projects were also included if they had an OVC sector code – see Annex 3 (projects marked *).
[119] When it was thought that all work with PRISM data would need to be done at DFID with limited access because of issues of security clearance.

Table 1: Relative merits of 'snapshot' and 'new activities' datasets

'Snapshot'	'New Activities'
Will provide a clear picture of the portfolio in each of the 'windows' being examined. This should be comparable to aggregated financial data compiled by DFID for each year. Overlapping projects/programmes may mask trends.	Focusing on new projects/programmes only may identify trends more clearly. Large size and long timeframes of some activities risks introducing significant distortions, e.g. a very large project/programme's start date may fall fortuitously within one 'window' and may give the impression of a trend where there is no such trend. This can be minimized by taking in new projects/programmes over a longer period, but this is difficult for the 'current' set because *Taking Action* has been operational for a short period of time.

The first possibility constitutes a 'snapshot' of all projects/programmes meeting the inclusion criteria that fall within a given time period. For the baseline, we took all projects/programmes that were active during FY03/04, as *Taking Action* was published in July 2004. For the current projects/programmes, we took the current FY, i.e. FY05/06[120]. Thus the search criteria entered into PRISM were:

- projects/programmes starting before April 1st 2004 and finishing after 31st March 2003 to identify the baseline
- projects/programmes ending after March 31st 2005 to identify the current group

However, we encountered a problem with planned and actual start dates. If a field is blank, e.g. no actual end date, i.e. the project/programme is ongoing[121], this record is excluded from the dataset. Consequently, searching by actual dates produced small, incomplete datasets. For this reason, we searched by planned date and generated a printed list of 'snapshot' projects/programmes for both the baseline and current periods during this preliminary data assessment phase[122].

The second approach is to look at new projects/programmes only. Because of the risk of the distortions discussed in table 1, we approached this by including projects/programmes from a two-year period for both baseline (FY 02/03 and 03/04) and current (FY04/05 and 05/06) datasets. For the purpose of searching PRISM for these datasets, we used:

- projects/programmes starting between March 31st 2002 and April 1st 2004 for the baseline

[120] Up to February 2006.
[121] It is also possible that some completed projects/programmes have no actual end date entered in PRISM.
[122] We later discovered that this dataset was also incomplete as PRISM contains some records without a planned start or end date. These records were not included in the original dataset. Ongoing programmes do not have set end dates (DFID, 2005c) but it is currently unclear why a project would have no planned start date.

- projects/programmes starting after March 31st 2005 for the current group

However, although we conducted these searches, we did not make printouts because we originally thought it best to try to collect data for one approach only and we chose the 'snapshot' method for this purpose.

Also during this stage, some notes on how to approach the mapping were prepared and an Excel template was developed for data collection, storage and analysis. In addition, at this time, some preliminary searches were made of DFID data on AIDA to get a sense of the size of the dataset and to test out the proposed Excel template, e.g. by entering in data from India.

Data Extraction

To some extent, the approach was modified when the team was provided with a CD containing an Access database of PRISM. From this, it was possible to extract data into Excel automatically. Initially, this was done by combining a number of the Access tables[123] and identifying all projects/programmes with a PIMS marker[124] for HIV[125], reproductive health, gender and human rights. A search was conducted[126] of remaining projects/programmes for 'HIV' and related terms[127] and projects/programmes containing these terms were included[128]. Because this search included the term 'AIDS', this included two inappropriate projects. These were later excluded during the manual process of filling in data fields (see Table 2)[129].

Table 2: Projects/programmes initially included in dataset but using 'aids' in a way unrelated to AIDS

No.	COUNTRY	PROJECT TITLE	PROJECT FULL TITLE	PROJECT PURPOSE
150480002	INDONESIA	No 2 1987 Nav Aids		Procurement, supply and shipment of marine aids to navigation to Ministry of Communications
676620058	NON SPECIFIC COUNTRY	water supply and sanitation access	water supply and sanitation access and use by physically disabled people	improved knowledge and use of affordable aids, methodologies and structures by organisations and individuals who assist physically disabled people and their families living in low income communities to maximise their access to and use of the domestic water cycle

[123] The tables used were PROJECT_POLICY_MARKER, POLICY, POLICY_INSTITUTION and PROJECTS.
[124] Either P or S.
[125] In PRISM, there are two PIMS markers for HIV/AIDS – 'HIV' and 'H/A'. Both were included for this purpose. However, for ease of analysis, these were combined into one system – see section on data analysis.
[126] In the PROJECTS table.
[127] Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome, AIDS and A.I.D.S.
[128] Initially, projects/programme with PIMS markers for gender or human rights were excluded from this free text search but this was later corrected.
[129] One inappropriate project/programme was included in the dataset because it included the term 'hiv' in the word 'archive'. This was only discovered after the analysis had been conducted and it was too late to exclude the project/programme from the dataset.

This initial exercise generated a dataset of around 800 records. We suspected the completeness of this dataset as we expected to generate around 1,600 records as a result of the preliminary searches we did on AIDA. As a result, we decided to undertake some quality checks on the dataset. This involved checking our dataset against:

- the printed list of 'snapshot' projects/programme generated in East Kilbride and described above
- a list generated from AIDA by searching for HIV among DFID-supported current and archived projects/programme

As a result, we were able to identify that our dataset was incomplete and that this was occurring because the Access version of PRISM failed to present a record if, in one of the three tables being combined, it did not have an entry in one or more of the fields being searched. Once we had identified this problem, we were able to generate a more complete list by searching in one table[130] only. This, however, resulted in some duplicate records[131]. We removed these by sorting according to MIS codes and removing duplicate records after collecting any additional information in the duplicate record. This resulted in a dataset of 1,424 records[132].

During the data extraction process, the Excel template we were using to collect, store and analyse data was modified considerably to contain data available in PRISM and to locate relevant information close to the data fields we were trying to fill.

Manual Filling of Data Fields

The terms of reference for the evaluation, in particular the TQA and Tables A and B, specify a number of fields in which we were expected to try to find trends. However, many of these are not specifically fields in PRISM or do not correspond completely with fields in PRISM. For this reason, the consultant responsible for this working paper personally reviewed all records in our dataset trying to generate information for all required fields. Inevitably, this involved some degree of subjective judgment and, consequently, the process is not likely to be fully replicable. However, we endeavoured to make the process as systematic as possible and have documented here the approach we followed. Information was gleaned from the data extracted from PRISM[133], from the consultant's own knowledge of several of the projects/programmes and from limited searches of readily available information, e.g. on the Internet.

[130] PROJECT_POLICY_MARKER.
[131] For example, where one project/programme is listed with more than one institution.
[132] In fact, it generated 1427 records but two were excluded as their reference to aids does not appear to be AIDS-related and there was one record which was completely blank apart from an MIS code (025555025).
[133] Particularly from the project/programme title and description.

Annex 1: Detailed Methodology

The following approach was followed for each field:

- **Funding Mechanism/Aid Instrument** – One problem we encountered here is the lack of an agreed terminology within DFID over aid instruments. We used categories provided for us initially by DFID staff and modified them to reflect DFID documents and the spread of projects/programmes within our dataset. In order to classify a project/programme to an aid instrument, we only allowed one project/programme to be allocated to only one aid instrument. We got the information from the PRISM field entitled 'aid type' using the following rules:

– JFS & volunteer grant/PPAs	Block grant/PPA
– All aid types mentioning TC[134]	TC
– JFS Accountable Grant/CSCF	Project
– Bilateral Country Grants	Programme, TC, project, vertical funds, sector support, budget support[135], debt relief (see table 3)
– Multilateral Grants[136]	Multilateral Grants (replaced original category of MOU)
– Budgetary Aid	Budget support[135]
– All aid types mentioning 'disaster'[137]	Disaster relief/preparedness
– Multi-funded master project	Programme, sector support, budget support[135]

Table 3: Details of rules followed for allocating aid type classified as 'bilateral country grants'[138]

Allocated as…	Criteria	Number of projects
Budget support *(Colenso checklist – programme aid)*[139]	Cross several ministries, poverty reduction focus, may mention PRSPs and/or budget support	14
Sector support *(Colenso checklist – project or sector aid)*	Support to one particular ministry across the sector, may mention budget or sector support or SWAP	22[140]
Debt relief	Mentions debt relief in title or purpose	22

[134] Includes sector-specific country TC, non-sector specific country TC, sectoral programmes TC, non project-specific country TC.
[135] Please note that all financial amounts for 17 projects/programmes classified as budget support were later excluded from the analysis.
[136] Also multilateral refugees grant, multilateral contributions, multilateral replenishment.
[137] Also Bilateral Refugees Country Programmes.
[138] A similar process was used to allocate multi-funded master project to programme (6), sector support (3), budget support (2), vertical funds (1) and project (1).
[139] See Colenso, 2005.
[140] 12 in health, 7 in education and 3 other.

Allocated as…	Criteria	Number of projects
(Colenso checklist – grants and other aid in kind)		
Programme[141] *(Colenso checklist – grants and other aid in kind)*	Discrete block of activity within a sector, e.g. reproductive health (10)	24
Vertical Funds *(Colenso checklist – grants and other aid in kind)*	Disease-specific programme – particularly HIV/AIDS (10) and TB (4)	14
Project *(Colenso checklist – grants and other aid in kind)*	Similar to programme but seems smaller, often run by NGO	8
Technical Cooperation *(Colenso checklist – grants and other aid in kind)*	Intervention to increase effectiveness of budget support	1

- **Policy Dialogue** – Although we were given 'policy dialogue' as an aid instrument, we failed to identify any projects/programmes that fell into this category using the above method. However, a number of projects/programmes seemed to fall into this category. In an attempt to identify these systematically, searches were carried out for the following terms[142] – policy, policies, dialogue, influence, high level, high-level, and parliament. All projects/programmes identified in this way were marked as being relevant to this topic[143].
- **Food security** – One particular topic of interest to the evaluation, in general, and the mapping, in particular, is that of food security. During the manual review of the projects/programmes, we identified a number that were relevant to the topic of HIV, AIDS and food security. Again, to try to make this more systematic, searches were conducted for food security and food[144]. Projects/programmes containing these terms were marked as relevant to this topic.
- **Bilateral or Multilateral** – We attempted to classify projects/programmes as either bilateral or multilateral. In general, this was straightforward. Most multilateral projects/programmes have the term in the project/programme title, the project/programme description or the aid type[145]. Most bilateral projects/programmes specify the country receiving the aid. For non-bilateral aid, we tried to classify it into one of five groups - UN, EU/IFI, other multilateral body, NGO or other/unknown. We faced two main problems:

[141] This is different from how programme and project appear to be classified within MIS codes (DFID, 2005c). In these, a project has a known start and end date while a programme has no planned end date. If these criteria were used, there would be 1,376 projects within our dataset and 48 programmes. We acknowledge that there may be problems with the 48 programmes as they may also not have any planned financial commitment and we have used this as our primary measure of activity size.

[142] A number of others were tried and rejected as not sufficiently sensitive. These included advice, evidence and G8.

[143] Except in a few situations where the use of high level was clearly referring to something else, e.g. high level of HIV in a community. A project/programme marked as 'policy dialogue' will also have been allocated to another aid instrument using the method described above.

[144] An attempt was made to extend the search by using the term livelihood but this was problematic because the term is widely used in the data fields.

[145] They also have a 7 as the fourth digit of the MIS code – the first of three digits in the second level code (DFID, 2005c).

- *How to classify through a DFID country office going to a multilateral, particularly the UN system?* In general, this is classified as bilateral aid[146]. We tried to identify these projects/programmes as a separate category – 'country-level UN'. However, this was not easy as there appears to be a spectrum between a UN-managed project/programme in-country and a government-managed project/programme with some UN support. The distinction was not always clear from PRISM data so in many cases the consultant had to make a personal judgment.
- *Regional and other non-country level projects/programmes* – all of these were allocated to one of the five categories outlined above, except in a few cases where it was clear from the project/programme title or description that it was benefitting one country only. In some cases, some of the regional projects/programmes appeared to be grouped country-level projects/programmes. However, these were allocated as regional projects/programmes, i.e. to one of the five categories[147].

- **Partner Type** – We attempted to classify partners responsible for a particular project/programme into a number of different categories. We did this mostly from the field in PRISM entitled institution (53%)[148] and also from the project/programme title/description (37%). In 9%[149] of projects/programmes, it was not possible to determine the partner type. Initially, we started with just government and NGO but expanded this based on feedback from DFID staff and experience with the dataset. In some cases, it was possible to get information about implementing partner from a simple Internet search. We faced a number of problems with this field:

  - *Absent information* – in many cases the institution field was blank and there was no identifying information in the project/programme title or description. In such cases, for country-specific activities, the project/programme was allocated to the most relevant government department on the basis of the project/programme title/description, e.g. MOH for health activities, NAC for AIDS-specific activities etc[150].
  - *Multiple partners* – in many situations, a project/programme involves many players. We attempted to identify the lead partner only. We only allocated a project/programme to a partnership

[146] For example, project/programme number '350735006 has a multilateral MIS code but is allocated to a country, Slovenia. Presumably, this is a mistake as the destination code '350' is for UNICEF (DFID, 2005c).
[147] It was not always clear which organisation was primarily responsible for a project/programme or to which category it belonged (see discussion on partner type).
[148] Figures based on a review of 200 projects/programmes
[149] This figure was for the 200 projects/programmes reviewed. For the dataset as a whole, it was 94/1424 (6.6%).
[150] It is likely that there are some errors in here and more accurate information could be obtained perhaps by reviewing this data based on information from level 1 of the MIS code.

where there seemed to be evidence of a fairly formal partnership.

- *Overlapping and blurring of categories* – it may not always be clear to which category an organisation belongs. For example, is an in-country NGO part of an international NGO or a local NGO? Is a global health partnership an NGO, a multilateral organisation or a partnership?
- *Relative invisibility of some sectors* – many of the technical cooperation projects/programmes are implemented by consultancy firms, some of which are for-profit, while others operate on a not-for-profit basis. Although some of these have been identified, many have not, and it is likely that a number of projects/programmes have been allocated to government when they are being implemented by such firms, albeit with/for the national government.

- **Focus of Intervention** –This proved to be one of the most difficult fields to fill in consistently[151]. Because of the nature of DFID's work, many of the projects/programmes supported do not fit well into these categories[152]. Hence initially, there were many in the category of other/unspecified[153]. We classified any one project/programme into as many of these categories as seemed appropriate. In general, projects/programmes were classified into one of the more specific categories on the basis of project/programme title/description when they referred to:

  - *Prevention* – preventing disease (including HIV); condoms; health education; community theatre; sex education; social marketing; STI treatment and prevention; information on HIV and AIDS; AIDS awareness; HIV test kits; counselling and testing; PMTCT; media programmes; behaviour change; HIV and AIDS interventions in the education sector; blood safety; life skills training; microbicides; vaccine development; and IEC
  - *Family planning and reproductive health services*[154] – family planning; contraceptives; reproductive health; abortion; and safe motherhood

[151] For this reason, this field was completed three times – the first time with other fields, the second time as a field in its own right to try to ensure consistency and the third time (following the Methods Working Group meeting) as a sub-set of AIDS-specific projects/programmes only.

[152] It is largely for this reason and based on feedback from the methods working group that this field was reviewed for the third time and analysis confined to AIDS-specific projects/programmes only.

[153] We reduced this number second time round by not allocating to this category if we allocated to one or more of the specific categories and also by separating out care and mitigation. General projects/programmes on HIV and AIDS were classified to each of prevention, care and support and mitigation – this included core support to UNAIDS, UNICEF etc. PPA to the Alliance was classified in same way – other PPAs were classified according to knowledge of organisations' activities.

[154] Because these proved difficult to classify as either prevention or care, these were introduced as a separate category. There is a small discrepancy between the number classified here as reproductive and sexual health projects/programmes (261) and those classified in this way when considering whether an activity is AIDS-specific or part of a broader, enabling activity (267).

  - *Research* – including operational research, surveillance and related studies; microbicides; and vaccine development
  - *Treatment* – relating to ARVs and other HIV-specific treatment, such as treatment of opportunistic infections; and traditional healers treating AIDS
  - *Care and support*[155] – especially for PLWHA but also including general health care and treatment[156]; social services; hospital-based initiatives; health sector support; general TB programmes; essential drugs; social safety nets; nutrition and feeding programmes; other specific medical interventions, e.g. on malaria, meningitis, vaccination; and social protection
  - *Mitigation* – anything related to impact mitigation; general development initiatives[157]; economic and livelihood issues; budget support; general education initiatives; and food security

- **M&E capacity development** – HIV and AIDS related projects/programmes, which mentioned monitoring and evaluation were initially identified, but simple project/programme evaluations/reviews were excluded. Three different levels of M&E capacity development were apparent. These are discussed further in the body of the working paper but these were not distinguished at this stage. They are:
  - monitoring of poverty reduction strategies
  - monitoring of health care/health sector initiatives
  - HIV and AIDS monitoring

- **Vulnerable populations** – Primarily, we focused on vulnerability to HIV infection[158]. However, in some projects/programmes the term vulnerability is used differently, either in terms of vulnerability as a result of HIV and AIDS[159], or in more general terms. Wherever a project/programme mentioned a particular vulnerable or target population, this was recorded as follows:

  - women – where women[160] or girls were mentioned specifically; gender; and all reproductive health projects[161]
  - young people[162] - mention of young people, youth, adolescents; further education programmes; and all education programmes unless restricted to primary level only

[155] Originally, care and mitigation were one category. However, these were separated as the types of projects/programmes falling into these two areas seemed quite distinct.
[156] Including projects/programmes focused on health management, planning and reform
[157] Although all these projects/programmes fulfill the criteria mentioned earlier for inclusion in the dataset
[158] For this reason, we did not note projects/programmes focused on PLWHA.
[159] As is often implied in much use of the term OVC
[160] Or related terms, e.g. lady
[161] We later compared our findings with the use of PIMS gender markers within the dataset. Although the numbers of projects/programmes marked by us as relevant to women and the number with a gender marker are broadly similar, there was in fact little overlap between the two groups. This issue is explored in the body of the report.
[162] Although young people have not yet been defined in terms of this evaluation, we assumed that the term primarily refers to those aged 15-25. This means that there is some overlap with children who are assumed to be those up to age 18.

  - OVC – any mention of children; all education programmes unless further education only; and projects/programmes implemented by organisations known to focus on children, e.g. UNICEF, SCF
  - other vulnerable groups – wherever a particular target group was mentioned, this box was checked and a note made of the group

- **HIV and AIDS specific activities** – This was the final field to assess and we did this according to the following criteria:

  - HIV or AIDS-specific (total) – Projects/programmes with a specific focus on HIV prevention, care and support for PLWHA and/or orphans, AIDS treatment etc.; treatment of STIs; projects/programmes focused on broader issues but examining specifically the role/impact of HIV and AIDS
  - HIV or AIDS-specific (partial) – as above but as part of larger programme, e.g. within Global Fund, which also supports disease-specific projects/programmes related to TB and malaria[163]
  - SRH – projects/programmes focused on reproductive health; family planning[164]; contraceptives; safe abortion; safe motherhood etc.
  - health activity – anything relating to health sector or health care; TB and other disease-specific projects/programmes
  - broader enabling action[165] – general development initiatives; general education; poverty reduction initiatives

Data Analysis

Following some initial analysis of the dataset by total number of projects/programmes and planned commitment[166], each variable was analysed by:

- number of new projects/programmes starting each year[167]
- planned commitment made each year
- actual expenditure in 2003/4 and 2005/6[168]

During the preliminary phase of data analysis, we encountered some problems with having two sets of HIV/AIDS PIMS markers. We therefore

[163] As there were very few of these projects/programmes, they were rolled into the former category of HIV or AIDS-specific (total) during the analysis phase. However, based on a specific request from the Methods Working Group, these projects/programmes are listed in Annex 13, p93.
[164] Condom social marketing projects/programmes have been classified as HIV-specific as many are titled HIV prevention projects.
[165] There is a PAM marker called enabling action and we compared the use of this against our own classifications. However, the PAM marker relates to enabling actions related to poverty and is, for example, used for quite a number of projects/programmes which are specific to the health sector.
[166] Based on feedback from the Methods Working Group, all financial amounts related to PRBS were excluded from this report.
[167] From 1987/8 to 2005/6.
[168] As this analysis was carried out prior to end of 2005/6 financial year, expenditure data was not yet complete for 05/06. Analysis has been done based on actual reported with no correction for the incomplete financial year. This needs to be borne in mind when reviewing data.

combined them into one set. We approached the issue of discordant markers by allocating them to either 'P' or 'S' as seemed appropriate from the project/programme description. A summary of how we did this is presented in table 4.

Table 4: Approach Taken with Discordant HA and HIV PIMS Markers

	Allocated as 'P'	Allocated as 'S'
Condom Social Marketing	1	
Health and Population Field Manager		1
Palliative Care	1	
Public Service Capacity Building		1
Film on vulnerable children	1	
Reproductive Health Services		2

For most of the preliminary analysis, it was necessary to sort the projects/programmes by actual start date. This was straightforward for most of them. However,

- For 13 projects/programmes, either the month or date was entered as one digit, e.g. 1 instead of 01. As a result, these projects/programmes did not initially sort correctly. This was corrected manually. In four of these cases, the middle digit exceeded 12. This was corrected by assuming that this was the date and the previous digits were the month[169].
- 77 projects/programmes had no actual start date. For these, the planned start date was used instead.

Analysis was carried out in Excel. First, we analysed the total dataset by actual start date according to number of projects/programmes and size (planned commitment). We then analysed each of the following fields according to number of projects/programmes by start date; size of planned commitment by start date and actual expenditure in FY 2003/4 and 2005/6:

- aid instrument[170]
- bilateral versus multilateral
- type of partner
- focus of intervention
- monitoring and evaluation capacity building
- types of vulnerable populations
- AIDS-specific versus broader enabling actions

[169] It is possible that other dates were recorded in this way but they were not detected.
[170] Including policy dialogue and food security.

Comparison to Official Spending Data Produced by SRSG

Throughout the preparation of this working paper, we have worked closely with DFID staff who have been finalising HIV/AIDS spending figures for 2004/5[171]. However, at the time of finalising this paper, their method and data had not been finalised. We were unable either to use their dataset or to compare our work with their methods and figures. We were provided with draft methods and we kept these in mind when compiling our own dataset[172]. However, our approach may differ from theirs in significant ways:

As SRSG were finalising their dataset, they compared ours with theirs. They found that they had 28 projects/programmes, which we did not have, while we had 417[173] projects/programmes that they did not have. We explored the reasons why we were missing the 28 projects/programmes and have concluded the following:

- 18 were probably inadvertently deleted during data sorting and cleaning
- Five were on the CD provided but had no relevant PIMS markers[174]
- Five were not on the CD provided[175]

Following the meeting of the Methods Working Group, we agreed to add these 28 projects/programmes to our dataset and to perform any further analysis with these included. However, with the limited time available and the amount of additional analysis required[176], this proved not to be possible without delaying the production of the final working paper. Consequently, this has not been done. New work done since the Methods Working Group meeting included:

- recalculating all financial calculations[177] excluding amounts relating to 17 PRBS projects/programmes
- providing tables to EvD, Global AIDS Policy Team, Corporate Strategy Group and Regional Divisions for quality assurance purposes
- reviewing and classifying a sample of 200 TC projects/programmes
- conducting regional and country-by-country analysis[178]

[171] This included staff from SRSG, Corporate Strategy Group and Global AIDS Policy Team.
[172] For example, by using PIMS markers for both HIV/AIDS and reproductive health, which is consistent with the way in which DFID has tracked spending on HIV and AIDS.
[173] SRSG have explored why these projects/programmes did not appear in their dataset. Reasons include a large number of projects which started in 2005/6 and much smaller numbers that we added because of free text searching and use of OVC sector codes
[174] Of these, one should have been picked up by free text searching and it is unclear why this did not happen.
[175] We conducted a search of the live version of PRISM on 5th April using the MIS codes. We were only able to locate 4/28 projects/programmes and only 2 of these had relevant PIMS markers.
[176] Particularly by regions and countries.
[177] For planned commitment and expenditures for 2003/4 and 2005/6.
[178] Country and regional data were extracted in slightly different ways. Country data was extracted based on the 'country' data field while regional data was extracted using MIS codes. There are some discrepancies in this method where a project/programme is allocated to a country but has a non-country-specific MIS code, e.g. 782636011 Latvia; 782636013 S Africa; 782636017 India; 782636017 Zambia; 782636027 Peru; 700634001 S Africa; 689624003 Zambia; 650621001 Ghana and 350735006 Slovenia.

Annex 1: Detailed Methodology

Limitations

As with all studies of this nature, there were a number of limitations. Although we do not believe that these undermine the validity of the trends identified, they do need to be borne in mind when interpreting data from this study.

- Many of the data fields were assigned by textual analysis of the project/programme title and description and not from specific data fields within PRISM. This means the exercise has a subjective element and could be difficult to replicate[179]. Inevitably, we made subjective judgment calls that might have been made differently had they been made by different people
- We were only able to access PRISM at DFID. This restricted our access to the system compared to an online system.
- The Access CD that we were provided with did not have the PRISM user interface nor linkages to further project/programme information. While it proved incredibly useful to have this resource, we did assess the projects/programmes using only the information on this disc and other readily available information sources, e.g. from online searches
- We had to conduct much of our analysis manually, partly because PRISM is not set up with the fields we were asked to explore and partly because PRISM does not appear to generate tailored reports comparing various fields
- Our limited experience in using PRISM – although the system appears to be extremely user-friendly, we were new to using the system. It is possible that some of the limitations we found with the system were due to our relative inexperience rather than inherent limitations of the system
- Not all fields within PRISM have been fully completed. For example, some projects/programmes have no named institution. Others have no actual or planned start/end dates[180]
- Not all data seems to have been entered correctly in PRISM. For example, at least one project/programme was identified with a start date after the end date. In addition, a number of projects/programmes were identified, which mention HIV or a related term in the project/programme title or purpose yet do not have an HIV/AIDS PIMS marker[181]. These projects/programmes are listed in Annex 3, p71[182]. This seems to indicate that some projects/programmes may

[179] Although we have rigorously documented our method to aid replication as much as possible.
[180] In some cases, this is understandable, e.g. no actual end date for projects that have not yet finished or no planned end date for programmes (DFID, 2005c) but this does not appear to explain all the absent data.
[181] The majority do not have an RH marker either, but there are three that have an RH marker but not one for HIV. Given our experience with condom social marketing and the fact that the projects/programmes without PIMS markers were older, complete projects/programmes, we wondered if this might be the case for these projects/programmes. Of 16 projects/programmes identified as HIV/AIDS-related but without an HIV PIMS marker (see Annex 3), we re-identified 15 from PRISM. Of these, 13 started after 2000 – including two in 2006. Four are still operational and these are shown in Annex 3, p71.
[182] Annex 5 (p77) also examines 359 projects/programmes which we classified as totally focused on HIV/AIDS. Of these, 11 have no HIV or AIDS PIMS marker, while 21 have an 'S' marker. Two projects/programmes have discordant HIV and HA markers and one project/programme has both P and S markers for HA.

not have been allocated relevant PIMS markers[183]. This is potentially significant as there may be others that have not been identified through this free text search[184]. In addition, all of the data analysis in this working paper is largely based on the assumption that data in PRISM, including the way PIMS markers are allocated, is correct.

- Projects/programmes are coded by different people and this may not be done consistently. We tested this by assessing coding of all projects/programmes, which mentioned the word 'condom'. We classified these into three types – condom social marketing; other condom promotion; condom promotion with other contraceptives. Table 5 shows how these projects/programmes were coded in PRISM. Whilst this variation could be due to differences between projects/programmes, which we could not detect from the title/purpose alone, it could be that this is inter-observer variability. If this is the case for fairly uniform projects/programmes, it is likely to be even more severe for non-standard projects/programmes. This would mean that any conclusions based on PIMS markers[185] might be less valid than they initially seem.

Table 5: Coding of condom projects/programmes in PRISM

	HIV			RH		
	P	S	None	P	S	None
Condom social marketing	15[186]	0	0	5	7	3
Other condom distribution	8	3	0	5	3	3
Condoms with other contraceptive distribution	6	0	0	1	1	4

- Work to clearly define terminology and definition regarding aid instruments within DFID is ongoing. Currently, there are a number of competing definitions. Our decision to allocate each project/programme to one aid instrument based largely on the description of aid type in PRISM may have resulted in more projects/programmes being classified as 'technical cooperation' and less as other instruments than if a different approach had been used.
- Because work was carried out in February 2006, financial data for 2005/6 is incomplete
- There were particular challenges to mapping the international context. These included:
    - limited availability of information (Guthrie, 2005; Alagiri et al., 2001)

[183] We further tested this by searching for 'condom' on PRISM. This identified 52 projects/programmes. Only 26 of these have an HIV/AIDS or RH PIMS marker, but all of these are completed projects/programmes with a start date prior to 14th July 1999.
[184] We intend to test out this possibility by searching for well-defined projects/programmes on PRISM, e.g. condom social marketing to see if there are any with no RH or HIV PIMS markers.
[185] E.g. the ActionAid suggestion that AIDS expenditure is more accurately determined from HIV/AIDS P-marked projects/programmes only rather than 'S' and 'P'-marked projects/programmes together.
[186] One of these projects/programmes was coded as P for HIV and S for HA.

- the absence of an agreed method for tracking spending on HIV and AIDS[187]
- different coding systems[188]
- limitations of coding systems[189]
- differences between budgets and expenditure[190,191,192]
- different financial years and currencies
- distortions of information depending on purpose[193]
- time lags in generating information[194]
- issues over research[195]
- different thresholds for inclusion of activities[196]
- particular challenges relating to humanitarian assistance (Harvey, 2004)
- risk of double counting funds through multilaterals[197]
- absence of disaggregated data for vulnerable populations (Dunn, 2005)
- no agreed approach to 'fair share' (Kates, 2005, AidWatch, 2004)

[187] Including whether to include only funds whose primary focus is HIV/AIDS (OECD/UNAIDS, 2004), spending on STIs (OECD/UNAIDS, 2004; MacKellar, 2005), reproductive health, more general funding[187] Allagiri et al., 2001), general health funding (OECD/UNAIDS, 2004), financing to multilaterals, debt relief and in-kind assistance.

[188] For example, whether to allow single or multiple purpose codes (OECD/UNAIDS, 2004).

[189] Coding is not always done correctly. Free text searching can supplement this and be used as a quality control measure.

[190] For example, a detailed analysis of donor spending on reproductive health, HIV and AIDS between 2000 and 2003 showed wide variation between predicted and actual spend. Twelve countries spent more than they predicted and nine less. The biggest variations were found in four countries, who all spent more than they predicted – Germany (US$69m), Netherlands ($102m), USA ($183m) and UK ($412m) (van Dalen and Reijer, 2005).

[191] In addition, disbursement does not equate to 'use'. For example, a bilateral may consider the funds disbursed once they have reached a multilateral or NGO (Kates, 2005; Dmytracenko, 2004; McGreevy, 2004).

[192] Expenditure figures are often incomplete (van Dalen and Reuser, 2005a).

[193] Many of the reports are produced for fundraising purposes. Donors may tend to 'highball' (McGreevy, 2004).

[194] For example, the OECD/UNAIDS report on spending in 2000-2002 was produced in 2004 (OECD/UNAIDS, 2004). Such delays are very common (van Dalen and Reuser, 2005a).

[195] Many donors exclude research spending which is not specifically for low/middle income countries (OECD/UNAIDS, 2004; Kates, 2005).

[196] OECD reports using $50k, $100k or levels set by governments.

[197] If they are also reported by the bilateral that is 'back funding' this.

ANNEX 2: REVIEW OF DFID PLANNING DOCUMENTS

Country Assistance Plans (CAPs)[198]

Cambodia	30/11/05
Jamaica	30/11/05
Nepal	30/09/05 and 29/02/04
Nigeria	03/05/05
Montserrat	17/02/05
Somalia	15/02/05
Pakistan	31/01/05
Burma	19/11/04
Palestine	13/07/04
Rwanda	28/06/04
Kenya	17/06/04
Zambia	31/05/04
India	29/02/04
Iraq	19/02/04
Vietnam	31/01/04
Peru	30/11/03
Uganda	31/08/03
Tanzania	30/06/03
Ethiopia	01/03/03 and 04/11/02
Bangladesh	11/01/03
Ghana	04/01/03 and 12/07/02
Malawi	04/01/03

Mozambique
DRC
Sudan
Angola

Regional Assistance Plans (RAPs)

Caribbean	16/09/04
Latin America	31/08/04
West Balkans	24/08/04
Central Asia, South Caucasus and Moldova	30/06/04
Middle East and North Africa	30/09/03

Institutional Strategy Plans (ISPs)

UNDP	14/12/05 and 12/11/00
UNIFEM	03/11/05 and 03/05/99
OHCHR	27/07/05
EU	31/05/05 and 08/08/01
UNFPA	07/05/05

[198] All the CAPs were downloaded from the DFID website apart from Angola, Mozambique, DRC and Sudan, which were obtained from InSight.

Annex 2: Review of DFID Planning Documents

UNAIDS	16/11/04
World Bank	30/09/04
UNHCR	30/07/02
WHO	08/01/02
Commonwealth Secretariat	27/08/01
Euro Bank for Recon and Dev	21/06/01
Caribbean Dev Bank	24/04/01
African Dev Bank	30/03/01 and 27/11/99
Asian Dev Bank	05/01/01 and 13/05/00
World Food Programme	01/10/00
Euro Investment Bank	01/03/00
UN	31/03/99

For each document, we compiled a score based on assessing the following criteria:

- CAPs *and RAPs*
    - Extent to which HIV and AIDS covered (scored 0-3)
    - Closing the funding gap – analysis of current funding in country; gap analysis; allocation of DFID funds; mention of donor coordination (1 point for each)
    - Political leadership – reference to MDGs; reference to UNGASS; involvement of/focus on senior politicians; role of National AIDS Council[199] leadership role of civil society including PLWHA; DFID workplace policy (1 point for each)
    - Better national programmes – mention of comprehensive or multisectoral; integrating treatment and care in health system; food security; vulnerable populations; links to broader issues of poverty (1 point for each)
    - Sustainability (1 point)
    - Building M&E capacity (1 point)

- ISPs
    - Extent to which HIV and AIDS covered (scored 0-3)
    - Closing the funding gap – analysis of current funding in country; gap analysis; allocation of DFID funds; mention of donor coordination (1 point for each)
    - Political leadership – reference to MDGs; reference to UNGASS; involvement of/focus on senior politicians; role of National AIDS Council; leadership role of civil society including PLWHA; DFID workplace policy (1 point for each)
    - International response – measures of effectiveness; table of strategic priorities; specific issues for individual institutions (1 point for each)
    - Sustainability (1 point)
    - Building M&E capacity (1 point)

[199] Or similar, such as national AIDS response, national AIDS strategy etc.

ANNEX 3: PROJECTS/PROGRAMMES IDENTIFIED BY FREE TEXT SEARCHING

Projects/Programmes with HIV or Related Term in Project/Programme Title or Description but has no HIV/AIDS PIMS Marker

HIV or AIDS Related Projects/Programmes

No.	COUNTRY	PROJECT TITLE	PROJECT FULL TITLE	PROJECT PURPOSE
346701	UN AIDS	UN Aids Core grant 2003	Joint United Nations Programme on HIV/AIDS (UNAIDS) Core contribution in 2003.	UNAIDS aims to enable UN organisations to better coordinate[200] their HIV/AIDS work and to strengthen the capacity of poorer countries to respond to the HIV/AIDS pandemic.
001555021	AFRICA REGIONAL	Support to IPAA	Support to International Partnership against Aids in Africa	To intensify, better co-ordinate and increase the effectiveness of national responses to HIV/AIDS in Burundi, Ethiopia, Ghana, Rwanda and other IPAA Countries
003555009	ANGOLA	HIV/AIDS - Consultant	HIV/AIDS - Institutional Assessment Consultant	As part of a World Bank preparation mission held in Angola from 13 - 24 October, to review the institutions created by the government to implement its multisectoral programme to combat HIV/AIDS and endemic diseases.
003555010	ANGOLA	HIV/AIDS Media Campaign	Pan-Africa Media Campaign to Combat HIV/AIDS	To assess the willingness of the Ministry of Health and broadcasters to work together in close partnership to combat HIV/AIDS.
025555035	GHANA	UNV HIV Aids (Rawlings)	DFID support to the United Nations Volunteers Association for the promotion of HIV / AIDS awareness in Africa.	The provision of a one-off payment of $100,000 to the United Nations Volunteers for the promotion of HIV /AIDS awareness in Africa by President Rawlings in his role as an Eminent Person, and a special team of experts.
031680007	KENYA	Pied Crow Educational Comic		To supply the comic to all primary schools in Kenya. Provides info on subjects ranging from Water supply, through AIDS prevention to Environmental protection. 2nd phase addresses greater sustainability.
046683002****[201]	NAMIBIA	Reducing Stigma Related to HIV/AIDS CSCF 298	Reducing Stigma Related to HIV/AIDS and People Living with AIDS in Namibia	Reduced discrimination towards people living with HIV/AIDS in Namibia
057680017	SIERRA LEONE	Capacity Building & Institute Strengthening Of MSSSL (1244)		To strengthen MSSSL to make provision for low and middle income women men and adolescents to access information and take effective

[200] This data has been entered directly from PRISM and has not yet been edited for spellings.
[201] Projects/programmes marked **** are still operational. In this case, this project/programme is PIMS marked 'P' as human rights.

Annex 3: Projects/Programmes Identified by Free Text Searching

No.	COUNTRY	PROJECT TITLE	PROJECT FULL TITLE	PROJECT PURPOSE
				measures to improve their reproductive health status, unwanted pregnancy AIDS
068555003	CENTRAL AFRICA REGIONAL	Supportive Work Environment	Developing a supportive work environment in DFIDCA and regional offices	To help staff in the DFIDCA regional cope with the impact of HIV/AIDS
072581027****[202]	ZAMBIA	World food Programme for drought response	Assistance to Populations in Southern Africa Vulnerable to Food Insecurity and the Impact of Aids	Protect lives and livelihoods of drought affected people
243555004****[203]	LATIN AMERICA REGIONAL	Aids2	Latin America HIV and AIDS Programme Phase Two - Including support for the International Centre for Technical Cooperation on HIV/AIDS Brazil (AIDS2)	To strengthen and make effective, technical cooperation on HIV and AIDS prevention and control, between selected Latin America (LA) Countries
338735033[204]		WHO's "Three by Five" Initiative	WHO's "Three by Five" Initiative	To support WHO's aim to get 3 million people with Aids in the developing world onto anti-retroviral therapy by 2005
338735034		WHO TB/HIV Report	WHO European Framework to Decrease the Burden of TB/HIV	To guide European countries in developing their national plans for reducing TB/HIV morbidity and mortality
059555046***[205]	SOUTH AFRICA, REPUBLIC OF	HIV/AIDS MSF Bridging Fund	HIV/AIDS Multisectoral support framework bridging fund	To broaden and strengthen the response of South African Institutions to HIV/AIDS through effective implementation of their plans
063683015***/****[206]	TANZANIA	CSCF 0345 Young Voices For Change	CSCF 0345 Young Voices For Change	Young Tanzanians (10-24) know, promote and enact their sexual and reproductive rights, including with regards to HIV/ AIDS.
786620060***	BOTSWANA	Impact of HIV/AIDS - Botswana	Impact of HIV/AIDS on Educational Attainment in Sub Saharan Africa - Literature Review & Country Studies	Research

[202] This project/programme is marked as 'other' in the fields relating to PIMS marker – unclear what this means.
[203] This project/programme appears to have no PIMS marker.
[204] From our Excel sheets, this does not seem to have a PIMS code for RH, H/A or HIV. It does, however, have IGE, N in the RH S column.
[205] Projects/programmes marked *** have an RH PIMS marker but no H/A or HIV marker despite having the term HIV in the project/programme title or purpose.
[206] This project/programme has a P PIMS marker for human rights.

ANNEX 4: TRACKING DFID SPENDING ON HIV AND AIDS: ISSUES RAISED

NAO, 2004	Inclusion of spending on sexual and reproductive health;
	Inclusion of general budget support – difficult to isolate what proportion of this used for HIV and AIDS. Reports that DFID relies on governments' own expenditure analyses;
	Estimation of spend on HIV and AIDS for multilaterals based on their reports;
	Regardless of way of measuring, DFID's spend on HIV and AIDS has been rising;
Janjua, 2003	Lack of clear budget lines for HIV and AIDS;
	Mainstreaming of HIV and AIDS into development activities;
	Challenges of PPAs and budget support;
	Using PIMS markers results in expenditure being inflated[207]; Concerns over counting expenditure on HIV/AIDS S marker;
	Limitations of analysis by sector – not all expenditure on HIV and AIDS falls in health sector;
	Issues over counting expenditure on sexual and reproductive health as contributing to HIV and AIDS – 'reproductive health care expenditures is a poor indicator of HIV/AIDS expenditure';
	Expenditure occurring through UK-based CSOs;
	Differences between commitment and expenditure data;
	PIMS system does not count projects below £100k;
	Shift away from project-based funding is problematic for tracking expenditure on HIV and AIDS- e.g. budget support and PPAs;
	Counting STI treatment and prevention as HIV/AIDS expenditure is 'erroneous';
Daly, 2005	No single accurate record of HIV and AIDS expenditure;
	No breakdown by type of activity or by target population;

[207] There seem to be two distinct concerns here – first the inclusion of RH-marked projects/programmes with little or no relevance to HIV and secondly, double counting of the same project/programme that has both an RH and HIV marker.

	Concern over removal of HIV/AIDS sub-sector from health sector expenditure; Concern over inclusion of figures from projects/programmes with HIV/AIDS 'S' markers (see Annex 4 for data on this); Restates many concerns from earlier report (Janjua, 2003), e.g. inclusion of all reproductive health activities, failure to focus on most vulnerable populations. Regards inclusion of reproductive health expenditure as 'double counting'; Regards lack of gender analysis as 'shameful';
ActionAid, 2005[208]	Definition of 'phantom aid' includes debt relief[209]; technical assistance[210] and some aid to middle-income countries[211]
DFID, 2005b	In response to a parliamentary question, figures were given for spend on HIV and AIDS in 2003/4. This excluded budget support as it said a method was being developed to calculate this. It included all projects/programmes with S or P for HIV/AIDS or reproductive health; Guidance on how to allocate HIV and AIDS spending within budget support was expected early in financial year 2005/6[212] Basic calculation method based on minute from Richard Calvert dated Sept 2004 (Annex B). This was basis for spending target and included: – bilateral spending with an HIV principal or significant marker; – bilateral spending with an SRH principal or significant marker[213]; – budget support, which is attributable under the methodology developed by SRSG; – multilateral contributions, in proportion to the extent to which the budget of the recipient organisation addresses HIV issues.

[208] Although this report is not specific to HIV and AIDS, it raises some relevant general points.
[209] This issue is very relevant as our dataset of 1424 projects/programmes contains 23 examples of debt relief as aid instrument.
[210] This issue is very relevant as most of the projects/programmes (by number) in our dataset of 1,424 projects are classified as technical cooperation, i.e. 1,027 or 72%. ActionAid concluded that 75% of technical assistance is 'phantom aid'. However, no evidence for this proportion is presented and it seems likely that the terms technical cooperation and technical assistance could be being used quite differently.
[211] Where aid to middle income countries exceeds 30% of official development assistance, any aid above this figure is counted as 'phantom'.
[212] Work is still ongoing on this although we are now approaching the end of FY05/06.
[213] The minute indicated that there was willingness to review the appropriateness of including projects/programmes with RH markers but without HIV markers over next 12-18 months – see Annex 6, p78.

	Annex C (Jan 2005) provided guidance on PIMS markers and input sector codes[214] in reference to spending target;
	To 2002/3 100% of spending on sector or budget support was included as HIV/AIDS expenditure if it had a P or S marker for HIV. For the response to the PQ on 2003/4, these figures were excluded;
	Concern that PIMS markers for HIV/AIDS not allocated consistently for budget support;
	From 2003/4, multilateral figures based on their reports of percentage spend on HIV and AIDS; Issues over different financial years and lags in notifying of changed proportions;
	NAO and PAC reported to have accepted inclusion of S HIV and AIDS marker and link to RH;
	Annex D reports that most RH projects/programmes receive an S or P marker for HIV – see Annex 6)
	Issue of NAO scrutiny of any approaches agreed;
	Issue of quality control of PIMS marker allocation;
	Issue of whether *TA* is explicit about including SRH projects/programmes in progress to spending target – see footnote on p19 of *TA;*
UNAIDS, 2005	Clearer methods at national level than in previous versions of guidelines – now focused on national HIV/AIDS accounts; Not completely clear on what to include and exclude;
	For international financing, OECD DCD annual questionnaire: • includes STI spend • does not disaggregate prevention etc. • limited to health sector
UNAIDS, 2003	Little guidance on what to include
Benn, 2005	Disputes ActionAid's claims about debt relief, TC and middle-income countries Gives examples of what these types of aid have achieved in practice ActionAid makes multiple deductions, overstates administration and presents some figures without evidence
International Development Committee, 2005	Question raised by Joan Ruddock based on NAO report as to whether amount spent on HIV and AIDS is 'exaggerated'. In response, Robin Gorna referred to more robust system

[214] Relevant in tracking the OVC spending target.

of monitoring the TA spending target and to this evaluation.

Overview of Projected Primary Funds for Population and AIDS Activities (US$m) for 2004-2006 (van Dalen and Reuser, 2005b)

Year	General contributions	Family planning	Reproductive health	STD/HIV/AIDS	Basic research	Total primary funds
2004	354	115	570	3473	193	4706
2005	390	117	613	3959	198	5277
2006	385	113	606	4216	190	5509
Change 04-06	+8.8%	-1.7%	+6.3%	+21.4%	-1.6%	+17.1%

ANNEX 5: HOW ARE AIDS-SPECIFIC PROJECTS/PROGRAMMES CODED BY DFID'S PERFORMANCE REPORTING INFORMATION SYSTEM FOR MANAGEMENT (PRISM)?

Note on Action Aid concern over using 'P' markers for expenditure (Janjua, 2003)

We reviewed 359 projects/programmes which we classified as being totally focused on HIV and AIDS.

11 had no HIV/AIDS PIMS marker
21 had an S marker – 19 HA, 2 HIV
28 had more than 1 marker – in most cases, this was an H/A P marker and an HIV P marker

- 2 cases with HIV P and HA S – condom social marketing in Kenya and palliative care in Uganda
- 1 case where a project/programme had both HA P and HA S marker

ANNEX 6: RAPID ASSESSMENT OF PROJECTS/PROGRAMMES WITH REPRODUCTIVE HEALTH MARKERS

Of 1,424 projects/programmes, 292 have RH P markers. Of these:

- 105 have HIV P markers[215] 36%
- 98 have HIV S markers 34%
- 89 have no HIV marker 31%

7/10 projects/programmes whose main focus is RH also contribute to HIV

Another 518 have RH S markers. Of these:

- 147 have HIV P markers[216] 28%
- 184 have HIV S markers 36%
- 187 have no HIV marker 36%

6/10 projects/programmes who make a significant contribution to RH also contribute to HIV

Table 1 shows the results of a rapid analysis of a 150 projects/programmes with RH P markers[217]:

Table 1: Types of projects/programmes with RH P markers and their spread among HIV/AIDS markers

	HIV P marker	HIV S marker	No HIV marker
Budget support	2	0	0
Health SWAP	4	0	0
Health project	4	11	16
Reproductive Health project	13	31	17
Family planning	3	4	3
Condom supply/social marketing	8	2	0
Mentions HIV in purpose	11	2	2
STI control	1	0	0
Others	3[218]	7[219]	6[220]

[215] Combining HIV and HA markers.
[216] Combining HIV and HA markers.
[217] Following the Methods Working Group meeting in April 2006, a number of DFID staff are reviewing projects/programmes with RH markers within this dataset.
[218] Support to UNFPA (2); work with NGOs.
[219] DHS (2); safe motherhood; cervical cancer; safe abortion; farm workers; project/programme with children.
[220] Female genital mutilation (2); support to UNFPA; income generation for women; safe abortion; demining.

ANNEX 7: SUMMARY OF VARIOUS DEFINITIONS OF AID INSTRUMENTS

Source	DFID, 2006b	Colenso, 2005	Foster and Leavy, 2001
Global Funds	Global Funds and Partnerships (GFPs) are characterised by a common set of objectives, new innovative services, a dedicated organisation and benefits cutting across more than one region of the world.	Excluded from notes as focused on country level	
Technical Cooperation	Technical cooperation is the provision of advice and/or skills in the form of specialist personnel, training, scholarships and grants for research and associated costs.	Includes with government and others	
PRBS	Poverty reduction budget support (PRBS) is when a donor provides funds directly to a partner government's central exchequer in support of their programmes, to assist poverty reduction.	Grouped together	Termed general budget support - said to differ from balance of payments support in that it focuses on local currency
SWAp/Sectoral Support	A Sector Wide Approach (SWAp) is a process where donors give significant funding to a government's comprehensive sector policy and expenditure programme (for example on health or education), consistent with a sound macro-economic framework.		Distinguishes sectoral support and SWAp
Multilateral Instruments		Excluded from notes as focused on country level	Recognised but not covered in detail
Centrally-managed Funds		Includes PPA and CSCF – excluded from notes as focused on country level	
Balance of Payments Support		Merged as non-budget support financial aid	Finance in support of a programme of policy reform measures, typically provided by IMF and World Bank

Annex 7: Summary of Various Definitions of Aid Instruments

Source	DFID, 2006b	Colenso, 2005	Foster and Leavy, 2001
Debt Relief			Reducing stock of obligations which government has to meet in future
Food Aid			
Projects		Through and outside government system	Three types distinguished - government systems, parallel systems and NGO/private providers
Social Funds and cash transfers		Includes World Bank's Community Driven Development model	
Grants and Other Aid in Kind		Mentioned but not defined	
Policy Dialogue		This will link to analytical work we have done on 'influencing'. It may seem unusual to understand `policy dialogue' as an instrument, but we want to extend aid effectiveness analysis and guidance beyond financial spend (which is what our systems currently track, although this may change under ARIES). In some countries it may also be the most important thing we do.	
Humanitarian Aid		Mentioned but not defined	
Comments		Notes differing definitions of aid instruments, e.g. blue book (DFID, 2006c), pink book	

ANNEX 8: PROJECTS/PROGRAMMES WITH A FOCUS ON M&E CAPACITY BUILDING

No.	COUNTRY	PROJECT TITLE	PROJECT FULL TITLE	PROJECT PURPOSE
003555012	ANGOLA	UNAIDS Country Support	Intensifying Country Support to Bring National Responses to HIV/AIDS to Scale in Angola, DRC, Ethiopia, Somalia and Sudan	To improve the country level effectiveness of UNAIDS by strengthening their capacity in regional offices, so as to enable countries to have one national AIDS authority, one agreed national monitoring and evaluation framework, to have strong government-led
020555011	ETHIOPIA	Intensifying UNAIDS Country Support	Intensifying Country Support to bring national responses to scale in Angola, the Democratic Republic of Congo, Ethiopia, Somalia and Sudan	To enable countries to have one national authority, one agreed national M&E framework, have strong government-led partnership forums and to increase participation from all sectors of society
031542095	KENYA	Monitoring & Evaluation System	Integrated Monitoring & Evaluation System for the Economic Recovery Strategy	Enhance the capacity of the government and non-state actors to report on the progress of implementation of the IP-ERS and related policy framework documents and to use the results to improve resource allocation and use.
044542065	MOZAMBIQUE	Budget Support 2003/4 - 2005/6	Multi Donor Budget Support 2003/4-2005/6	To support the evolution, implementation and monitoring of the PRSP (PARPA)
058555003	SOMALIA, DEMOCRATIC REP	UNAIDS Country Support	Intensifying Country Support to Bring National Responses to Scale in Angola, the Democratic Republic of Congo, Ethiopia, Somalia and Sudan	To enable countries to have one national authority, one agreed national M&E framework, have strong government-led partnership forums and to increase participation from all sectors of society
058581035	SOMALIA, DEMOCRATIC REP	Medecins San Frontieres Prov of Primary Health Care Somalia	Medecins sans Frontieres: Provision of Primary Health Care for the Population in Jowhar, Mahadaay and Adan Yabal Districts Middle Shabelle Region, Somalia	To provide free PHC and to increase services provided to women monitoring of epidemic diseases and maintaining the response capacity for possible epidemic outbreaks. To consolidate the local management of PHC centres and to chlorinate wells during the…
060555010	SUDAN	Intensifying UNAIDS Country Support	Intensifying Country Support to Bring National Responses to HIV/AIDS to Scale in Angola, DRC, Ethiopia, Somalia and Sudan	To improve the country level effectiveness of UNAIDS by strengthening their capacity in regional offices, so as to enable countries to have one national AIDS authority, one agreed national monitoring and evaluation framework, to have strong government-led
063052001	TANZANIA	National Poverty Mon Syst	Support to Pooled Fund National Poverty Monitoring System	To strengthen Government's capacity building and analyse data on poverty

Annex 8: Projects/Programmes with a Focus on M&E Capacity Building

No.	COUNTRY	PROJECT TITLE	PROJECT FULL TITLE	PROJECT PURPOSE
068581010	CENTRAL AFRICA REGIONAL	Strengthen WHO SAHC Response	Strengthening WHO presence and response to the Humanitarian crisis in Southern Africa	Effective monitoring and response to health and nutrition situation during 2003
071581082	CONGO, DEM REP	United Nations AIDS Five Country Support	Intensifying Country Support to Bring National Responses to HIV/AIDS to Scale in Angola, DRC, Ethiopia, Somalia and Sudan	To improve the country level effectiveness of UNAIDS by strengthening their capacity in regional offices, so as to enable countries to have one national AIDS authority, one agreed national monitoring and evaluation framework, to have strong government-led
073555009	ZIMBABWE	2005 Zimbabwe Demographic Health Survey	2005 Zimbabwe Demographic Health Survey	To collect baseline data on health indicators and data needs of the MDGs Monitoring and Reporting Processes
073581032	ZIMBABWE	UN Coordination and Monitoring of Humanitarian Interventions	support to UN Humanitarian Coordination and Monitoring of Humanitarian and recovery interventions in Zimbabwe	To ensure effective coordination and monitoring of humanitarian and relief operations
139555081	BANGLADESH	SHAPLA : Technical Assistance for Reviews	SHAPLA Technical Assistance for Reviews	To support the Government of Bangladesh in Co-ordination and monitoring of it's health and Population sector programme
142555003	BURMA	HIV/AIDS NATIONAL RESPONSE	Systems for HIV/AIDS National Response in Myanma	Two short term consultancies to develop an integrated monitoring and evaluation system and a results framework and log frame for the national response to HIV/AIDS in Myanmar
283555013	UKRAINE	UNAIDS 30nes in Ukraine	Support a government-led co-ordination mechanism via UNAIDS to tackle HIV&AIDS in Ukraine	To support a government-led co-ordination mechanism to implement a coordinated response to HIV&AIDS in Ukraine
292542059	RUSSIAN FEDERATION	Nizhny Addressing HIV/Aids	Nizhny Novorod partnership programme: addressing HIV/AIDS project	to build capacity in the Oblast authorities (including oblast HIV/AIDS centre) to design, implement, monitor and evaluate targeted cost effective cross-sectoral policies and programmes for prevention of HIV/AIDS.
292555097	RUSSIAN FEDERATION	HIV/AIDS Three Ones Facility Project	HIV/AIDS Three Ones Facility Project in the Russian Federation	To support the implementation of UNAIDS' "Three Ones" principles at federal level in the Russian Federation
294542011	KAZAKHASTAN, REPUBLIC OF	UN AIDS Secondments	UN AIDS Central Asia Regional Office, Regional Monitoring and Evaluation Adviser	Under the supervision of the UNAIDS Regional Coordinator, the Regional Monitoring and Evaluation Adviser will work with respective governments and UN Theme Groups on HIV and AIDS to strengthen UNAIDS' contribution to effective national leadership.
729636012	NON SPECIFIC COUNTRY	UNAIDS AIDS Donor Conference	UNAIDS: AIDS Donor Alignment Consultation 2004	Funding a UNAIDS conference to promote the three ones 1 - One agreed HIV/AIDS Action Framework that drives alignment of all partners. 2 - One national AIDS authority, with a broad - based multisectoral mandate. 3 - One agreed country - level monitoring an

Annex 8: Projects/Programmes with a Focus on M&E Capacity Building

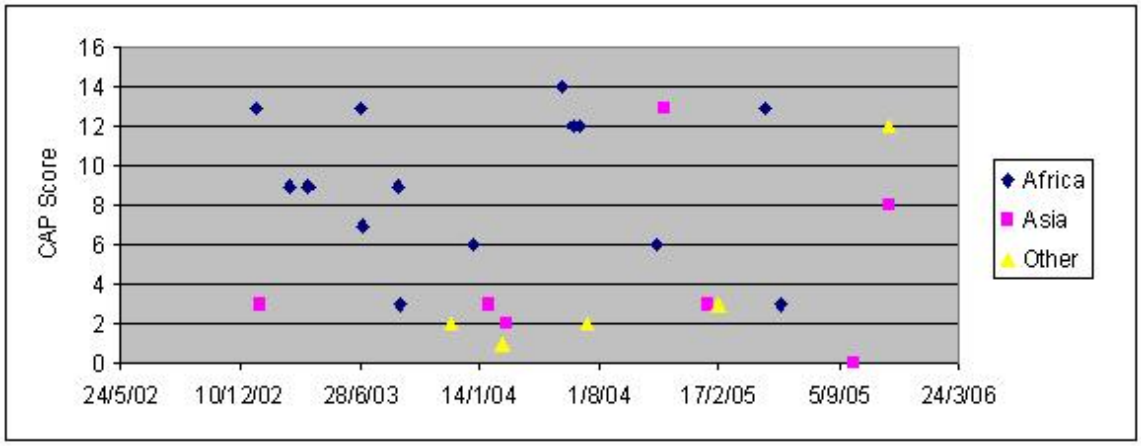
No.	COUNTRY	PROJECT TITLE	PROJECT FULL TITLE	PROJECT PURPOSE
729640001	NON SPECIFIC COUNTRY	identify equity indicators	Identifying effective and appropriate equity indicators to be included in a basic equity-oriented health information system	To fund the indicators paper for the HEALTH METRICS NETWORK group on integrating equity into HIS (Health Information System)
729653006	NON SPECIFIC COUNTRY	Health Metrics Network	DFID funding for the Health Metrics Network	Improve country health information systems (HIS) in ways that meet the needs of both country and global stakeholders, to ensure availability and use of timely and robust health information at a sub-national, national and global levels
732620020	NON SPECIFIC COUNTRY	Expanding Communication for Social Change	Expanding Communication for Social Change Approaches in Eastern and Southern Africa: Developing Monitoring and Evaluation Methods for Country Initiatives	The main output of this work will be a set of guidelines and principles of participatory monitoring and evaluation that local community leaders can understand, train others in, and use to monitor and evaluate progress toward their communication goals…
782621186	NON SPECIFIC COUNTRY	Measure Monitor & Evaluating Health Systems Performance	Measuring, Monitoring and Evaluating health systems performance to achieve pro-poor health outcomes.	To improve existing and develop new tools for measuring the health of the poorest and monitoring health systems pro-poor performance
782621190	NON SPECIFIC COUNTRY	EU Development: Monitoring	Health Systems Resource Centre: Support for European Union Development Work: Monitoring	To facilitate meetings, prepare documents and reports. To produce a Technical Review Paper - a synthesis of global work on M&E frameworks.
782622187	NON SPECIFIC COUNTRY	UNAIDS Programme Adviser	Secondment of Health and Population Adviser to UNAIDS as Senior Programme Adviser	To provide technical support to UNAIDS in the development and implementation of HIV/AIDS related programmes designated as "Executive Director Initiatives" such as Global Strategy, Africa Initiative and Evaluation and Monitoring.
782622216	NON SPECIFIC COUNTRY	C G Secondment to WHO	Prof C G, Liverpool School of Tropical Medicine: Secondment to WHO (World Health Organisation)	To help develop epidemiological surveillance system capable of measuring HIV/AIDS disease burden across the spectrum that can be related to care needs and provision
782622248		WHO Adviser to PRP Unit	World Health Organisation - Adviser: Planning, resource Coordination and Performance Monitoring Unit, General Management Group	Support to the ongoing efforts to define the Medium Term Strategic Plan

ANNEX 9: POOLING OF FUNDS FOR HIV AND AIDS[221]: SELECTED COUNTRIES[222]

Country	Project/Programme in Dataset Characterised as Budget Support	Project/Programme in Dataset Characterised as Sector Support	Country Identified Donor Coordination over HIV and AIDS as an issue in CAP
Afghanistan		✓	
Bangladesh		✓	
Burma			✓
China		✓	
DRC			✓
Ethiopia	✓		✓
Ghana	✓	✓	✓
India		✓	
Iraq	✓		
Jamaica			✓
Kenya		✓	✓
Malawi	✓	✓	✓
Montserrat		✓	
Mozambique	✓	✓	
Nepal		✓	
Pakistan	✓	✓	
Rwanda		✓	✓
Sudan			✓
Tanzania	✓	✓	✓
Uganda	✓		✓
Vietnam	✓		
Zambia		✓	✓

[221] See Table A 3g5.
[222] Proposed 'case study' countries highlighted in yellow.

ANNEX 10: SCORING DFID COUNTRY ASSISTANCE PLANS ON THEIR COVERAGE OF HIV AND AIDS



ANNEX 11: PROJECTS/PROGRAMMES RELATED TO FOOD SECURITY

No.	COUNTRY	PROJECT TITLE	PROJECT FULL TITLE	PROJECT PURPOSE
031680076	KENYA	Kapsokwony Integrated Rural Development Programme JFS1046		The project includes strategies for increasing food security, provision of savings and credit facilities, enhancing health, water quality and environmental sanitation, education, community institution building..
063680020	TANZANIA	Biharmulo Project (474)		To promote sustainable development by reversing environmental damage; ensure food security; resolve labour bottlenecks; enable women's access to income; develop sub-village structures; investigate AIDS programs
087680019	BRAZIL	Projeto Ibeji For the Street children (JFS 1205)		Project is based in Salvador and aims to assist children "at risk" due to being on the streets. It will provide safe place to go where food, shelter, legal advice, training, I-G opportunities are available.
003680005	ANGOLA	Child Rights and Welfare - JFS 1663	Country Programme - Angola: Making a Reality of Children's Rights	To develop initiatives and new approaches to child protection and social welfare, urban poverty, food security, health and access to other basic services such as education during periods of relative stability and/ or conflict.
021581013	NIGER	World Health Organisation Health Response to Niger	World Health Organisation Health Response to the Food Crisis in Niger	To improve the health and nutritional surveillance systems, strengthening the health coordination mechanism and supporting the development of a health access policy and framework
025680033	GHANA	Integrated Food Security Project (JFS 1555)	Food Security Project	To improve the standard of living by ensuring adequate food all year round.
033615031	LIBERIA	Liberian Secondees - WFP	Liberian Secondees - World Food Programme	To increase the capacity of WFP to delivery emergency humanitarian assistance in Liberia.
037508007	MALAWI	DFID Support to the Inputs for Assets programme of Malawi	Sustaining Productive Livelihoods through Inputs for Assets (SPLIFA)	To enhance the food security of marginal farmers in the achievement of enhanced livelihoods for poor people in Malawi
037508008	MALAWI	Targeted Inputs Programme 03/04 Increase food production	Targeted Inputs Programme 03/04 Increase food production	To increase staple food production for 1.7 million poor, food insecure households in rural areas of Malawi
037680015	MALAWI	Country Programme JFS 1545	Country Programme - Malawi	To develop an integrated livelihood security programme which includes HIV/AIDS, health, water and sanitation and food security initiatives that targets vulnerable and marginalised people.
068500003	SOUTH AFRICA, REPUBLIC OF	Regional Hunger & Vulnerability Programme For S Africa	Regional Hunger & Vulnerability Programme for Southern Africa	Improved national and regional food security policy at national and regional levels in the SADC region
068581006	CENTRAL AFRICA REGIONAL	IFRC Regional Appeal	Support for the IFRC Regional Appeal Southern Africa : Food Aid and Humanitarian Assistance	To provide food assistance to pre targeted highly vulnerable groups in four countries in Southern Africa (primarily HIV/AIDS affected populations)

Annex 11: Projects/Programmes Related to Food Security

No.	COUNTRY	PROJECT TITLE	PROJECT FULL TITLE	PROJECT PURPOSE
068581009	CENTRAL AFRICA REGIONAL	Support for IFRC	Support for IFRC Regional Appeal :Southern Africa Food Aid and Humanitarian Assistance	To provide general and targeted food aid in the region and supplementary feeding for home based care programmes
072559011	ZAMBIA	CARE Partnership Programme Agreement Zambia	CARE Partnership Programme Agreement Zambia	Enable the poorest to better manage risk associated with food security destitution and HIV/AIDS
072581022	ZAMBIA	Improving Vulnerability Assessment	Improving Vulnerability, food security and nutrition assessment	To improve policies and coordination among institutions and agencies involved with food security at regional and national levels
072581027	ZAMBIA	World food Programme for drought response	Assistance to Populations in Southern Africa Vulnerable to Food Insecurity and the Impact of Aids	Protect lives and livelihoods of drought affected people
072581028	ZAMBIA	Support to Vulnerability	Social Protection (Support to Vulnerability Assessment)	To improve policies and co-ordination among institutions and agencies involved with food security at regional and national levels
073581018	ZIMBABWE	UN Humanitarian Assistance and Recovery Programme	UN Humanitarian Assistance and Recovery Programme	To meet the emergency health and food needs of poor and displaced persons in Zimbabwe
073581022	ZIMBABWE	Urban Feeding Programme	Urban Feeding Programme Phase 1	To provide food support to vulnerable people in urban areas of Zimbabwe affected by food shortages
073581024	ZIMBABWE	Vulnerable Farm Workers Relief Human Aid	Vulnerable Farm Workers Relief (Humanitarian Aid), Recovery and Empowerment Programme	Provision of food relief, recovery and social protection needs to displaced former commercial farm workers and empowerment of farm worker communities
073581025	ZIMBABWE	NGO Feeding 2003/04	NGO Humanitarian Assistance Programme 2003/04	To provide food support and livelihood improvements to vulnerable people in areas of Zimbabwe affected by food shortages
073581026	ZIMBABWE	NGO Agricultural Recovery 2	Emergency agricultural recovery for vulnerable households (2003 to 2004)	To assist the recovery of agricultural production and increase access to food through the distribution of essential sees, fertilizer and advice
073581029	ZIMBABWE	HIV/AIDS Humanitarian Support	Humanitarian Support for HIV/AIDS affected households 2003 2004	To provide food support to HIV/AIDS affected households in both urban and rural areas of Zimbabwe
073581036	ZIMBABWE	Protracted Relief	Protracted Relief Programme Phase 1	The project's purpose is to stabilise food security and to protect the livelihoods of some 1.5milion people in Zimbabwe, particularly households affected by AIDS
137615033	AFGHANISTAN	Sustainable Development in Afghanistan	Sustainable Development in Badakhshan and Konar Provinces, Afghanistan	To sustainably improve household food-security and health in poor rural settlements in 8 districts of 3 provinces in Afghanistan

Annex 11: Projects/Programmes Related to Food Security

No.	COUNTRY	PROJECT TITLE	PROJECT FULL TITLE	PROJECT PURPOSE
730636019		Urban families under pressure	Urban families under pressure: HIN/AIDS, economic decline, safety nets and livelihood strategies in Zambia and Kenya	Will investigate the impact of short term shocks and long duration stresses due to economic decline and ill-health, especially HIV/AIDS, on the livelihood strategies of poor urban households and wider social networks in Nairobi, Kenya and Lusaka and a cop
733637002	NON SPECIFIC COUNTRY	Urban Families Pressure	Urban Families under Pressure: HIV/Aids economic decline, safety nets and livelihood strategies in Zambia and Kenya	to investigate the impact of short term shocks and long duration stresses due to economic decline and ill-health especially HIV/AIDS, on the livelihood strategies of poor urban households and wider social networks in Nairobi, Kenya and Lusaka, Zambia and
745620025	NON SPECIFIC COUNTRY	Funding to International Forum Rural Transport Development	Funding to International Forum for Rural Transport and Development (IFRTD)	International Forum for Rural Transport and Development works to particularly facilitate application of policies, technologies and planning frameworks that will satisfy the accessibility and mobility needs and improve the livelihoods of poor women, men an

ANNEX 12: FULL GLOSSARY

ADB	Asian Development Bank
ACTSA	Action for Southern Africa
ADD	Action on Disability and Development
AIDA	Accessible Information on Development Activities
AIDS	Acquired Immunodeficiency Syndrome
AMC	Advance Market Commitments
AMREF	African Medical and Research Foundation
ARIES	Activities Reporting and Information e-System
ARV	Antiretroviral
ASAL	Arid and Semi-arid Lands
BHC	British High Commission
BRAC	Bangladesh NGO
CA	Central Africa
CAP	Country Assistance Plan
CBHC	Community-Based Health Care
CBO	Community-Based Organisation
CDROM	Compact Disc Read Only Memory
CEDC	Children in Especially Difficult Circumstances
CIMT	Change Impact Monitoring Table
CRD	Central Research Department
CSCF	Civil Society Challenge Fund
CSW	Commercial Sex Worker
DAC	Development Assistance Committee
DCD	Development Cooperation Directorate
DCI	Irish Aid
DDE	Department of Distance Education
DFID	Department for International Development
DOH	Department of Health
DRC	Democratic Republic of Congo
DTI	Department of Trade and Industry
EC	European Commission
EFA	Education for All
EMAD	Europe, Middle East and Americas Division
ESP	Essential Services Package
ESSP	Education Sector Support Programme (Rwanda)
EU	European Union
FA	Financial Aid
FASE	Education Sector Common Fund (Mozambique)
FCO	Foreign and Commonwealth Office
FGO	Federal Government
FP	Family Planning
FY	Financial Year
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFPs	Global Funds and Partnerships
GMS	Greater Mekong Sub-region
GNI	Gross National Income
Go	Government of

Annex 12: Full Glossary

GTZ	German Development Organisation
H/A	HIV/AIDS PIMS Marker
HAP	Health, AIDS and Population
HIV	Human Immunodeficiency Virus
HLSP	Consultancy firm – member of Mott MacDonald Group
HNPSP	Health, Nutrition and Population Sector Programme
HPG	Humanitarian Policy Group
HSR	Health Sector Reform
HSRC	Health Systems Resource Centre
ICDDRB	International Centre for Diarrhoeal Disease Research, Bangladesh
ICPD	International Conference on Population and Development
ICTR	International Criminal Tribunal for Rwanda
IDASA	Institute for Democracy in South Africa
IDP	Internally Displaced Person
IDU	Injecting Drug User
IEC	Information, Education, Communication
IFFG	Investing for Future Generations
IFI	International Financial Institution
IFRC	International Federation of Red Cross and Red Crescent Societies
IFRTD	International Forum for Rural Transport and Development
IMF	International Monetary Fund
IOE	Institute of Education
IOM	International Organisation for Migration
IPAA	International Partnership against AIDS in Africa
ISP	Institutional Strategy Plan
JFS	Joint Funding Scheme
KESSP	Kenya Education Sector Support Programme
LA	Latin America
LGA	Local Government Area
MASSAJ	Malawi Safety, Security & Access to Justice
MCH	Mother and Child Health
MDG	Millennium Development Goal
MERG	Monitoring and Evaluation Reference Group
MIS	Management Information System
MOD	Ministry of Defence
MOH	Ministry of Health
MOU	Memorandum of Understanding
MRC	Medical Research Council
MSF	Médecins sans Frontières
MSI	Marie Stopes International
MSM	Men who have Sex with Men
MSSSL	Marie Stopes Society of Sierra Leone
NAC	National AIDS Council
NAO	National Audit Office
NCCK	National Council of Churches of Kenya
NGO	Non-Government Organisation
NHS	National Health Service
ODA	Official Development Assistance

OECD	Organisation for Economic Cooperation and Development
OHCHR	Office of the United Nations High Commissioner for Human Rights
OI	Opportunistic Infection
OSI	Open Society Institute
OVC	Orphans and Vulnerable Children
P	Principal
PAC	Public Accounts Committee
PAHO	Pan American Health Organisation
PAI	Population Action International
PAM	Poverty Aim Marker
PARPA	PRSP in Mozambique
PCOSP	Primary Community Schools Project (Malawi)
PDP	Performance and Development Plan
PHC	Primary Health Care
PIMS	Policy Information Marker System
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
POA	Programme of Action
PPA	Programme Partnership Agreement
PQ	Parliamentary Question
PRBS	Poverty Reduction Budget Support
PRISM	Performance Reporting Information System for Management
PRP	Planning, Resource Coordination and Performance Monitoring Unit, WHO
PRSP	Poverty Reduction Strategy Paper
PSI	Population Services International
RAP	Regional Assistance Plan
RDHC	Reproductive Disease Control Service
RESSP	Education Sector Support Programme (Rwanda)
RH	Reproductive Health
S	Significant
SADC	Southern African Development Community
SAHC	Southern Africa Humanitarian Crisis
SCF	Save the Children Fund
SCUK	Save the Children, UK
SC-US	Save the Children, US
SESAP	Support to Education Sector Analysis and Planning (Nigeria)
SFD	Social Fund for Development
SHAPLA	Strengthening Health and Population for the Less Advantaged
SIDA	Swedish International Development Agency
SPLIFA	Sustaining Productive Livelihoods through Inputs for Assets
SRH	Sexual and Reproductive Health (also RSH)
SRSG	Statistical Reporting and Support Group
SSS	Social and Scientific Systems
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TA	Taking Action
TB	Tuberculosis

Annex 12: Full Glossary

TC	Technical Cooperation
TQA	Table of Questions and Approaches
UBEP	Universal Basic Education Project (Nigeria)
UHPP	Urban Health & Poverty Project
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNCT	United Nations Country Team
UNDP	United Nation's Development Programme
UNDPKO	United Nations Department of Peacekeeping Operations
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nation's Development Fund for Women
UNV	United Nations Volunteer
UPE	Universal Primary Education
US	United States of America
WDR	World Development Report
WHO	World Health Organisation
YSW	Young Sex Worker

ANNEX 13: PROJECTS/PROGRAMMES CLASSIFIED AS AIDS-SPECIFIC (PARTIAL)

No.	COUNTRY	PROJECT TITLE	PROJECT FULL TITLE	PROJECT PURPOSE
063680020	TANZANIA	Biharmulo Project (474)		To promote sustainable development by reversing environmental damage; ensure food security; resolve labour bottlenecks; enable women's access to income; develop sub-village structures; investigate AIDS programs
144680028	CAMBODIA	Various Programmes Cambodia Save The Children JFS 1008		Support for the midwives association. Kratie Province Child-focused development initiative. Ministry of social affairs, training needs assessment. HIV/AIDS prevention. Support to local NGOs.
149680168	INDIA	TB Control, Leprosy Eradication HIV/AIDS Awareness (JFS 1239)		Project aims to achieve a direct impact on the prevalence & awareness of TB, Leprosy, Aids, & reduce the social/economic consequences of these through staff training, health education & awareness raising.
001555029	AFRICA REGIONAL	African Summit on HIV/AIDS,TB and Malaria	African Summit on HIV/AIDS, TB and Malaria : Preparation of Key Summit Documents	To support the preparation of four technical papers for the Africa Heads of State Summit on HIV/AIDS, TB and Malaria to be held in Abuja, Nigeria May 2006.
031680007	KENYA	Pied Crow Educational Comic		To supply the comic to all primary schools in Kenya. Provides info on subjects ranging from Water supply, through AIDS prevention to Environmental protection. 2nd phase addresses greater sustainability.
283555008	UKRAINE	HIV/Aids Control Project	Procurement and financial management support Consultancy to WB/Ministry of Health Tuberculosis and HIV/AIDS Control Project.	To assist the Ukrainian Ministry of Health in finalising the design of the World Bank's Tuberculosis and HIV/Aids Control Project and associated loan documents.
292555069	RUSSIAN FEDERATION	TB/AIDS Co-operation with WB	The Russia Tuberculosis/Acquired Immune Deficiency Syndrome (TB/AIDS) Project (RU-PE 64237) with the World Bank	The Proposed Project Aims at Controlling the Epidemics of Tuberculosis (TB) and HIV/AIDS and Sexually transmitted Diseases (STD's) in the Russian Federation. The two main Objectives are to Reduce the Prevalence of TB and the Incidence of HIV infection and
729633002	NON SPECIFIC COUNTRY	Global Fund To Fight AIDS, TB and Malaria Replenishment	UK Hosted Global Fund to Fight AIDS, TB and Malaria Replenishment Meeting, 5-6th September 2005	To host an event to raise sufficient resources for the Global Fund to Fight AIDS, TB and Malaria for 2006, 2007 and the 2005 shortfall.

Annex 13: Projects/Programmes Classified as AIDS-Specific (Partial)

No.	COUNTRY	PROJECT TITLE	PROJECT FULL TITLE	PROJECT PURPOSE
729633004	NON SPECIFIC COUNTRY	Advance Market Commitments (AMCs)	Advance Market Commitments to Stimulate the Development of Vaccines for Low-Income Countries	Preparatory work to develop a concept for Advance Market Commitments that stimulates the development of vaccines (e.g. for malaria and AIDS) for low-income countries
730646003	NON SPECIFIC COUNTRY	Support to WDR 2007	Support the preparation of the World Development Report 2007	To inform and assist the World Bank with the preparation of the World Development Report (WDR) 2007, in particular to ensure that the report adequately addresses the issues of AIDS and adolescent sexual health
733637006	NON SPECIFIC COUNTRY	Global Enterprise HIV Vaccine	Facilitation and Administrative Support To: Global Enterprise, Global Engagement, Global Action Meeting	Find a Vaccine for HIV/AIDS
782636048	ZAMBIA	The Zambian Pro Test	The Zambian Pro Test Project : A Package to reduce the impact of Tuberculosis and other HIV - related diseases	Development of a sustainable, replicable model package to reduce impact of TB and HIV in poor urban settings
782640001	NON SPECIFIC COUNTRY	Global Health Fund Support	Global Fund to Fight AIDS, TB and Malaria (GFATM):: Creation and Support Work	Support the expanded coverage of critical interventions for the prevention and treatment of HIV/AIDS, TB and Malaria
782641008	NON SPECIFIC COUNTRY	Global Fund Tracking Study	4-Country Tracking Study of the Global Fund to fight AIDS, TB and Malaria (GFATM)	To give countries (Governments and other country stakeholders) a voice and an opportunity to report their perspectives on the Global Fund. The study aims to produce findings and make recommendations that will contribute to successful GFATM implementation
782646001	NON SPECIFIC COUNTRY	Global Fund to Fight AIDS, TB and Malaria	Global Fund to Fight AIDS, TB and Malaria, United Kingdom Contribution	To support the expanded coverage of critical interventions for the prevention and treatment of HIV/AIDS, TB and Malaria
782646002	NON SPECIFIC COUNTRY	Global Fund for AIDS, TB and Malaria Board Meetings	Global fund to fight AIDS, TB and Malaria DFID HSRC support to HPD-HPG 2002 (GFATM board meeting, Washington, April)	HSRC will provide support to DFID's HPD adviser in preparing for the discussions at the Board meetings and for shaping DFID's position on key policy issues
782646003	NON SPECIFIC COUNTRY	GFATM: HSRC Support	Global Fund for fight AIDS, TB and Malaria: DFID Health Systems Resource Support 2002-2003	HSRC will provide support to DFID's Health and Population Department advisers in preparing discussions at the Board meetings and for shaping DFID's position on key policy issues.
782646004	NON SPECIFIC COUNTRY	Asia Partnership Development Workshop	Global Fund to fight AIDS, TB and Malaria: Asia Partnership Development Workshop: March 28-29	To improve the effectiveness of the Global Fund to fight AIDS, TB and Malaria.

ANNEX 14: SPREAD OF HIV AND AIDS ACTIVITIES BY COUNTRY

Country	No. of projects/ progs	No. of new projects/ progs 2005/6	Total planned comm.[223] (£m)	Exp. 05/06 (£m)	Pop (m)[224]	Total planned comm. per capita	Exp. 05/06 per capita	Adult HIV prev.[225]	No. people living with HIV	Gross National Income per capita[226]	Global Fund ratio - burden of disease[227]	Global Fund composite index
Afghanistan	9	0	4.67	0.13	23.90	0.196	0.006	0.1	N/A	N/A	N/A	5
Albania	1	0	0.18	0.00	3.17	0.057	0.000	0.1	N/A	2120	0.05	3
Angola	15	4	7.22	1.24	13.63	0.530	0.091	3.9	240000	930	4.19	5
Armenia	1	1	0.50	0.50	3.06	0.163	0.163	0.1	2600	1060	0.09	3
Bangladesh	50	5	314.19	3.33	146.74	2.141	0.023	0.1	N/A	440	0.23	5
Belarus	1	0	0.16	0.01	9.89	0.016	0.001	0.3	N/A	2140	0.14	3
Benin	1	0	1.40	0.00	6.74	0.208	0.000	1.9	68000	450	4.22	5
Bolivia	15	0	18.51	0.05	8.81	2.102	0.006	0.1	4900	960	0.10	3
Botswana	2	0	0.08	0.00	1.79	0.044	0.000	37.3	350000	4360	8.56	4
Brazil	4	0	0.72	0.01	178.47	0.004	0.000	0.7	660000	3000	0.23	3
Burkina Faso	4	0	1.63	0.00	13.00	0.125	0.000	4.2	N/A	350	12.00	8
Burma	14	1	17.50	3.90	49.49	0.354	0.079	1.2	330000	N/A	N/A	5
Burundi	5	4	3.30	2.83	6.83	0.483	0.414	6	250000	90	66.67	8
Cambodia	12	1	53.88	4.38	14.14	3.811	0.310	2.6	170000	350	7.43	8

[223] Excluding poverty reduction budget support

[224] This information was mostly taken from WHO or UNAIDS website. It allowed comparison of commitment and expenditure between countries on a per capita basis

[225] From UNAIDS website

[226] From the World Bank website

[227] These are both calculated using methods that have been used by the Global Fund for prioritising its own resource allocations (Global Fund, 2005a/b). Essentially, the method for estimating disease burden is described in the Global Fund's guidelines for fifth round applications (p4) and consists of multiplying the adult HIV prevalence by 1000 and dividing that by the GNI per capita. Figures above 5 are taken as evidence of high burden of disease. We calculated this figure for each country and in two cases (Ghana and Cambodia) obtained different results from those published by the Global Fund in 2005. The composite index is described on the Global Fund website (Global Fund, 2005b) and consists of a score out of eight based on two related variables – the burden of disease described above and the World Bank ranking of whether a country is a low, lower-middle or upper-middle income country

Annex 14: Spread of HIV and AIDS Activities by Country

Country	No. of projects/ progs	No. of new projects/ progs 2005/6	Total planned comm.[223] (£m)	Exp. 05/06 (£m)	Pop (m)[224]	Total planned comm. per capita	Exp. 05/06 per capita	Adult HIV prev.[225]	No. people living with HIV	Gross National Income per capita[226]	Global Fund ratio - burden of disease[227]	Global Fund composite index
Cameroon	1	0	0.18	0.00	16.02	0.011	0.000	6.9	560000	810	8.52	8
Chad	1	0	1.00	0.00	8.60	0.116	0.000	4.8	200000	250	19.20	8
China	30	1	139.52	10.36	1311.71	0.106	0.008	0.1	840000	1500	0.07	3
Colombia	1	0	0.22	0.00	44.22	0.005	0.000	0.7	190000	2020	0.35	3
Congo	1	0	0.05	0.00	3.72	0.013	0.000	6.6	N/A	760	8.68	8
Congo (DRC)	17	3	11.69	2.18	52.77	0.222	0.041	4.2	1100000	110	38.18	8
Cote D'Ivoire	1	1	0.20	0.00	16.63	0.012	0.000	7	570000	760	9.21	8
Cuba	1	0	0.31	0.00	11.30	0.027	0.000	0.1	3300	N/A	N/A	3
Ecuador	1	1	0.50	0.10	13.00	0.038	0.007	0.3	21000	2210	0.14	3
El Salvador	1	0	0.22	0.00	6.52	0.034	0.000	1.1	7800	2320	0.47	3
Ethiopia	19	2	15.76	1.97	70.68	0.223	0.028	4.4	1500000	110	40.00	8
Gambia	1	0	0.23	0.00	1.43	0.158	0.000	1.6	N/A	280	5.71	8
Georgia	4	0	5.38	1.09	5.13	1.049	0.212	0.1	3500	1060	0.09	3
Ghana	25	0	115.13	14.90	20.92	5.503	0.712	3.1	350000	380	8.16	8
Guatemala	2	1	0.98	0.07	12.35	0.079	0.005	1	N/A	2190	0.46	3
Guinea	1	0	0.50	0.00	8.48	0.059	0.000	3.2	N/A	410	7.80	8
Guyana	3	0	3.85	0.00	0.77	5.029	0.000	2	N/A	1020	1.96	3
Haiti	5	0	4.05	0.01	8.33	0.486	0.002	5.6	260000	400	14.00	8
Honduras	2	1	1.57	0.56	6.94	0.227	0.081	1.8	63000	1040	1.73	3
India	53	5	908.31	42.16	1065.46	0.853	0.040	0.8	N/A	620	1.29	5
Indonesia	3	1	25.53	10.34	219.88	0.116	0.047	0.1	110000	1140	0.09	3
Iran	5	0	1.63	0.00	68.92	0.024	0.000	0.1	14000	2320	0.04	3
Iraq	4	0	5.53	-0.05	25.18	0.220	-0.002	0.1	500	N/A	N/A	3
Jamaica	2	0	0.29	0.15	2.65	0.111	0.056	1.2	22000	3300	0.36	3
Kazakhstan	4	1	2.05	0.42	15.43	0.133	0.027	0.2	16500	2250	0.09	3
Kenya	43	2	218.46	10.79	31.99	6.829	0.337	6.7	1200000	480	13.96	8
Kyrgyzstan	6	0	7.59	0.02	5.14	1.476	0.004	0.1	3900	400	0.25	5
Laos	2	0	0.20	0.00	5.66	0.036	0.000	0.1	1700	390	0.26	5
Latvia	1	0	0.22	0.00	2.31	0.095	0.000	0.6	7600	5580	0.11	1

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Lesotho	3	0	8.28	0.51	1.80	4.602	0.285	28.9	320000	730	39.59	8
Liberia	14	4	4.12	0.93	3.37	1.222	0.277	5.9	100000	120	49.17	8
Macedonia	1	0	0.07	0.00	2.06	0.034	0.000	0.1	200	2420	0.04	3
Madagascar	3	0	3.27	1.59	17.40	0.188	0.091	1.7	140000	290	5.86	8
Malawi	63	9	360.62	15.75	12.11	29.779	1.301	14.2	900000	160	88.75	8
Mali	6	0	30.82	1.56	13.01	2.369	0.120	1.9	140000	330	5.76	8
Mauritania	1	0	0.84	0.00	2.89	0.291	0.000	0.6	9500	530	1.13	5
Mexico	1	0	0.35	0.01	103.46	0.003	0.000	0.3	N/A	6790	0.04	1
Moldova	1	0	0.18	0.00	4.46	0.039	0.000	0.2	N/A	720	0.28	5
Mongolia	3	1	0.90	0.21	2.59	0.346	0.081	0.1	N/A	600	0.17	5
Montserrat	2	0	2.07	0.00	0.01	230.345	0.000	N/A	N/A	N/A	N/A	N/A
Mozambique	27	2	64.17	4.68	18.86	3.402	0.248	12.2	1300000	270	45.19	8
Namibia	5	0	2.51	0.03	1.99	1.260	0.016	21.3	210000	2380	8.95	6
Nepal	14	2	93.39	4.52	25.16	3.712	0.180	0.5	61000	250	2.00	5
Nicaragua	12	2	12.32	1.27	5.47	2.253	0.232	0.2	N/A	830	0.24	5
Niger	5	2	2.03	0.14	11.97	0.170	0.012	1.2	70000	210	5.71	8
Nigeria	39	1	344.07	19.04	124.01	2.775	0.154	5.5	3600000	430	12.79	8
Pakistan	34	3	191.74	17.83	153.58	1.248	0.116	0.1	74000	600	0.17	5
Papua New Guinea	1	0	0.26	0.00	5.71	0.046	0.000	0.6	16000	560	1.07	5
Paraguay	1	0	0.01	0.00	5.88	0.002	0.000	0.5	15000	1140	0.44	3
Peru	12	0	12.44	0.38	27.17	0.458	0.014	0.5	82000	2360	0.21	3
Philippines	3	0	1.00	0.08	80.00	0.013	0.001	0.1	9000	1170	0.09	3
Russia	28	1	36.17	0.46	142.25	0.254	0.003	0.6	860000	3400	0.18	3
Rwanda	13	3	46.07	1.78	8.39	5.491	0.212	5.1	250000	210	24.29	8
Senegal	3	0	3.43	1.53	10.10	0.340	0.152	0.8	44000	630	1.27	5
Sierra Leone	12	0	9.91	0.23	4.97	1.994	0.047	1.5	N/A	210	7.14	8
Slovenia	1	1	0.15	0.00	1.98	0.076	0.000	0.1	N/A	14770	0.01	1
Solomon	1	0	0.12	0.00	0.48	0.246	0.000	0.1	N/A	560	0.18	5

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Islands												
Somalia	12	0	6.05	0.67	9.89	0.612	0.068	1	N/A	N/A	N/A	5
South Africa	51	2	151.23	8.44	45.03	3.358	0.188	21.5	5300000	3630	5.92	5
Sri Lanka	4	2	15.74	3.18	19.07	0.825	0.167	0.1	3500	1010	0.10	3
St Helena	1	0	5.72	0.86	0.01	762.667	114.477	N/A	N/A	N/A	N/A	N/A
Sudan	36	10	43.98	18.62	33.61	1.308	0.554	2.3	400000	530	4.34	5
Swaziland	3	0	0.96	0.00	1.08	0.887	0.000	38.8	220000	1660	23.37	6
Tanzania	31	4	97.78	3.69	36.98	2.644	0.100	8.8	1600000	320	27.50	8
Togo	5	0	2.01	0.14	4.91	0.408	0.028	4.1	110000	310	13.23	8
Turks and Caicos	1	1	0.06	0.02	0.02	2.714	0.724	N/A	N/A	N/A	N/A	N/A
Uganda	58	5	69.89	13.03	25.83	2.706	0.505	4.1	530000	250	16.40	8
Ukraine	10	2	0.92	0.21	48.52	0.019	0.004	1.4	360000	1270	1.10	3
Uzbekistan	2	0	1.94	0.00	26.09	0.074	0.000	0.1	11000	450	0.22	5
Vietnam	6	2	5.91	1.78	81.38	0.073	0.022	0.4	220000	540	0.74	5
West Bank and Gaza	3	0	3.97	0.00	2.50	1.589	0.000	0.1	N/A	1120	0.09	3
Yemen	4	0	15.46	7.18	20.01	0.773	0.359	0.1	12000	550	0.18	5
Yugoslavia	6	2	11.46	0.79	10.53	1.088	0.075	0.1	N/A	2680	0.04	3
Zambia	58	6	214.02	14.54	10.81	19.799	1.345	16.5	920000	400	41.25	8
Zimbabwe	37	4	143.48	11.10	12.89	11.131	0.861	24.6	1800000	620	39.68	8

The UK Government's new AIDS strategy (*'Taking Action: The UK's Strategy for Tackling HIV and AIDS in the Developing World'*) was launched by the Prime Minister in July 2004. The Department for International Development (DFID) is the lead Government department.

An interim evaluation of *Taking Action* has been commissioned by DFID in 2006, to take stock of how the strategy is being implemented so far, generate lessons, and lay the groundwork for a more systematic and detailed evaluation in 2008/9. The evaluation is being carried out by independent consultants: a consortium between Social and Scientific Systems, Inc. (USA), the Institute of Education, University of London and the Mexico National Institute of Public Health. More information on the interim evaluation and its publications is available on http://www.dfid.gov.uk/aboutdfid/performance/evaluation-news.asp.

This is the first of three working papers to be produced for the interim evaluation. The findings and conclusions in this paper are provisional and may be revised once further evidence has been considered. Readers who have views or evidence to contribute to the evaluation are welcome to contact the consultants.

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