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DEVELOPING A NEW HIV AND AIDS STRATEGY: LESSONS LEARNED FROM THE INTERIM EVALUATION OF TAKING ACTION

DEPARTMENT FOR INTERNATIONAL DEVELOPMENT

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LESSONS LEARNED FROM THE INTERIM EVALUATION OF *TAKING ACTION*

This is an extract from the following report : Social & Scientific Systems, Inc, (2007) Interim Evaluation of '*Taking Action: The UK Government's Strategy for Tackling HIV and AIDS in the Developing World':* Final Report. DFID, Glasgow, Evaluation Report 676, xxxiii + 282pp. An electronic version is available at http://www.dfid.gov/aboutdfid/evaluation.asp

Summary

Introduction

S1 This paper is **an extract from the main report** of the interim evaluation of '*Taking Action: the UK's Strategy for Tackling HIV and AIDS in the Developing World*'. The objective of the evaluation is to make recommendations in four areas: (1) to improve implementation and monitoring of the current strategy; (2) on how best to measure the success of the strategy, looking forward to the final evaluation of *Taking Action* in 2008/9; (3) for the UK Government's next steps on AIDS from 2008; and (4) regarding future UK (especially DFID) strategies on development issues. The full evaluation (*Social & Scientific Systems, Inc, (2007) Interim Evaluation of 'Taking Action: The UK Government's Strategy for Tackling HIV and AIDS in the Developing World': Final Report. DFID, Glasgow, Evaluation Report 676, xxxiii + 282pp*) can be accessed at http://www.dfid.gov/aboutdfid/evaluation.asp

S2 This extract concentrates on lessons learned from the first two years of implementing *Taking Action* which are particularly relevant to the development of a new AIDS strategy. It is comprised of Chapters 10-12 of the report, which are designed to answer the following three evaluation questions:

- 'Is *Taking Action* still the most relevant strategy for the UK to Adopt to Tackle HIV and AIDS in the Developing World?' (Chapter 10)
- 'How are Potential Tensions Between Top-Down AIDS Targets and a Flexible, Country-Led Approach Being Managed?' (Chapter 11)
- '*Taking Action* is a Cross-Whitehall Strategy, contains spending targets, and was developed through a consultative process. What lessons can be learned for developing future AIDS and other strategies?' (Chapter 12)

S3 A brief summary of relevant findings and recommendations follows, extracted from the report summary.

Is *Taking Action* Still the Most Relevant Strategy for the UK to Adopt to Tackle HIV and AIDS in the Developing World? (Chapter 10)

S4 *Taking Action* is a broad HIV and AIDS strategy that includes statements which reflect the UK's position on various issues and some strategic choices, e.g. the establishment of a spending target. However, it is less useful in prioritising or guiding action. As a strategy with a focus on HIV and AIDS in the developing world, *Taking Action* is less relevant to middle-income countries, e.g. China and Russia.

S5 Overall, *Taking Action* remains a relevant strategy for the developing world, although there have been a number of developments since it was conceived in 2004. These include the push for universal access to HIV prevention, care and treatment; the emergence of new global partners and initiatives; changes in the

aid environment, e.g. Paris Declaration and UN reform agenda; development of new policy frameworks, e.g. the 2006 White Paper; and emergence of new technical evidence, e.g. on male circumcision.

How are Potential Tensions Between Top-Down AIDS Targets and a Flexible, Country-Led Approach Being Managed? (Chapter 11)

S6 Although the main rationale for a spending target is to make sure enough money is going to a priority issue, it is also an effective way of raising the political and public profile of an issue and of giving 'traction' to a strategy within a government bureaucracy. Arguments against spending targets are both conceptual and practical. The main conceptual arguments against are that central targets create statistical anomalies and perverse incentives, contradict the UK's commitment to country-led approaches and see the UK's contribution in isolation from other donors. Practical problems with a spending target relate to the processes involved in agreeing the target, setting the target at an appropriate level, establishing an appropriate method for tracking spend, and ensuring that adequate information systems are in place.

S7 Lessons learned from having an AIDS spending target are presented in detail in section 11.23. While spending targets may be helpful in raising the profile of an issue, their number should be very limited and they should be fully embedded in management systems, particularly planning processes. Where spending targets are set, the method for monitoring needs to be agreed in advance and information systems need to be adequate for collecting the data required.

Taking Action is a Cross-Whitehall Strategy, Contains Spending Targets, and was Developed Through a Consultative Process. What Lessons Can Be Learned for Developing Future AIDS and Other Strategies? (Chapter 12)

S8 A key feature of the introduction of *Taking Action* was extensive consultation with DFID's external stakeholders, including NGOs, other government departments and parliamentarians. Consultation within DFID, particularly around the imperatives behind the introduction of a spending target and the implications of managing this target, could have been stronger.

S9 Issues relating to *Taking Action* as a Cross-Whitehall strategy are discussed in the main report. It is unclear how *Taking Action* fits with other DFID strategies and with other UK strategies on HIV and AIDS, e.g. the Department of Health's National Strategy for Sexual Health and HIV in England, which was introduced in 2001, and equivalent plans in Scotland, Wales and Northern Ireland.

S10 With respect to a strategy on AIDS after *Taking Action*, this needs to have an action plan to provide a framework for monitoring and evaluation. Progress towards clearly defined outcome targets could raise the profile of UK support to HIV and AIDS internationally more effectively and provide better results incentives than a second spending target.

Recommendations

S11 These are the relevant recommendations from the interim evaluation:

Future AIDS Strategy

1. *Decide whether the successor to Taking Action should be a strategy on HIV and AIDS overall or a strategy on HIV and AIDS in the developing world.* This decision would influence whether this is a UK or DFID strategy, or perhaps a joint initiative of more than one department, e.g. DFID and FCO. Which ever approach is followed, there needs to be closer links between this and domestic HIV and sexual health strategies and issues of relevance to other government departments, such as TRIPS, access to medicines and asylum seekers.

2. *Develop a 'we believe' policy paper on HIV and AIDS and an action plan.* The former is primarily for an external audience and should set out the UK vision and position on HIV and AIDS. The action plan would be primarily to guide implementation and monitoring by relevant departments. This should include clear priorities, actions and measurable objectives. For more details of the proposed content of these respective papers, see Box 37.

Future Strategies in General

3. *Develop fewer central strategies and focus on implementing and monitoring these.* It is important to ensure that strategies are more strongly linked to each other, in line with DFID Development Committee recommendations on policy coherence.

4. *Ensure that strategies are embedded within DFID's overall business model.* Decision-making and review processes for DDPs and CAPs should routinely assess the coherence of plans with priorities set out in strategies such as *Taking Action*.

5. *Ensure that development of future strategies involves sufficient external and internal consultation.* Internal consultation is particularly important in relation to any spending targets and the practical implications of managing these.

6. *Limit the number of spending targets.* Where there are to be targets these should be embedded within DFID's business model, have a method for calculation established in advance and be trackable with existing information systems. Progress towards clearly defined objectives and indicators in any future strategy could raise the profile of UK support to issues, including HIV and AIDS, internationally more effectively than a second spending target.

7. *Ensure that joint UK Government strategies clarify departmental roles and responsibilities*. They should also include a clear set of indicators.

10. Lessons Learned – Continued Relevance of Taking Action

In Brief

Question: Is *Taking Action* (still in 2006) the most relevant strategy for the UK to adopt to tackle HIV and AIDS in the developing world? Are there major outstanding issues that are not adequately addressed in *Taking Action* (bearing in mind that the UK is only one player among others). What are the implications for future AIDS strategy?

Taking Action is a broad strategy on HIV and AIDS that provides a menu of options. It includes both statements which reflect the UK's position on various issues and strategic choices, e.g. the establishment of a spending target on AIDS. However, it is less useful in prioritising or guiding action. Middle-income countries, such as China and Russia, do not see a strategy that focuses on HIV and AIDS in the developing world as relevant.

Overall, *Taking Action* remains a relevant strategy for the developing world, although there have been a number of developments since it was conceived in 2004. These include the push for universal access to HIV prevention, care and treatment; greater focus on the links between sexual and reproductive health and HIV and AIDS; the emergence of new global partners and initiatives; changes in the aid environment, e.g. Paris Declaration on Aid Effectiveness and UN reform agenda; development of new policy frameworks, e.g. the 2006 DFID White Paper; and new evidence on the beneficial effects of male circumcision in reducing HIV infection in men.

10.1 This Chapter provides a brief overview of *Taking Action*, progress towards international targets[214] and challenges to progress, key developments since 2004 and emerging issues. In the light of these it identifies areas of work that could be given higher priority during the remaining timeframe of *Taking Action.*

Taking Action: A Brief Review of Strengths and Gaps

10.2 *Taking Action* provided a clear statement of UK intent and is a broad framework for tackling HIV and AIDS. It is a bold strategy that fits well into DFID's poverty focus and strong championing of the Millennium Development Goals. DFID was awarded the Institute for Public Policy Research 'Oscar' for best policy of 2004 for *Taking Action*. The strategy articulates clearly the causes and effects of the epidemic; recognises the importance of international targets, partnerships and harmonisation with other donors; emphasises the need for a more comprehensive response that integrates prevention, treatment and care; gives greater prominence to the needs of women, children and vulnerable groups; and promises to place human rights at the centre of UK actions. It also highlights the importance of building an enabling environment and supporting an effective multisectoral response and of focusing on countries with concentrated epidemics as well as countries experiencing generalised epidemics.

[214] See also section 1.5-1.6 (p3) and 10.10-10.12 (p133)

10.3 *Taking Action* was the first strategy of its kind in DFID. Although an action plan[215] was developed by the GAP team it was not integrated into *Taking Action*.

10.4 *Taking Action* also highlighted a number of inter-related topics, e.g. the links between sexual and reproductive health, HIV and AIDS. The UK has given this issue considerable policy attention, e.g. influencing the EU HIV Prevention Statement to reflect this. This has enabled EU countries to take a common position on this issue in other fora. DFID recently commissioned a study to explore the policy, financing and institutional factors that enable or constrain integration of SRH and HIV programmes (Druce et al., 2006). The design of more recent country programmes has also addressed the issue of linkages between HIV and SRH more explicitly (see Box 26). However, the role of sexually transmitted infections in relation to HIV is not reflected in *Taking Action.* More generally, UNAIDS has also highlighted the lack of coordination between diagnosis and treatment of STI and HIV (UNAIDS, 2006).

Box 26 Linking HIV and AIDS to Sexual and Reproductive Health in Country Programmes

The **DRC** country case study reported that, given high levels of fertility and maternal mortality, there is considerable demand for reproductive health information and services, including contraception and family planning (Cleland and Sinding, 2005; Alexandratos, 2005). Discussions, including with HIV-positive widows, indicate significant desire for contraception. Of the 15 women living with HIV who participated in the case study focus group, 13 were widows and several had as many as seven children. There is an urgent need to link HIV prevention, treatment and care services, including PMTCT, to family planning and other reproductive health information and services.

DFID has firmly embedded HIV into reproductive health in **Zimbabwe**. The focus on women is primarily through strengthening reproductive health services, including family planning, maternal and child health and PMTCT. The new Maternal and Newborn Programme will greatly expand opportunities for women to have safe pregnancies and reduce mother to child transmission of HIV. DFID's support to the female condom programme provides an opportunity to address HIV prevention, while also strengthening women's social support networks.

10.5 Views differ about the purpose of *Taking Action,* in particular whether it is primarily an external position paper, a strategy to guide programming or a mix of both. *Taking Action* includes elements of DFID target strategy, policy and practice papers.

[215] Mandatory for all DFID strategies since the end of 2005

10.6 *Taking Action* has more than 130 commitments and this makes it more useful as an advocacy document to enable an external audience to understand the UK's position than as a guide to prioritise action. *Taking Action* has been considered less relevant in middle income countries, e.g. Russia and China that do not consider themselves part of the developing world. There is limited acknowledgement in the strategy of regional differences in the epidemic and in the factors that drive it (see Box 27). A related issue for DFID is that countries with the most severe or rapidly developing epidemics do not necessarily correlate well with poverty as measured by GDP per capita (DFID, 2006d).

Box 27 *Taking Action*: Relevance to National Responses to HIV and AIDS

The country case study conducted for this evaluation in **Zimbabwe** noted that *Taking Action* was seen by DFID Zimbabwe as extremely relevant to their work in a number of specific ways. It provided clarity that the UK will support ART. It also provided, together with the Country Assistance Plan, an enabling framework from which advisers could select the most relevant interventions for a particular country. However, some concerns were raised that DFID, in general, and *Taking Action*, in particular has too strong an emphasis on finances, including types of aid instruments, and therefore overlooks critical issues, such as the human resource crisis (see Box 28, p130) and the ongoing need for technical assistance. It was also noted that the strategy is less clear about how it will be implemented and how progress will be measured.

The **China** country case study noted that *Taking Action* would be more useful if it prioritised UK intentions by region or even sub-region. Currently, the strategy appears strongly focused on Africa and not all of the general principles in the strategy are appropriate to China.

10.7 With the exception of the DFID HIV Treatment and Care Policy (DFID, 2004b), *Taking Action* is not explicit about how HIV and AIDS fits with other DFID or UK Government policies and strategies, e.g. on sexual and reproductive health rights (DFID, 2004f), maternal health (DFID, 2004g), aid modalities, human resources for health (see Box 28, p130) and gender. The links between HIV, AIDS, education[216] and food security are referred to briefly, but the strategy is not explicit about how HIV and AIDS will be addressed in the work of other sectors such as livelihoods, health, social development or governance.

10.8 Review of *Taking Action* and interviews conducted for this evaluation highlighted views on issues that could be more fully covered in the strategy[217]:

- **Responding beyond the health sector** – Although *Taking Action* emphasises the importance of a strong multisectoral response to HIV and AIDS and commits DFID to comprehensive and integrated responses that address the development causes and consequences of the epidemic, the strategy does

[216] In the context of universal primary education

[217] However, if *Taking Action* is to be truly strategic, it may need to choose certain areas to prioritise and other areas to leave to others – please see Table 19, p139.

not clearly describe how this will be done. There are some concerns that *Taking Action* and this evaluation are too health-focused[218].

- **UK contribution to greater alignment and harmonisation of international response to HIV and AIDS** – although the UK has contributed strongly to improving the international response to HIV and AIDS (see from section 3.19, p15), this has mostly focused on the contribution of others, particularly multilateral agencies. There has been less focus on the extent to which UK agencies, e.g. DFID, have introduced incentives and made changes to their systems and communications to promote harmonisation and alignment[219,220].

- **Supply security** – Although supply shortages threaten progress in HIV prevention (UNFPA, 2005), there is no explicit commitment in *Taking Action* to HIV and SRH supply security. In 2005, the UK and the Netherlands commissioned a series of studies (Druce, 2006) and DFID is

Box 28 Critical Shortages of Human Resources for Health Threaten Ability to Scale-up AIDS Responses in Many Countries

In **Zimbabwe**, although data is patchy, there is strong evidence that shortages of health personnel are extremely significant. Causes are multiple and include the poor macroeconomic environment, low salaries and high rates of illness and death as a result of AIDS. This crisis is having severe effects on the health sector. For example, plans to scale up the provision of ART require significant external financing if the human resource requirements are to be met. Positive responses have been made by the Zimbabwean Government, including the creation and training of new categories of health worker, such as the primary care nurse. With the recent establishment of a Health Services Board, there are active plans to develop a comprehensive strategy for human resources for health in Zimbabwe.

In **Zambia**, the Ministry of Health has developed a national strategy for addressing the situation of human resources for health, costed at US$313 million over three years. This provides a basis on which donor support can be focused to respond effectively to this crisis. Key steps are likely to include increasing pre-service training, scaling-up of retention schemes and hastening processes of public sector reform.

[218] This was raised in a consultation meeting with the UK Consortium on AIDS and Development about the draft of this final report. Specific sections cited as being too health-focused included 'doing more with less' (from section 8.14, p109); strengthening human resources for health (see Box 28); reference to women on antiretroviral therapy (section 1.6, p3) and the section on research (sections 3.39 - 3.41, p20). However, this final version of the report contains sections with a focus on issues beyond the health sector, including orphans and vulnerable children (section 3.8, p12); civil society (from section 6.40, p70); training for different groups of advisers (section 8.10, p108) and examples from the education sector (see Annex 5, Example 11, pA81). Nevertheless, the criticism is broadly accepted. However, it reflects the focus of *Taking Action* (DFID, 2004a), the terms of reference for this evaluation (DFID, 2005a) and different availability of information from different sectors, e.g. on research.

[219] Issues relating to this topic were discussed at the 9th meeting of the OECD DACWorking Party on Aid Effectiveness and Donor Practices. This included a paper on incentives for alignment and harmonisation prepared by the World Bank and DFID (OECD/DAC, 2007).

[220] Following the UNAIDS PCB meeting in December 2006, DFID country programmes were instructed to only fund joint UN programmes for HIV and AIDS which is seen as an incentive for grater country-level harmonisation and alignment (see section 3.25, p16).

planning to significantly increase its investment in improving supply security.

- **Gender** – *Taking Action* gives high priority to women but has little focus on gender issues, including male roles. A recent evaluation of DFID's gender-related policy and practice (DFID, 2006u) notes a lack of explicit guidelines on how to mainstream gender into HIV/AIDS programmes. Joint efforts are being made by a number of DFID teams[221] to address gender, HIV and AIDS more systematically. In line with commitments in *Taking Action* the GAP team has recently commissioned a review of gender-based violence and HIV.

- **Community engagement** – NGO respondents highlighted limited attention to community responses and issues such as the impact of HIV and AIDS on older people as gaps in *Taking Action*.

- **Palliative care** – Some NGO respondents also highlighted this as a gap in *Taking Action*.

- **Conflict and fragile states** - *Taking Action* does not refer to fragile states. It does commit the UK to support the work of UNAIDS in some countries[222] emerging from conflict but the UK's overall approach to HIV and AIDS in post-conflict states is not clear. Also, there have been developments in this area since *Taking Action* was launched, e.g. the publication of a new DFID White Paper (DFID, 2006c). Box 29 highlights issues related to the post-conflict setting in DRC.

- **Tuberculosis** – In most countries, TB, HIV and AIDS are inter-linked, with TB causing the deaths of many people living with HIV and AIDS. There are also particular concerns over the emergence of extensively drug resistant TB (XDR-TB). However, these issues are not addressed in *Taking Action*.

Box 29 Responding to HIV and AIDS in a Fragile, Post-Conflict State: An Example

The **DRC** country case study concludes that work with the health sector to re-establish basic health care infrastructure is essential to achieving universal access to treatment and care. However, it also finds that this alone is not sufficient. Attention to livelihoods and food security are critical, as are measures to reduce the HIV risk posed by development initiatives in other sectors, such as road rehabilitation. Integrating HIV prevention into activities such as resettlement of refugees and disarmed militias may be as important impacts as work in the health sector. Immediate efforts to improve access to preventive interventions are crucial. These are significant challenges in the absence of infrastructure and a functioning government.

[221] Including the Global AIDS Policy Team, the Reproductive and Child Health Team and the Gender Team

[222] Angola, DRC, Somalia and Sudan

10.9 Issues that are given priority in *Taking Action* but which have received less attention in practice include[223]:

- **HIV prevention and young people** – While *Taking Action* takes a strong position on the importance of a comprehensive approach to prevention and DFID has taken a leading role internationally in advocating for comprehensive approaches, this position is not always reflected in country programming (see Box 30).

Box 30 Approaches to Young People in National Programmes

In **Zimbabwe**, DFID has addressed the needs of young people in a realistic and comprehensive way, providing a counterweight to other agencies that stress a more simplistic 'ABC' approach to behaviour change. However, this has been on a relatively small scale and some NGOs feel this is not being done vigorously enough[224]. In the national response, prevention initiatives for young people have been influenced by particular agendas, e.g. an emphasis on promoting abstinence before marriage.

Similarly, in **Zambia**, the HIV prevention strategy for young people outlined in the National HIV/AIDS/STI/TB Intervention Strategic Plan emphasises sexual abstinence, and the JAPR documents that HIV prevention among young people is now strongly focused on promoting an abstinence-only agenda. Apparent effects of this approach include delayed sexual debut[225] but reduced condom usage at last sex with a non-regular partner[226].

In December 2005, the IDC expressed concern that 'Universal access to HIV/AIDS treatment will only be achieved if treatment programmes are accompanied by scaling up of evidence-based HIV prevention programmes. Given the increasingly moralistic tone of prevention programmes implemented by the US and their preference for bilateral donor relations, DFID has crucial role to play as a leader in the wider global response to HIV/AIDS.'

- **Human rights, stigma and discrimination** – *Taking Action* gives high priority to these issues and makes a commitment to ensure the human rights of marginalised and vulnerable groups are given proper attention, including supporting legislative reform and working with the formal justice sector. A recent audit of stigma and discrimination conducted by the GAP team concludes that, 'DFID has been tackling HIV and AIDS related stigma and discrimination in a variety of ways. However, given its importance in slowing and reversing the epidemic, it is not receiving the level of attention required or that was committed to in the UK's strategy *Taking Action'* (DFID, 2006v).

[223] Also see section 3.2, p8

[224] For example, a leaflet produced by PSI with USAID and DFID endorsement focused on HIV prevention and young people emphasised abstinence particularly strongly under the heading 'sex can wait' (USAID et al., undated)

[225] By 1.5 years for young women and 2.5 years for young men

[226] For example, this declined among young women from 35% in 2003 to 26% in 2005

The Wider Context

Progress and Constraints in Tackling HIV and AIDS

10.10 In 2001, global targets for HIV and AIDS were set for 2005 as part of the UNGASS Declaration of Commitment. Such global targets play an important role in mobilising action and provide a basis for tracking whether commitments made have been honoured. *Taking Action* committed the UK to continue to work towards all internationally agreed HIV and AIDS targets. Progress towards a selection of global targets is shown in Table 18[227]. However, global targets also have some limitations[228]. Because of these limitations and particularly its commitment to country-led approaches, the UK has been a strong advocate of national rather than international targets.

10.11 Despite progress, there is still a significant gap between these targets and the current situation. Prevention and treatment services remain inadequate. Less than 50% of young people have comprehensive knowledge of HIV and AIDS. Only 9% of men who have sex with men and less than 20% of injecting drug users receive HIV prevention services. Only 10 of 24 countries reporting data for sex workers have achieved at least 50% coverage of this population with prevention services. Only 9% of pregnant women are covered by services to prevent HIV infection in infants. Globally, antiretroviral drugs only reach one in five of those who need them, and the treatment needs of vulnerable groups, including sex workers, injecting drugs users, men who have sex with men, refugees and prisoners are poorly addressed (UNAIDS, 2006). Many countries have made patchy progress. Some have expanded access to treatment but made little progress in scaling up prevention programmes, while others have succeeded in prevention but made fewer gains in making treatment available.

Table 18. Progress towards Global Targets for HIV and AIDS in 2005

Global Targets 2005	Global Results 2005	Comment
Total annual expenditure: US$7-10 billion	US$7.5-8.5 billion (estimated range)	Global target achieved
Percentage of youth aged 15-24 who correctly identify ways of preventing HIV transmission and reject major misconceptions about HIV transmission: 90%	Male: 33% (country range 7-50%) Female: 20% (country range 8-44%)	No country achieved this
Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis: 80% coverage	9% (country range 1-59% coverage)	No country achieved this
Percentage of people with advanced HIV infection receiving antiretroviral therapy: 50% coverage; 3 million people on treatment	20% (country range 1-100% coverage) 1.3 million people on treatment	21 countries achieved 50% coverage target; global target for number of people on treatment not achieved. All PSA countries apart from Sudan have data on this indicator. Of those, all but Nepal have

[227] Data source for this table and most of the information in sections 10.10 to 10.13 is UNAIDS, 2006

[228] For example, the absence of baseline information against which to measure overall progress in reducing HIV prevalence

Global Targets 2005	Global Results 2005	Comment
		comparative data for 2003 and 2005. In all of them, except Pakistan, provision of ART has increased. In some cases, Kenya, Lesotho, Malawi, Rwanda, South Africa, Uganda, Zambia, Cambodia, China, Indonesia and Vietnam, this increase is very considerable. Nine PSA countries have more women on ART than might be expected[229], while six have less[230]. All PSA countries have fewer children on ART than might be expected. There are particular concerns over the lack of data on ART access for the most vulnerable populations.
Percentage of young males and females aged 15-24 who are HIV infected: 25% reduction in most affected countries	Males: 1.4%[231]; Females: 3.8%[232]; No comparable data on this age cohort is available from 2001. Progress towards target can only be measured in individual countries	6 of the most affected countries achieved this. In particular, HIV prevalence rates among 15-24 year olds have declined in four African PSA countries[233], remained static in eight[234] and increased in three[235,236].
Estimated percentage of infants born to HIV-infected mothers who are infected in 2005: 20% reduction	26% of infants born to HIV-infected mothers were also infected; In 2001, approximately 30% of infants were infected. There has been an estimated 10% reduction in HIV transmission between 2001 and 2005	11 of the most affected countries achieved this

10.12 The main challenges to achieving the Millennium Development Goal for HIV and AIDS, the six UNGASS targets and national HIV and AIDS objectives have been identified as: financing; implementation; co-ordination; technical capacity and infrastructure; leadership; social barriers; and the involvement of people living with HIV and AIDS (UNAIDS, 2005b). Specific constraints identified more recently include (UNAIDS, 2006):

- HIV prevention – diminishing support for prevention in some regions; inadequate supplies of condoms; untreated STI and poor coordination of STI and HIV services.
- Care, support and treatment – out-of-pocket costs to patients; concentration of treatment sites in urban areas; high cost of second-line

[229] Malawi, Nigeria, Rwanda, South Africa, Tanzania, Zambia, Zimbabwe, Cambodia, China

[230] Ethiopia, Ghana, Kenya, Uganda, India, Vietnam

[231] Measure of uncertainty 1.1-1.8%

[232] Measure of uncertainty 3-4.7%

[233] Ethiopia, Kenya, Rwanda and Zimbabwe

[234] Ghana, Lesotho, Malawi, Nigeria, Sierra Leone, Tanzania, Uganda and Zambia

[235] Mozambique, South Africa and Sudan

[236] Insufficient data in DRC

antiretroviral drugs; inadequate coverage of HIV testing services; stigma; shortages of human resources for health; weak supply management; and lack of integration of HIV care with other health services.

- Human rights – lack of, or failure to enforce, laws and regulations protecting people living with HIV from discrimination; policies and laws that prevent access to prevention and treatment services e.g. laws prohibiting access to condoms and needles for prisoners or criminalising sex between men.

10.13 UNAIDS recommends the following to ensure that countries can deliver the promises made in 2001:

- Sustain and increase commitment and leadership
- Sustain and increase financing
- Aggressively address AIDS-related stigma and discrimination
- Strengthen HIV prevention
- Build treatment access
- Strengthen human resources and systems
- Ensure available and affordable products for HIV prevention and treatment
- Invest in research and development for drugs, microbicides and vaccines
- Counter the impact of AIDS

Developments since 2004

10.14 Key developments since *Taking Action* was launched include:

- **Increased funding** – including commitments to double development aid made by the G8 and EU in 2005 and increased financing for HIV and AIDS through PEPFAR and the Global Fund.
- **Changes in the aid environment** – including the Paris Declaration on Aid Effectiveness in March 2005[237], which commits DFID and other donors to reform the way in which aid is delivered, with a focus on country ownership, harmonisation, alignment, results and mutual accountability (High Level Forum, 2005); the increased focus on UN reform; the emergence of new development partners such as the Bill and Melinda Gates and Clinton Foundations; and the launch of new aid instruments, such as UNITAID.
- **New policies and agendas** – including the launch in 2006 of the UK Government's White Paper (DFID, 2006e) and the endorsement in 2005 by the G8 industrialised countries, the UN World Summit and the African Union of the 'universal access' goal.
- **Developments in the epidemic** (see Box 31, p137) – including growing diversity between and within regions (Moses et al., 2006); increasing feminisation of the epidemic[238]; growing recognition of the need to expand access to paediatric treatment (UNICEF, 2006; WHO, 2006; Clinton Foundation, 2006) and evidence from two major trials of the protective effect of male circumcision in relation to HIV transmission among men (NIAID, 2006).

Priority Issues

10.15 Documents that have explored future scenarios and emerging issues (Barnett, 2004; UNAIDS, 2005c; UNAIDS, 2006) indicate that the following are likely to be priority issues in the next few years:

- **Sustaining momentum**[239] – including ensuring the donor community meets existing commitments, in face of the likely risk of 'AIDS fatigue' as attention focuses on other issues, such as climate change.
- **Increasing financing** – including providing long-term and sustainable funding, meeting the funding gap (see section 3.5, p10), and providing the additional financing required to meet the 'universal access' goal.
- **Strengthening health and social systems** – including addressing human resource shortages, especially in sub-Saharan Africa (see Box 28, p130), supporting the role of non-state actors in service delivery, and strengthening social safety nets for affected communities and families.

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[237] Following up on the Rome declaration

[238] Women between 15-24 account for 60% of people with HIV and AIDS in Sub Saharan Africa. Young women aged 15-24 years in this region are three times more likely to be HIV positive than young men (UNAIDS, 2006)

[239] These headings are used as the structure for Table 19, p139.

- **Working in fragile and post-conflict states** – including the need for effective HIV/AIDS programming in these challenging settings, which have one sixth of the total population in developing countries but account for a third of those living with HIV in the developing world (DFID, 2006d)
- **Addressing prevention and treatment challenges** – including identifying effective approaches to behaviour change, ensuring evidence-based prevention programming, increasing resistance to first-line antiretroviral drugs and need for more expensive second- and third-line treatment, and implications of the spread of extensively drug resistant TB (XDR-TB) (UNAIDS and WHO, 2006)
- **Tackling underlying causes** – including effective efforts to improve the status of women and girls, address stigma and discrimination and protect the rights of vulnerable and marginalised population groups.

Box 31 Snapshot of the HIV and AIDS Epidemic

Based on the 2006 Epidemic Update (UNAIDS and WHO, 2006):

- 39.5m people were living with HIV in 2006. Of these, 37.2m were adults and 2.3m children under 15
- 4.3m adults and children were newly infected with HIV in 2006
- The most striking increases in the number of people living with HIV have occurred in East Asia, Eastern Europe and Central Asia
- In sub-Saharan Africa, the epidemic is highly diverse – e.g. HIV prevalence has declined in Zimbabwe, Kenya and urban Burkina Faso but the epidemic continues to grow in Mozambique, South Africa and Swaziland
- Women are disproportionately affected. For every 10 men there are 14 women living with HIV
- In Asia, there is evidence of HIV outbreaks among MSM in Cambodia, China, India, Nepal, Pakistan, Thailand and Vietnam; India, which has more than two-thirds of people in the region living with HIV, has a highly diverse series of epidemics
- In Eastern Europe, injecting drug users represent two-thirds of people infected with HIV. Most people living with HIV in the region are in Russia and Ukraine
- In Latin America, the largest epidemics are in the countries with the largest populations, such as Brazil and Mexico. Unprotected sex between men is a central feature of epidemics in most Latin American countries
- The Caribbean remains the second-most affected region in the world, despite a decrease in infection levels in the Bahamas and urban Haiti and stabilisation in Barbados and the Dominican Republic
- In Oceania, Papua New Guinea is experiencing a rapidly increasing and serious epidemic
- In the Middle East, Sudan accounts for 80% of people living with HIV in the region

Taking Action in the Context of Current and Future Priorities

10.16 There are many competing priorities clamouring for the UK's attention in regard to HIV and AIDS. Factors to consider when making choices include areas where the UK has had success to date (see Table 19, p139), major gaps in the international response and the UK's comparative advantage in different areas (see Box 32). Table 19 (p139) and the conclusions of the health zero based review (see Box 33) identify where the UK might focus its efforts until 2008, and in its subsequent HIV and AIDS strategy. It also highlights issues that could be left to other agencies. Recommendations are presented in the Executive Summary (pxxi) and further issues to consider in Chapter 14 (p179).

Box 32 Areas of UK Comparative Advantage in Responding to HIV and AIDS

Areas in which the UK has a proven comparative advantage in responding to HIV and AIDS include:

- Policy dialogue and exerting influence
- International and national leadership and experience on issues relating to Paris Declaration on Aid Effectiveness, including harmonisation
- Willingness to take a stand on and tackle contentious issues
- Support for sexual and reproductive health and rights
- Innovative approaches
- Flexibility and responsiveness to national priorities
- Informed and high quality sectoral engagement and technical assistance
- Capacity to strengthen the evidence base

The most valued characteristic of DFID support in **Zimbabwe** is its flexibility. DFID staff are seen as constructive and willing to communicate openly on a range of issues. DFID has supported contentious issues, such as humanitarian aid to those affected by Operation Murambatsvina. In **DRC**, while its financial contribution is relatively small compared to those of others, DFID's flexibility, ability to respond to urgent needs and willingness to provide multi-year funding are valued. The UK has a stronger commitment to harmonisation than many other donors and can play an important role in DRC and other post-conflict settings where governments are weak and donor collaboration is critical.

Box 33 Health Zero Based Review (DFID, 2006d)

The DFID Zero Based Review: Health Case Study highlights the need for health systems that can ensure a regular supply of drugs, an efficient network of facilities and laboratories and well-qualified staff to achieve the health MDGs and provision of HIV treatment. It states the need to increase funding to meet the recurrent costs of recruiting, training and retaining health workers; expanding and maintaining physical infrastructure; improving drug procurement and distribution systems; and building core management skills at central and peripheral levels.

Table 19. Areas where UK has Had Most Success in Responding to HIV and AIDS in the Past and Suggested Future Priorities

Issue[240]	Comments
Sustaining momentum:	
Relevance to middle-income countries★	*Taking Action* emphasises tackling HIV and AIDS in the developing world. It also highlights the importance of epidemics in middle-income countries, where HIV and AIDS is largely concentrated in vulnerable and marginalised groups such as injecting drug users and sex workers. Decisions to close DFID offices in countries including Russia, Ukraine and China have implications for how the UK and DFID will continue to support efforts to tackle HIV and AIDS in these contexts and how DFID's significant achievements in areas such as harm reduction will be sustained. The stated strategy is to encourage multilaterals to address the HIV and AIDS epidemics in middle-income countries more effectively. Country case studies in Russia and China raised questions about how effectively these agencies can address the needs of vulnerable and marginalised groups or encourage governments to do so, and the extent to which they will continue to support innovative work by civil society organisations. Any future strategy should consider the potential contributions that could be made by NGOs, networks, foundations and, in Eastern Europe specifically, the EC and how DFID can support and monitor the effectiveness of these contributions. The role of the FCO in countries where DFID does not have a presence also needs to be considered.
Commitment and leadership★	The UK should continue its active role in promoting international commitment and strong national leadership.
Increasing financing:	
Meeting the funding gap★	The UK needs a clear position with regard to its role in addressing the funding gap for meeting 'universal access' goals and more specifically in financing drugs to sustain and expand treatment.
Long-term, predictable funding★	The UK should continue its leadership on long-term, predictable financing.
Strengthening health and social systems:	
Security of supplies★	Commitment from DFID and others will be crucial to ensure growing emphasis on new technologies is not at the expense of existing interventions. The UK should take forward plans to increase investment in SRH supplies.
SRH (including STI) and HIV linkages★	The UK should continue existing efforts to strengthen SRH and HIV linkages. Areas of focus could include PMTCT and improved SRH for HIV positive women; improved HIV prevention in pregnancy; linking of HIV and SRH supply management and reproductive health rights of PLWHA and members of vulnerable populations.
Human resources for health★	The UK should build on lessons learned to date in supporting national governments to address critical shortages of healthcare professionals.
Supply management	The UK could leave this to other agencies that focus on logistics and supply chain issues such as the US Government, UNFPA and UNICEF, which is the lead agency on this issue under the UNAIDS cosponsor division of labour.
Service delivery by non-state actors★	DFID should continue its support for civil society partners to play this role.
Social safety nets★	DFID should continue to focus on social protection for affected communities and families, including the elderly and vulnerable children, through social transfers and safety nets programming.

[240] Priorities for the UK and DFID are marked ★

Issue[240]	Comments
Community responses	DFID should continue its support for civil society partners to play this role.
Strengthening systems in fragile states★	Better evidence concerning effective approaches to working in post-conflict settings is required. The role that conflict plays in HIV needs to be better understood and planned for in any future HIV and AIDS strategy if DFID continues to expand its support to post-conflict countries. DFID is developing a conflict policy and this represents an opportunity to ensure that HIV and AIDS is considered as well as to inform future HIV and AIDS strategy and ensure greater internal policy coherence. Support to ensure that fragile states can access available resources also needs to be addressed. Fragile states, such as DRC and Sudan, where there is less in-country capacity to put together proposals, though individual grants perform as well as grants in other states, have a higher failure rate for proposals, which leads to low levels of additional funding and unbalanced portfolios.
Addressing prevention and treatment challenges:	
Evidence base for comprehensive approaches to prevention★	DFID should concentrate on contributing to the evidence base. Technical agencies such as UNAIDS, WHO and UNFPA should be encouraged to produce guidance on effective approaches to prevention in the context of increasing access to treatment and growing numbers of sero-discordant couples, and on preparing for access to new prevention methods as these become available.
Treatment access★	This should include: consideration of DFID's role in countries that are not Global Fund or PEPFAR recipients; ensuring that the needs of vulnerable and marginalised groups are not neglected in the drive to 'universal access' and supporting alternative models of service delivery in contexts where such groups are unlikely to be reached by public sector services. DFID could leave leadership on paediatric treatment to other organisations focusing on this issue, such as UNICEF, MSF and the Clinton Foundation.
Palliative care	A forthcoming review of HIV, AIDS and palliative care (HLSP, 2007) is likely to recommend that DFID focus its attention on a number of areas including working with other agencies to ensure that palliative care is recognised in the broad continuum of prevention, treatment and care; and supporting improved access at country level to medicines needed to manage pain, other symptoms and opportunistic infections. In particular, this may include policy dialogue on over-restrictive laws on opioids for pain relief and drug substitution therapy.
Drug resistance	Action to address technical challenges such as drug resistance should be left to agencies such as the WHO.
Drug pricing and second-line treatment★	The UK should continue to focus efforts on strengthening the capacity of developing country governments to engage on TRIPS issues and on global efforts to address variations in the prices of antiretroviral drugs, in line with recommendations of the IDC in December 2005 (IDC, 2005) that DFID should work to expand the capacity of developing countries to utilise flexibilities in the TRIPS agreement to gain access to affordable medicines, and of the Public Accounts Committee report on DFID 2005.
Tackling underlying causes:	
Gender★	DFID should build on its experience and comparative advantage in gender work. More emphasis could be given to support civil society partners to identify effective approaches to working with men and boys and to address women's legal and property rights and the underlying causes of gender inequalities.
Stigma and discrimination★	The UK should focus on policy dialogue and support for civil society partners.
Rights of vulnerable and marginalised groups★	The UK should focus on policy dialogue and support for civil society partners.

11. Lessons Learned – Managing Tensions between Central AIDS Targets and Country-Led Approaches

In Brief

Question: How are the potential tensions between top-down AIDS targets and a flexible country-led approach being managed? What are the lessons (a) for future UK AIDS strategy (b) for other UK development strategies?

The AIDS spending target is a central feature of *Taking Action* as a strategy. However, the method used to determine the level of this is not clearly documented. A new method to track progress towards this was agreed in early 2007. There are a number of tensions between this spending target and other centrally-determined strategies, on the one hand, and country-led approaches, on the other. These have been effectively managed to date as UK spending and activities on HIV and AIDS are broadly in line with countries' priorities and burdens of disease. However, these tensions may become more evident as pressure mounts to raise spending on HIV and AIDS by 30% per year in order to meet the spending target.

The main value of spending targets is to ensure that adequate levels of funds are available for a particular issue. They also serve to raise the profile of a particular issue and give a strategy traction within a government bureaucracy. Drawbacks of spending targets are both conceptual and practical. They may be seen as contrary to the UK's commitment to country-led approaches to development and risk seeing the UK's financial contribution to national responses to HIV and AIDS in isolation from other donors.

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

There is no evidence yet that limitations in absorptive capacity have affected the UK's ability to meet this spending target. However, there are concerns in countries visited about different aspects of absorptive capacity, e.g. inadequate human resources in Zambia and the ability of UN agencies to handle increases in funding in Zimbabwe. These concerns are particularly significant when considering increased levels of international funding for AIDS overall and not the UK's contribution in isolation.

UK Spending Target on HIV and AIDS

11.1 As part of its commitment to 'closing the funding gap' *Taking Action* committed the UK government to spending £1.5 billion on HIV and AIDS over three years[241], of which £150 million would be spent on programmes to meet the

[241] From 2005/6 to 2007/8

needs of orphans and other children, particularly in Africa, made vulnerable by HIV and AIDS[242] (DFID, 2004a).

11.2 The principles underlying *Taking Action* and its spending target were described in a memo to DFID's Development Committee in May 2004 (Schultz, 2004). This stated that the spending target would be set at a level which continued the annual rate of increase of bilateral spending on HIV and AIDS from 1999/2000, which was cited as 30-50%. However, although the memo contained figures for HIV/AIDS spending for the period from 1997/8 to 2003/4[243,244], it did not use these to derive figures for the spending target. It appears that this was done later. The evaluation team has been unable to obtain documented evidence of these calculations. This absence of a clearly documented basis for calculating the level of the spending target is a major weakness, and has hampered efforts to monitor progress towards achieving the target. The methods that DFID used to track HIV/AIDS spending at the time of adopting *Taking Action* have since been challenged (Janjua, 2003; NAO, 2004; Daly, 2005; ActionAid, 2005; International Development Committee, 2005; DFID, 2005b; Benn, 2005) and recently revised (Benn, 2007).

11.3 There have been many attempts to define how the AIDS spending target is to be tracked. These have recently been concluded (see section 3.5 and Table 2, p10). Challenges faced are not unique to the UK Government but also affect others seeking to track spending on HIV and AIDS. They include how to deal with:

- Poverty reduction budget support (PRBS)
- Activities that have a significant but not principal focus on HIV and AIDS
- Spending on activities with a principal or significant focus on sexual and reproductive health
- Programme partnership agreements (PPAs) which provide strategic funding to 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
- Spending by government departments other than DFID (see Table 2, p10)

[242] There were a number of other financial commitments to particular agencies, including the Global Fund, UNAIDS and UNFPA (SSS, 2006a, section 3.1)

[243] Calculations contained in this memo (p11) show that spending on HIV and AIDS was being identified through the use of PIMS markers for HIV and reproductive health on DFID's information system, PRISM. Bilateral spending was taken as 100% of all spending with such a marker, regardless of whether it was a P (principal) or S (significant) marker. Budget and sectoral support and PPAs were treated the same way as other projects/programmes, although separate totals were shown with and without general budget support. This approach was consistent with the method being used at that time, but is no longer consistent with the method being used (seeTable 2, p10). This means that the spending target was set using one method but is now being tracked with a different method. The new method, in general, gives lower figures for the UK's spending on HIV and AIDS than the old method (see Figure 2, p11).

[244] Provisional figures for 2003/4

Tensions between Top-Down AIDS Targets and Flexible Country-Led Approaches

11.4 There is a potential tension between central spending targets[245] and a commitment to country-led approaches[246]. This is perhaps most clearly seen in financial decision making where commitment to central spending targets might require funds to be spent in one way while a country-based needs assessment might draw different conclusions. However, as the analysis in other parts of this report shows (see sections 4.17 to 4.20, from p35 and section 5.12, p44), UK bilateral spending on HIV and AIDS is largely consistent with the burden of disease in countries, and decisions about resource allocation have been consistent with country plans and needs.

11.5 This tension is not unique to spending targets. It is seen in terms of any central policy or strategy. For example, DFID's Corporate Performance Framework faces the same tensions (OECD DAC, 2006). Table 20 (p144) seeks to outline in more detail the tensions that can arise between central targets and country-led approaches.

11.6 Nor are these tensions unique to the UK. Similar tensions are also faced by the Global Fund and have been extensively documented (Radelet, 2004; Caines, 2005). Other institutions and initiatives facing these tensions include: CIDA (Lavergne and Alba, 2003); the World Bank's Comprehensive Development Framework[247] (World Bank, 2003); and the 3 by 5 initiative[248] (DFID, 2005g).

[245] Particularly as they multiply

[246] See section 6.2, p56 for more discussion of country-led approaches

[247] These issues are quite extensively explored in this document because the comprehensive development framework was based on four principles – long-term and holistic vision; country ownership; results orientation; and country-led partnerships. The evaluation explored complementarity and tensions between these principles.

[248] Criticisms of the central global target in '3 by 5' were influential in the current push for 'universal access' not having any central global target rather emphasising the need for country-led approaches.

Table 20. Tensions between Central Targets and Country-Led Approaches[249]

Issue	Central Targets	County-Led Approach
Time Frame	Short; emphasis on urgent delivery; sees AIDS as an emergency situation	Long-term view with strong focus on systems for sustained delivery of services
Capacity Development	Secondary emphasis; means to deliver results	Central focus
Ends or Means	Ends, i.e. results matter. How they are achieved is of less importance	Means, i.e. processes matter as much as results. Strong emphasis on using country systems and harmonising with other donors
Accountability	Largely financial, i.e. to providers of funds, e.g. tax payers in donor countries	Strong value of country ownership, i.e. accountable to people of the country through elected government
Reporting	Probably heavy and donor-specific	Lighter, integrated into national systems and harmonised with other donors
Quality Standards	Derived from international best practice, e.g. through technical assistance	Derived from participation of and consultation with national stakeholders

Pros and Cons of Spending Targets

11.7 The question of pros and cons of spending targets can be considered in two ways. First, it can be considered specifically in relation to a spending target on HIV and AIDS[250]. Second, it can be broadened to spending targets more generally. Table 21 (p145) summarises the possible pros and cons of central spending targets.

11.8 The main imperative for the spending target in *Taking Action* was the high public and political priority placed on HIV and AIDS in international development. Reasons for this include the scale and impact of the epidemic[251], the need for the international response to be urgently and significantly expanded, and the track record of many national governments in failing to respond promptly and adequately[252].

[249] Based on work relating specifically to the Global Fund

[250] This approach may also touch on the pros and cons of *Taking Action* as an overall strategy.

[251] Particularly in parts of Sub-Saharan Africa

[252] This has occurred in both countries with generalised epidemics and those with concentrated epidemics. A particular problem in concentrated epidemics is that those disproportionately affected are the most marginalised groups, such as injecting drug users, sex workers and men who have sex with men. In many countries, responding to an epidemic mainly affecting these sub-populations is not a public or political priority because of widespread stigmatising attitudes towards members of these groups.

Table 21. Possible Pros and Cons of Central Spending Targets

Pros	Cons
Mechanism for giving a priority issue higher public and political profile Potential to strengthen political and public financial accountability of UK Government departments, in general, and DFID, in particular AIDS spending target has resulted in a higher profile for HIV and AIDS within government departments, in general, and within DFID, in particular As part of the overall strategy can act as a 'yardstick' for assessing priority given to HIV and AIDS by parts of the UK Government, e.g. DFID country offices Having a spending target has the potential to give 'bite' to efforts to mainstream a priority issue into projects/programmes in other sectors, i.e. in the case of HIV and AIDS, beyond the health sector A spending target may be a counter-weight to other policies. For example, it has been possible to fund activities on HIV and AIDS in parts of Europe, Middle East and the Americas because of the spending target, in spite of DFID's '90/10 rule'[253] Having a spending target to report against has raised the profile of information systems, in general, within DFID, and specifically the Policy Information Marker System (PIMS[190(p115)])	Seen as a supply driven, one-size fits all approach Promoting 'AIDS exceptionalism' which may have adverse effects on attention given to other issues Central spending targets run counter to DFID's way of working which prioritises country-led approaches. They risk promoting 'vertical' programmes and undermining use of aid instruments such as PRBS and sectoral support. There are concerns that spending targets are unduly focused on identifying UK contributions[254] Availability of funds for HIV and AIDS may drive programme development rather than need Risk of considering UK funding in isolation without consideration of international and country context Concerns over process for adopting the spending target (see section 11.2, p142), i.e. it was done quickly with less consultation than desired by some DFID staff. There are also concerns over the way it is being used and additional work involved in reporting against the target Level at which target is set may be problematic. If it is too high, it may be unrealistic. If it is too low, it risks encouraging a minimalist approach The breadth or narrowness of a spending target may affect spending patterns, e.g. there are concerns that having an AIDS spending target may have diverted resources away from a broader focus on SRHR For the AIDS spending target, there was no clearly agreed and documented method for tracking it at the time it was introduced although this has now been addressed (see section 3.5, p10). DFID's information systems, e.g. PRISM and PIMS were not intended for this purpose and may not be up to the task

11.9 Having a spending target is one mechanism by which the UK Government can show that it is prioritising this issue[255]. It also seeks to quantify the Government's commitment financially and potentially provides an

[253] This is derived from target 6 in DFID's Public Service Agreement which states that 'the proportion of DFID's bilateral programme going to low-income countries is at least 90%' (DFID, undated).

[254] Sometimes referred to as 'flag-planting' and/or 'branding'

[255] Although this will be less the case as the number of other spending targets increases

accountability mechanism for this[256]. The spending target has raised the profile of HIV and AIDS within the UK Government, as a whole, and particularly within DFID. As part of the strategy, it provides a mechanism by which the relative priority given to HIV and AIDS by different parts of the UK Government, including DFID, can be assessed[257]. A spending target gives some 'bite' to a strategy that it would otherwise lack. This could potentially drive mainstreaming of HIV and AIDS issues into sectors beyond health and allow specific support to be provided on this issue in lower middle income countries[258]. Finally, having a spending target has raised the profile of information systems within DFID. Tracking progress against a spending target requires a good information system and for it to be used competently and consistently.

11.10 However, there are both conceptual and practical problems with spending targets. Conceptually, central spending targets run counter to the UK's commitment to country-led approaches, do not fit into DFID's current business model (CSG, 2004)[259], risk viewing UK contributions in isolation from those of other donors and diverting funds from other areas of development. In practice, the latter does not appear to have occurred, possibly due to the increase in DFID's overall budget[260].

11.11 Practical problems with spending targets can be grouped into four main categories:

- *Process* – concerns over the rapid introduction of the AIDS spending target and the limited consultation process with DFID staff (see section 11.2, p142).
- *Level* – if the spending target is set too high, it risks being unrealistic and/or creating significant spending distortions in efforts to meet it. If set too low, it risks changing nothing because it can be met through 'business as usual'.
- *Method* – the method to be used to track progress towards a spending target needs to be agreed and documented before the target is set. If this is not done, there is a risk that any proposed method will be evaluated in terms of the results it gives in relation to the spending target[261].

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[256] Although currently, there are considerable limitations on this which are discussed in the section on 'cons'

[257] Although it would be easier to do this if *Taking Action* had a monitoring and evaluation framework. This approach is also not universally welcomed within DFID as it runs counter to the current business model and the principles of country-led approaches to development.

[258] When other policies might suggest that such activities should not be supported

[259] This model is illustrated in Figure 23, p42. Under this model, DFID staff work towards the MDGs through their own Personal Development Plan/Performance Measurement Framework. This contributes, in turn to team/departmental objectives, which contribute to country assistance plans or institutional strategy papers. These then contribute towards Directors' plans for delivery and the Public Service Agreement. The AIDS spending target does not appear to fit into this scheme although it can be argued that *Taking Action* has influenced this model at different levels.

[260] There is a risk that this may happen as DFID strives to continue to increase AIDS spending by 30% per year to meet the spending target (see section 3.5, p10).

[261] This has certainly been problematic in terms of the AIDS spending target and may have contributed to the delay in finalizing the method for tracking this target (see section 3.5, p10)

- *Information systems* – DFID's current information systems were not designed for monitoring progress towards spending targets and are not really suited for this purpose. If spending targets become a regular part of DFID's work, information systems need to be established and utilised to make it possible to accurately track progress towards these targets.

Experience of Managing these Tensions

11.12 These tensions have not been experienced yet because the strategy is in its early stages and the method for tracking AIDS spending has recently been agreed (see section 3.5, p10). Before this, it appeared that the spending target was on track. Under the new method, the UK will need to increase HIV and AIDS spending by 30% per year if the target is to be met. Tensions between meeting this challenging rate of increase and maintaining the UK's commitment to country-led approaches are likely to increase as the deadline for reaching the target nears.

11.13 Nevertheless, there is some early experience of managing the tensions in country offices and in other parts of DFID. Table 22 presents experience of these tensions for each of the countries visited for the purpose of this evaluation. It appears that tensions are most keenly felt where there are well-developed country-led approaches, e.g. Zambia and Ethiopia and least keenly felt where these are not well-developed, e.g. DRC and Zimbabwe.

Table 22. Managing Tensions between Central AIDS Targets and Country-Led Approaches: Experience from Country Case Studies

Country	Comment
China	No specific tensions were identified. DFID selected elements from *Taking Action* which fitted an understanding of priorities shared with the Chinese Government. This allowed the provision of critical support to innovative approaches among those most vulnerable to HIV infection in China, particularly injecting drug users.
DRC	No specific tensions were identified. This is largely because of extremely limited government capacity in DRC. As a result, it is not really appropriate to think of a country-led approach in such a fragile state. Major donors agree that HIV and AIDS are one of the main priorities in the country.
Ethiopia	Tensions have been keenly felt by DFID Ethiopia and relate both to the targets themselves and the methods to calculate them. Based on country context (including epidemiological situation, availability of other sources of HIV funding and national absorptive capacity), DFID Ethiopia decided not to provide specific AIDS funding but to focus support on other areas, such as building coordination capacity and health systems strengthening. There is a fear that pressure to meet the central spending target could undermine that decision although this has not yet happened. There are also tensions because of the method used to track both AIDS and OVC spending target[262].

[262] Previously, UK supported Ethiopia through PRBS but now funds Protection of Basic Services (PBS). In 2005/6, DFID Ethiopia estimated that its spending on HIV and AIDS was around £3m, based on allocating 5% of PRBS to AIDS spending. This rose to around £30m in 2006/7 because of counting 50% of funding through PBS. This gives the impression of a ten-fold increase in AIDS funding although the content of the programme had changed relatively little. This risks creating perverse incentives for using particular aid instruments (for more detail see summary of Ethiopia country case study, pA23). Although PSNP appeared in *Taking Action* as a way of supporting OVC, funding for this does not count towards that spending target as it has no PIMS marker for HIV/AIDS nor a sector code for OVC. Allocating it a PIMS marker for HIV/AIDS would mean that 50% of its spending would count towards the overall AIDS spending target.

Country	Comment
India	There is a tension between DFID's approach in India and the spending target on OVC because the latter is seen as a sub-set of HIV spend. This is not appropriate for India where very few of the many orphans and vulnerable children are as a result of HIV and AIDS.
Russia	No specific tensions were identified related to the AIDS spending target. However, there have been acute tensions between country priorities on HIV and AIDS, e.g. focused prevention among vulnerable populations and reducing UK aid for Russia in preparation for closure of DFID's country office in 2007.
Zambia	There are concerns that central spending targets undermine the UK's commitment to country-led approaches particularly as targets multiply. Because of the very high HIV prevalence, all DFID-funded activities have significant AIDS impact. However, staff were reluctant to give all activities an S PIMS marker for HIV[263]. 5% of Zambia's PRBS funding counts towards the AIDS target, even though UK does not fund AIDS in this way. If the UK's AIDS funding went through PRBS, the current method would report a reduction in AIDS spending even if spending levels remain unchanged. Support for OVC initiatives, e.g. through the STARZ programme do not contribute to the OVC spending target because levels of financing are neither fixed nor known, so the allocation of a weighted sector code for OVC is not possible.
Zimbabwe	No specific tensions were identified. Indeed, *Taking Action* fits well with UK commitment to provide humanitarian assistance to the Zimbabwean population and priorities identified within the country's strategic plan on HIV and AIDS.

11.14 Some of the tensions have been handled by regional directorates without passing these on to country offices. This has involved different approaches in different directorates. For example, within DFID's Africa Directorate, to date it has been largely possible to meet the regional spending target without changing funding decisions. This was because DFID was already supporting a large number of activities with a principal or significant focus on HIV and AIDS. The tension has, therefore, been managed by using country-level considerations for decision-making purposes and the central targets simply for reporting back and accountability. It seems unlikely that this would be possible in the remaining years of the strategy if the spending target is to be met.

11.15 On the other hand, in Europe, Middle East and the Americas, new projects/programmes have been funded that have a focus on HIV and AIDS. It appears that it was only possible to fund these activities because of these spending targets. To date, these decisions have fitted well with national/regional priorities and the main tension has been between the AIDS spending target and the '90/10 rule' (see Box 2, p41).

Absorptive Capacity[264]

11.16 Although there were some concerns expressed about absorptive capacity in countries visited for this evaluation (see Box 34 p148), there is no evidence that these factors have yet affected the UK's ability to disburse or use the funds that are needed to meet the AIDS spending target in *Taking Action.*

[263] Because under the old method this would have resulted in 100% of spend being counted to the AIDS target. This would only be 50% under the new method (see section 3.5, p10).

[264] The term absorptive capacity is used to cover a wide range of areas including macroeconomic effects of increased external aid flows (ODI, 2005); suppression of national capacities because of increasing dependency; and inability to spend effectively the funds provided.

Box 34 Issues Affecting Absorptive Capacity: Examples from Case Study Countries

In **Zambia** the severe human resources for health crises (see Box 27, p129) is likely to adversely affect the country's ability to use additional resources for the national response to HIV and AIDS.

In **Zimbabwe** donors are increasingly channelling funds through UN agencies because of constraints on providing money to the Zimbabwean Government. It is unclear if all these agencies have the capacity to absorb this level of resources.

In **Ethiopia** there has been a massive influx of financial resources for the national response to HIV and AIDS, particularly from PEPFAR and the Global Fund. Utilisation of these resources by EMSAP and HAPCO has been slower than planned.

11.17 However, UK funding can not be considered in isolation. There are widespread concerns that recent massive increases in funding for national responses to HIV and AIDS, particularly from the World Bank, the Global Fund and PEPFAR, will not be able to be fully utilised because of problems with absorptive capacity.

11.18 It is concerns about the ability to use funds received that is the focus of much discussion of absorptive capacity. It can result in slow disbursement and/or misuse of funds. Causes include an inadequate institutional and policy environment, and limited technical and management capacity, e.g. due to inadequate human resources (ODI, 2005). However, although there are many anecdotes, there is little systematic evidence of a problem with new AIDS financing. Neither the World Bank MAP nor PEPFAR publish figures of disbursement rates so that what evidence there is is largely drawn from experience of the Global Fund (Bernstein and Sessions, 2007). Analysis of use of their funds showed that disbursement rates were higher:

- In politically stable countries
- In low income countries
- In countries with poor health systems
- Where the Principal Recipient was from the private sector (both for-profit and not-for-profit) or a multilateral agency (Lu et al., 2006)

11.19 A recent study (Bernstein and Sessions, 2007) examined Global Fund experience in two countries, Ethiopia and Uganda[265]. In both, disbursement of funds was slower than expected. In Ethiopia, this appears to have been a temporary problem which has now been addressed[266]. In Uganda, there were not only severe implementation delays but there was also reported to be 'serious mismanagement' of funds resulting in suspension of the grant[267].

[265] These are interim findings and further results are expected, also from Mozambique and Zambia.

[266] HAPCO had planned to spend $21.3 million within six months of the grant starting but only managed to spend $6 million in the first nine months. However, at 18 months, they had spent $34.4 million of a planned $40.4 million.

[267] Although the grant has now resumed

11.20 Although this might seem to be evidence of limited absorptive capacity in developing countries, there are those who believe this to be a 'myth' (Moghalu and Mbikusilu-Lewanika, 2003) promoted by donor agencies. 'International organisations like to use the absorptive capacity excuse, but in truth many of them are misinterpreting the term…" (Utan, 2005). They argue that the problems arise largely because of ways in which aid is provided in a fragmented and unpredictable way including with different disbursement procedures and financial years; with bureaucratic procurement requirements; with requirements for the establishment of new structures; and with highly centralised ways of working. All these factors contribute to high transaction costs.

11.21 A range of solutions have been proposed to the problems of absorptive capacity. These fall into two main groups. First, there are those, e.g. PEPFAR and the Global Fund who argue that the limitations are largely due to an excessive and exclusive focus on government capacity. They advocate greater use of non-state actors, e.g. outsourcing procurement through UNICEF in Ethiopia and M&E through a consultancy in Uganda (Bernstein and Sessions, 2007). Although PEPFAR has not produced evidence to support this approach, evidence from Global Fund experience suggests that non-state actors acting as Principal Recipients are able to disburse funds more rapidly than government agencies (Lu et al., 2006). However, there are also concerns about the absorptive capacity of civil society organisations (Chesnais et al., 2005).

11.22 Second there are those, including DFID, who argue that a key way to reduce problems due to absorptive capacity would be to increase aid effectiveness by implementing the principles of the Paris Declaration. These include greater harmonisation of donor efforts and increasing alignment with national priorities.

Lessons Learned

11.23 The following lessons have been learned from the experience of the AIDS spending target. These apply not only to future AIDS strategies and spending targets but also to other areas of development:

- Any spending targets should be introduced in a coherent way as part of DFID's overall planning process, including a detailed process of consultation with staff and other stakeholders. There needs to be clarity as to how the spending targets relate to each other.
- Any spending targets that are agreed need to be institutionalised into DFID's business model, in particular the Public Service Agreement, Directors' Delivery Plans and Country Assistance Plans[268].
- The method for measuring progress towards the spending target needs to be agreed before it is introduced and the target level set. Decisions over methods should take into account good practice internationally, and, in complex areas, such as HIV and AIDS, would benefit from consultation with key players[269].

[268] This also applies to Regional Assistance Plans and Institutional Strategies where appropriate.

[269] Such as NAO, UNAIDS and major NGOs working in this field

- Information systems need to be in place, and used consistently, to allow progress to spending targets to be accurately tracked.

12. Lessons Learned for Future Strategies

In Brief

Question: *Taking Action* has several interesting features: it is a Cross-Whitehall strategy, contains spending targets, and was developed through a consultative process. What lessons can be learned for developing future strategies (AIDS and other) from the process of developing *Taking Action*.

A key feature of the introduction of *Taking Action* was extensive consultation with DFID's external stakeholders, including NGOs, other government departments and parliamentarians. Consultation within DFID, particularly around the imperatives behind the introduction of a spending target and the implications of managing this target, could have been stronger.

A Cross-Whitehall strategy has enabled DFID to engage with other government departments and the inter-departmental coherence group has been useful. However, lack of clearly specified roles and responsibilities for other government departments in delivering the strategy has made its implementation across UK Government harder to measure. This has meant that, according to the International Development Committee, although billed as the UK strategy on HIV/AIDS in the developing world *Taking Action* is in reality a DFID strategy. Focused inter-departmental working groups e.g. on the G8 meeting in 2005 and on access to medicines, have been the most effective examples of Cross-Whitehall action. It is unclear how *Taking Action* fits with other DFID strategies and with other UK strategies e.g. the Department of Health's National Strategy for Sexual Health and HIV in England, introduced in 2001, and equivalents for Scotland, Wales and Northern Ireland.

The Process of Developing *Taking Action*

Origins

12.1 The development of *Taking Action* was driven by high-level UK Government political commitment to HIV and AIDS as a critical global issue and followed the *Call to Action*, which was launched in December 2003 by the Prime Minister. Ministerial and senior management support within DFID for *Taking Action* has been much stronger than for any other DFID strategy.

12.2 The new strategy reflected the desire on the part of ministers for a Cross-Whitehall strategy that would support a more comprehensive response to the epidemic (see section 11.8, p144). Unlike previous strategy papers, *Taking Action* would have a spending target to highlight the importance the UK Government attached to HIV and AIDS and to give the strategy 'traction' within DFID.

12.3 The lead on developing *Taking Action* was taken by the newly created Global AIDS Policy team within DFID's Policy Division, established as part of a major reorganisation of the Department. The team leader was recruited externally with a view to bringing in an individual with an 'AIDS activist' background.

12.4 Issues regarding the inclusion of a spending target within the strategy are discussed elsewhere in this report (see section 11.1, p141).

Consultation with Stakeholders

12.5 The process of developing *Taking Action* involved extensive consultation with external stakeholders, including MPs, All-Party Parliamentary Groups, other government departments, academic institutions, the private sector, and NGOs through the UK NGO AIDS Consortium. External stakeholders interviewed for this evaluation have very positive views about the consultation process and welcomed the opportunity to be involved in developing the strategy.

12.6 Considerable efforts were also made by the GAP team to consult within DFID. Staff in country offices reviewed drafts and, in some cases, also sought inputs from national governments and other partners. This degree of country level consultation was also unusual at the time, although development of subsequent DFID strategies has involved a considerable degree of consultation with country offices. However, some staff said that it would have been helpful to have had more internal consultation about how the spending target would be managed and measured.

12.7 DFID staff responsible for developing *Taking Action* also said that the consultation process could have been better planned. This view is shared by those responsible for coordinating NGO inputs. In particular, it would help to be clear from the start about the inputs required and about the role of senior management at different stages in the process. Although the consultation timeframe was reasonable, inadequate time was allowed at the end of the process to prioritise the wide range of issues, described by one respondent as a 'wish list', identified by different stakeholders or to discuss how the strategy might be delivered. One NGO respondent pointed out that consultation on the treatment and care document (DFID, 2004b) was conducted in parallel with consultation on *Taking Action* but the two processes were not coordinated or linked.

12.8 DFID staff responsible for developing *Taking Action* said that the strategy might have benefited if more time had been allowed for systematic review of the evidence base and analysis of the comparative advantage of DFID and other government departments.

Fit with Other Strategies and Systems

12.9 The need to ensure *Taking Action* fitted with other corporate strategies and systems was highlighted in a paper submitted to the DFID Development Committee on 18th May 2004 (Schultz, 2004). However, there are a very large number of these. *Taking Action* makes few references to other strategies. This reflects limited coherence between strategies in general in DFID[270].

[270] Analysis of other policies and strategies (see Annex 8, pA121) indicates that HIV and AIDS are addressed in some of these.

12.10 The issue of policy coherence within DFID was the subject of a review in early 2005 (Ladbury, 2005). The review found that at the level of joining up and sharing information on policy work DFID is reasonably coherent but that there was scope for improvement in coherence in terms of 'how activities fit together and logically support DFID's corporate principles and higher level goals'. The review findings were considered by the 9 March 2005 Development Committee which agreed actions to ensure greater clarity and discipline on the development of policy work and better joining up between policy development and its implementation. These include: distinguishing more clearly between different sorts of policy products, their audience and status; seeking approval for a Policy Concept Note before commencing significant policy development work; setting priorities for policy work; making it mandatory for all new policy papers to include an internally discussed and agreed implementation strategy; and providing support from Policy Division for policy implementation.

12.11 Less attention has been paid to how *Taking Action* relates to other UK Government strategies on AIDS, for example, the Department of Health's National Strategy on HIV and Sexual Health in England, introduced in 2001, or to the potential for a Cross-Whitehall approach to HIV and AIDS in the UK. It appears that the UK regards HIV and AIDS in the developing world as separate from the epidemic in the UK, rather than as interlinked. In a recent hearing, the House of Commons International Development Committee (IDC) raised concerns over poor coordination between the Home Office, FCO and DFID over access to ART in the UK of failed asylum seekers (IDC, 2006b).

Working across Whitehall

12.12 This section explores ways of working across more than one UK Government department, i.e. Cross-Whitehall. First, this explores strengths and weaknesses of Cross-Whitehall strategies. Second it examines other mechanisms for Cross-Whitehall working which can either be used alone or in combination with a strategy.

Strengths and Weaknesses of *Taking Action* as a Cross-Whitehall Strategy

12.13 Officials interviewed for this evaluation view HIV and AIDS as a global issue that merits a UK Government rather than a departmental approach. The fact that *Taking Action* is a Cross-Whitehall strategy has played an important role in raising the profile of HIV and AIDS in the developing world across the UK Government. In the international arena, a strong UK Government position is far more effective than a departmental position, as demonstrated by the tangible achievements of the UK's G8 and EU Presidencies.

12.14 At country level the FCO has made an important contribution to taking forward *Taking Action*. The strategy was launched through the FCO network. HIV and AIDS are included in the objectives of FCO staff, e.g. in Zambia. DFID country evaluations, case studies conducted for this evaluation and examples of Post activities (see Box 35, p156) highlight the role of the FCO and the high levels of awareness and commitment of FCO staff to HIV and AIDS.

12.15 However, with its emphasis on HIV and AIDS in the developing world, *Taking Action* is largely a DFID agenda and DFID leads on implementing the strategy. In its recent enquiry, the House of Commons International Development Committee concluded that '*Taking Action*, although billed as the UK strategy on HIV/AIDS in the developing world, is in reality only the strategy of DFID' (IDC, 2006a).

12.16 *Taking Action* does not explicitly set out shared objectives and, without higher level departmental commitment and additional resources, there is limited incentive for other government departments to do much beyond their existing work.

12.17 It is important to acknowledge and address different interests and approaches, rather than assuming that government departments share common interests. For example, there are differences in approaches to issues such as migration and asylum, criminalisation of HIV transmission, and recruitment of overseas doctors through the Highly Skilled Migrant Programme. Lessons could be learned from DFID experience of working with the FCO in the Overseas Territories, which have highlighted differences in understanding of and approaches to development.

12.18 The impact of *Taking Action* as a Cross-Whitehall strategy is difficult to measure as the roles and responsibilities of other government departments in delivering commitments are unspecified. Efforts to track implementation of *Taking Action* across the UK Government have been limited, there are practical problems in doing this, and the evaluation found no evidence that the coherence group is monitoring progress against the overall commitments in *Taking Action* (see section 9.3, p120).

12.19 Views differ about whether or not a future HIV and AIDS strategy should cross Whitehall. Some would welcome a more explicit joint agenda (IDC, 2006b) with the roles and responsibilities of different departments clearly stated, while others recognise that this may not be feasible.

Box 35 The FCO Contribution: Country Examples

In **China** there is regular liaison between the DFID office and the British Embassy in Beijing, particularly on individual human rights cases and public relations events. Links are good. There is scope for greater synergy and complementarity in support for HIV and AIDS, and small amounts of targeted Embassy support for civil society organisations could have more impact if they were linked to larger DFID initiatives.

With the Embassy taking the lead, the UK Government works in a joined up way to strengthen political leadership in **DRC**. The main challenge at the time the country case study was conducted was to see the country through the presidential election on 30th July. In the period leading up to the election, while the UK had not been pushing the transitional government on HIV and AIDS *per se*, the Embassy consistently drew attention to human rights abuses by the Congolese army, including the 'raping with impunity' that contributes to the spread of HIV. "We've done a lot on this. What we haven't done is go to the ministers for an AIDS campaign. This we will do once there is a legitimate elected government".

Within the FCO in **India**, HIV and AIDS are covered by both the political and economic desks. They often approach DFID for advice on HIV and AIDS issues on an *ad hoc* rather than a regular basis. For example, DFID was approached for advice on India's representation on the Global Fund's board. To date, the FCO has not played a major role in promotion of HIV/AIDS leadership in India, but acknowledged that, given the right brief from DFID, they could ensure high level visitors from the UK communicate appropriate HIV and AIDS messages to their Indian counterparts. In addition, FCO fellowships to the UK could be used strategically to build leadership on HIV and AIDS.

In **Zambia**, the FCO has been active in policy dialogue on HIV and AIDS. FCO activities have included: advocating for the private sector to increase efforts to provide antiretroviral drugs; providing political leadership in cooperation with DFID; managing a small grants scheme; and advocating for improved prison conditions in cooperation with UNAIDS.

The Ambassador and Deputy Ambassador in **Ethiopia** demonstrate high levels of knowledge and awareness of HIV and AIDS and a strong commitment. Ten per cent of HMA's small project fund supports community HIV projects. However, responses do not appear to be informed by specific objectives.

In **Zimbabwe**, the Embassy has supported some HIV and AIDS activities as part of its diplomatic efforts. This includes spending 10% of the annual £200,000 small projects budget on HIV and AIDS activities. In 2006/7, this has been supplemented by an additional £100,000 from DFID to support HIV and AIDS interventions at community level. The small projects budget has funded HIV/AIDS NGOs, including to provide psychosocial support to children living with HIV and AIDS and to improve access to HIV/AIDS information for deaf people.

The FCO supports HIV and AIDS activities through Small Grants Schemes in a number of countries. For example, the FCO in **Cameroon** is supporting both VSO and Peace Corps volunteers to implement community HIV awareness and prevention activities. In **Mozambique**, grants are being provided to support HIV work by the Catholic and Methodist churches and Islamic leaders. FCO small projects in **Nepal** focus on children and youth, including HIV and drugs awareness training for young people, and support for efforts by the government, UNICEF and NGOs to tackle child trafficking and sexual exploitation of children.

Mechanisms for Inter-Departmental Working

12.20 HIV and AIDS has an inter-departmental coherence group, chaired by DFID, which meets twice a year and is attended by representatives from other departments including the Foreign and Commonwealth Office (FCO), Department of Health (DH), Home Office (HO), Department of Trade and Industry (DTI) and the Treasury (HMT). The group is considered to be a useful forum, which has helped to improve communication and collaboration. Officials in other departments believe that UK Government action on HIV and AIDS in the developing world is more 'joined up' as a result.

12.21 While coherence group meetings are valuable in terms of exchanging information and identifying opportunities to link actions, the impact of the group, including the extent to which it has influenced departmental decisions, is less obvious. The group does not have an explicit process for joint priority setting, has no clearly-assigned roles and responsibilities, is not currently able to fulfill a monitoring role and lacks funds to provide an incentive for joint working. Also questioned was the contribution that departments can make to the wide-ranging agenda covered by meetings. For example, the key shared objective for the DTI is access to medicines, TRIPS and related issues, and the department has less interest in other issues.

12.22 Staff in DFID and other departments consider that focused Cross-Whitehall groups, such as the '2005 units' established to plan and prepare for the UK's G8 and EU Presidencies and the access to medicines group, are most effective. *Taking Action* has provided the opportunity to use such groups to promote coherence across government and wider engagement on issues which are of concern to more than one department such as TRIPS, human resources for health and harm reduction.

12.23 DFID has worked closely with other government departments on harm reduction issues through the coherence group, to identify how to advance the harm reduction agenda and, specifically, how to take forward the UK's Harm Reduction Policy Paper published on World AIDS Day in 2005. In addition, the Home Office and FCO have prepared a draft paper designed to initiate wider discussion of the UK approach to UN drugs bodies, reflecting concerns that the UN lacks clear commitment to the harm reduction agenda (Cross-Whitehall Coherence Group, 2006).

12.24 One example of effective joint work across departments was planning for the high level UNGASS meeting in June 2006. A virtual team was established involving the DFID GAP team, FCO, UK Missions to the UN in New York and Geneva, and the DH. This enabled the UK to develop and promote a strong common position and these combined efforts helped to ensure key issues and commitments were included in the UNGASS Declaration.

12.25 In some cases, joint UK Government policy papers may be more appropriate than joint strategies, e.g. on conditionalities in poverty reduction (DFID et al., 2005a), which involved collaboration between DFID, FCO and HMT, and on access to essential medicines (DFID et al., 2005b) which involved DFID, DH

and DTI. Again, however, while a shared position is useful, it is also important to identify measurable outcomes and departmental roles in delivering these.

Lessons Learned from Other Experience

12.26 The experience of implementing and monitoring a Cross-Whitehall strategy to tackle HIV and AIDS is not dissimilar to that highlighted in a NAO review (NAO, 2005b) of joint targets in conflict prevention and management (DFID, FCO and MOD), debt relief (DFID and HMT), MDGs (DFID and HMT), and trade barriers (DTI, DFID and FCO). The review concludes that joint targets are important in the international arena to signal UK intent and commitment to external stakeholders and that the importance of joint working is reflected in the increasing number of joint PSA targets. However, achieving these is not easy. Challenges relate to setting objectives and priorities, developing common understanding of how to achieve joint targets, determining roles and responsibilities, implementing appropriate working arrangements, and monitoring and reporting performance. More specifically, the review concludes that:

- Targets need to be better defined i.e. so that they are not too broad or too narrow.
- Joint targets can stimulate joint working, but have limited value in influencing how departments organise themselves or on their activities.
- Departments were often already working together prior to the introduction of joint targets. This was not the case regarding conflict, where changes in arrangements were driven by the need to manage pooled budgets as much as by having a joint target.
- Plans tend to have a single department focus rather than being the result of joint planning, although joint targets help to ensure plans are coherent.
- With the exception of conflict, resources used were those already committed.
- There is a lack of joint delivery plans, shared milestones and performance indicators, creating challenges in accountability for delivery.
- Reporting of progress varies and is assessed in a different sense.

12.27 Unlike *Taking Action*, the Conflict Prevention Pools[271] established in 2001 and involving FCO, MOD, HMT, DFID and the Cabinet Office, are not a strategy but have a specific remit to promote joint analysis and priority setting. There is also a joint budget. Evaluation of the Conflict Prevention Pools concluded that inter-departmental work on this issue was effective and should continue (Austin et al., 2004). It found that a Cross-Whitehall approach had a positive effect on mobilising international partners and promoted better interaction and cooperation between departments especially in London, but that additional resources had enhanced existing departmental programmes rather than enhancing overall UK efforts in conflict prevention. It also found that the different agendas and working cultures of different departments and relationships between individuals are key factors in the success of any Cross-Whitehall initiative.

[271] Global Conflict Prevention Pool and Africa Conflict Prevention Pool

Evaluation recommendations included analysis of the differences in understanding and ways of working of different departments, allocation of dedicated staff resources and adoption of an agreed set of performance indicators.

12.28 The International Development Committee (IDC, 2006b) report on conflict and development also concludes that 'because the Pools fund relatively small departmental projects they do not by themselves demonstrate a joined up approach. Policy coherence is desirable but it is important to be clear about the policy around which coherence is sought'.

12.29 Lessons learned from other donors, specifically a SIDA review of its HIV and AIDS strategy, also reinforce many of the issues identified by this interim evaluation of *Taking Action*, such as the need for staff to have particular competencies in relation to HIV and AIDS, and for there to be a stronger focus on implementing strategies and tracking their implementation (see Box 36 – Vogel et al., 2005).

Box 36 Key points from evaluation of SIDA HIV and AIDS strategy

HIV and AIDS were identified as a strategic priority for SIDA in 2004. The SIDA strategy took a multisectoral approach to HIV and AIDS, with mainstreaming as the principal method. The evaluation found that the strategy had resulted in: establishment of staffing and structures to address HIV and AIDS, and increased competence and awareness; and a higher profile of HIV and AIDS in Swedish development cooperation, in terms of funding and country programmes. However, the evaluation also found that: staff were unclear about how to implement the strategy and which aid instruments to use; staff were overwhelmed by the demand to do more with less; and the strategy lacked benchmarks. The evaluation recommended that SIDA:

- Situate HIV and AIDS so that it plays a more central role in poverty reduction and is more clearly related to key policy orientations
- Produce a short, concise up to date policy that spells out concrete goals for scaling up HIV/AIDS work and sets specific targets
- Ensure that monitoring systems provide clear information to measure progress
- Provide staff with clearer orientation on priorities and match staffing with priorities
- Develop better training to build AIDS competence

Lessons Learned from the Process of Developing and Implementing *Taking Action*

12.30 The following specific lessons for future HIV and AIDS strategy and other development strategies can be drawn from the process of developing *Taking Action*:

- There should be clear agreement about the purpose of and audience for strategy documents, e.g. whether it is intended primarily to communicate the UK Government or DFID position on an issue to external stakeholders or to guide organisational priorities and action. Suggestions for how this might be addressed in a future strategy on HIV and AIDS are contained in Box 37 (p161).

- Consultation on future strategies needs to be well planned and managed, in particular in setting out the purpose of consultation, the inputs required and how these will be used, and the involvement of senior management.
- Internal consultation during the process of setting spending targets and to determine how these targets will be managed and measured is critical.
- Adequate time should be allowed for external and internal consultation including country level involvement of DFID and FCO, national governments, CSOs and other partners, and for prioritisation.
- Adequate time is also required for systematic review of the evidence base and analysis of the comparative advantages of DFID and other government departments.
- Cross-Whitehall strategies are of benefit when the issue is of cross-cutting interest, for example, trade, security, conflict. The advantages are less obvious when a strategy reflects the agenda of one department.

12.31 In addition, as HIV and AIDS in the developing world are mainly of concern to DFID, and to a lesser extent the FCO, the bulk of the work in implementing and monitoring *Taking Action* has been done by DFID. In future a decision needs to be taken about whether the UK should:

- Develop a Cross-Whitehall strategy on HIV and AIDS which covers not only the response globally but also the UK's domestic response. Such a strategy might allow more meaningful participation of government departments other than DFID, could appear more relevant to middle-income countries and could enable more meaningful, effective and joined-up engagement on related issues, e.g. TRIPS, access to medicines and treatment for asylum seekers *or*
- Develop a DFID strategy on HIV and AIDS in the developing world – with coordination with other departments as appropriate, e.g. FCO.

Box 37 Policy Paper and Action Plan

The policy paper should

- Set out the UK's broad direction and frame HIV and AIDS in terms of the way the UK Government, in general, and DFID in particular works, i.e. its 'business model'
- Build on and update the existing strategy, based on analysis of what has changed in the external environment and likely emerging issues (see section 10.14, p136) and consolidating achievements to date
- Be more explicitly based on analysis of UK Government and DFID comparative advantage (see Box 32, p138).
- Set out a clear position e.g. on issues such as prevention and harm reduction
- Reflect commitments in the 2006 White Paper (DFID, 2006e – see Box 38, p162)
- Provide more explicit guidance on selection of partners, including how the UK Government will work with new players
- Reflect greater coherence across Whitehall and greater internal coherence within DFID, including stronger links to issues such as sexual and reproductive health, gender, human resources for health and to other sectors such as governance, education and livelihoods
- Distinguish between country-led and government-led approaches and national and government programmes
- Be more nuanced, particularly for regions outside Africa – e.g. linking HIV and sexual and reproductive health services is most appropriate in settings with generalised sexual epidemics and less appropriate where HIV is spread largely through injecting drug use
- Explain how the UK will work in countries with no DFID presence, including through the FCO and partners such as UN agencies, global funding mechanisms, regional programmes, civil society organisations and networks
- Take account of likely emerging issues e.g. rising costs of treatment as more people gain access and need for second-line therapy rises; implications of resistance to ART and anti-TB drugs; new development funders (e.g. China); increasing influence of conservative political agendas (US, accession states, Islamic world); risk of 'AIDS fatigue' as new issues, e.g. climate change, energy, move centre stage

The action plan should:

- Be clear on how the UK will support the drive for 'universal access' (including ensuring that the needs of marginalised groups are not neglected), sustainability of ART and addressing the growing global funding gap
- State the UK's commitment to supporting initiatives in countries with concentrated epidemics, including middle-income countries, which build capacity to deliver effective but contentious services to the most vulnerable, such as harm reduction programmes
- Inform and feed into DFID planning processes (see section 5, p40), in line with recent changes instigated by the Development Committee and the equivalent as appropriate for other government departments
- Highlight issues that the UK Government and specific departments will focus on and include a small number of measurable commitments
- Focus on implementation and delivery, with a stronger emphasis on outcomes and measuring results
- Have a monitoring and evaluation framework that is developed at the time of setting the strategy, with clear indicators including those that are relevant and can be measured at country level

Box 38 Reflecting Commitments in the White Paper

The White Paper makes specific commitments to:

- Delivering promises and commitments made in 2005, including increasing the development budget; pressing ahead with the IFF and other innovative financing mechanisms; concentrating efforts on the poorest countries and fragile states; doubling funding for science and technology research
- Putting support for good governance at the centre, including focusing on state capability, responsiveness and accountability
- Helping people to have public services, including committing at least half of all future direct UK support for developing countries to public services to strengthen, among areas, health care, social protection and efforts to tackle HIV and AIDS, and agreeing ten year partnership commitments with developing countries
- Reforming the international system, including the UN and international financial institutions, supporting regional organisations such as the ADB and AU, and working more closely with European partners

DEPARTMENT FOR INTERNATIONAL DEVELOPMENT

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LONDON
1 Palace Street
London
SW1E 5HE
UK

GLASGOW
Abercrombie House
Eaglesham Road
East Kilbride
Glasgow
G75 8EA
UK

Tel: +44 (0) 20 7023 0000 Fax: +44 (0) 20 7023 0016
Website: www.dfid.gov.uk
E-mail: enquiry@dfid.gov.uk
Public Enquiry Point: 0845 300 4100
If calling from abroad: +44 1355 84 3132
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