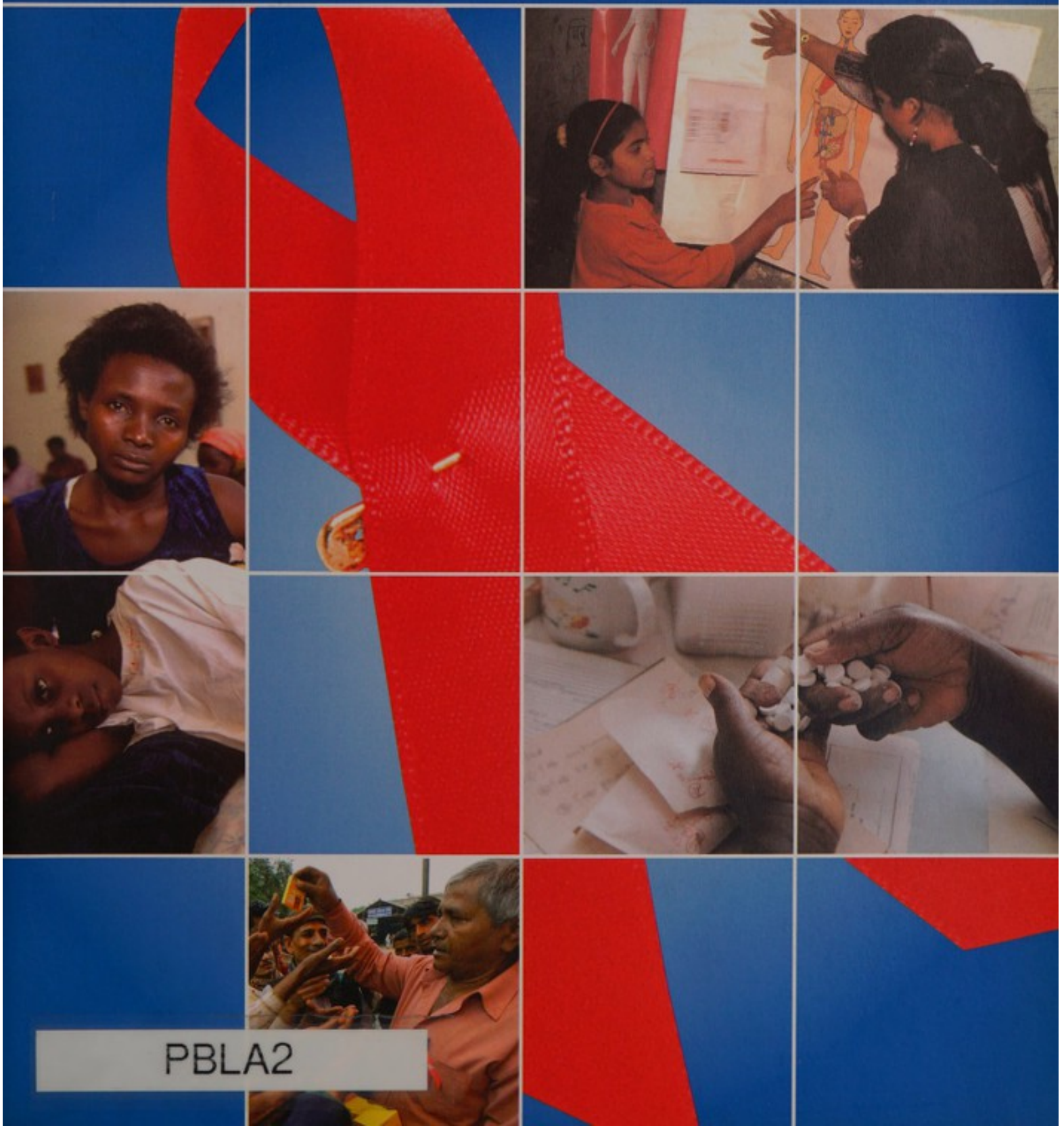
Responding to HIV/AIDS : report by the Comptroller and Auditor General / [National Audit Office] ; Department for International Development.

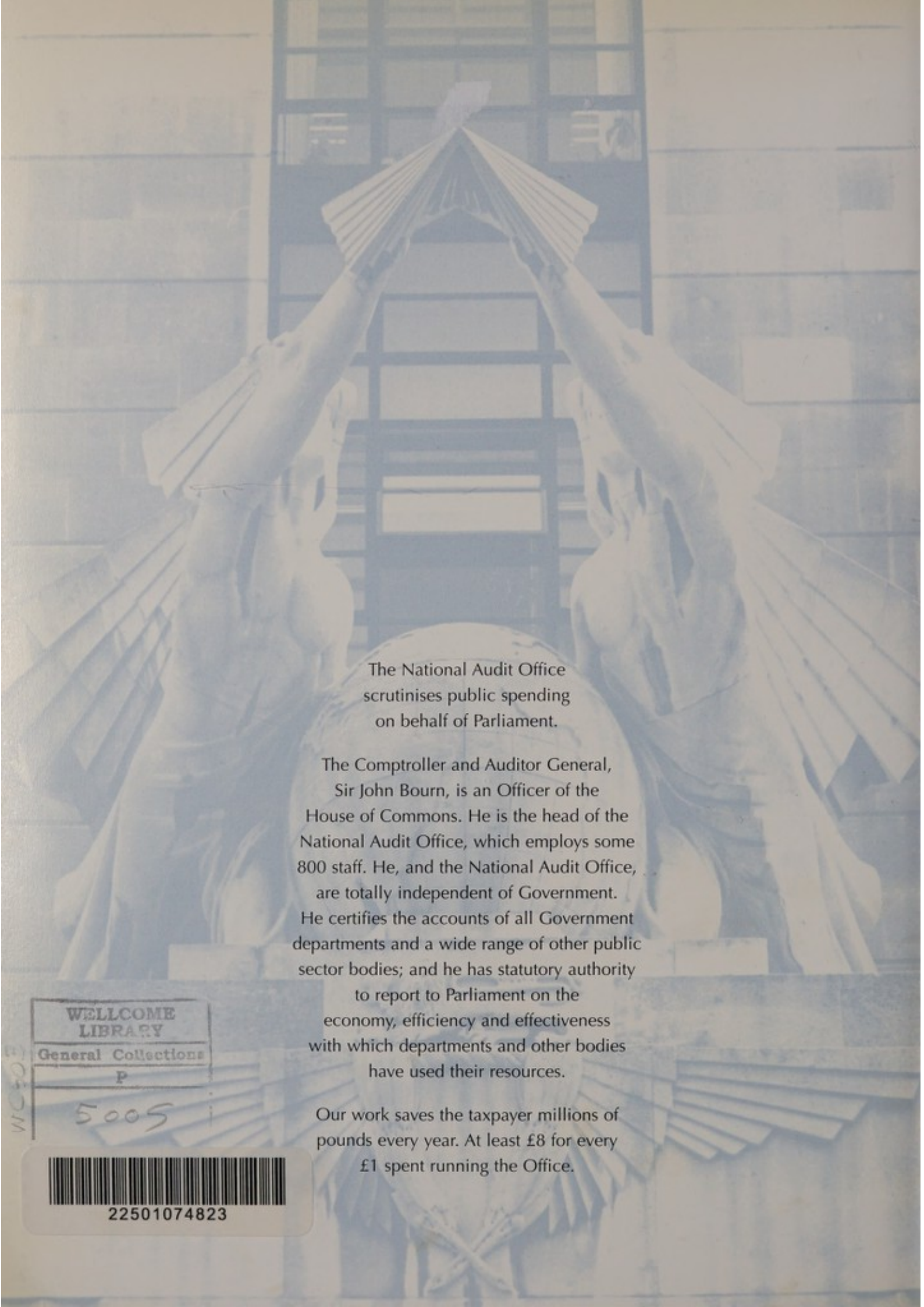
NATIONAL AUDIT OFFICE

Department for International Development

Responding to HIV/AIDS

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 664 Session 2003-2004: 18 June 2004





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Department for International Development

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John Bourn
Comptroller and Auditor General

National Audit Office
16 June 2004

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Contents

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executive summary

'... the [HIV/AIDS] epidemic continues its lethal march around the world, with few signs of slowing down. In the course of the past year, every minute of every day, some 10 people were infected.'

Kofi Annan, United Nations Secretary General, Message on the Occasion of World AIDS Day, 1 December 2003

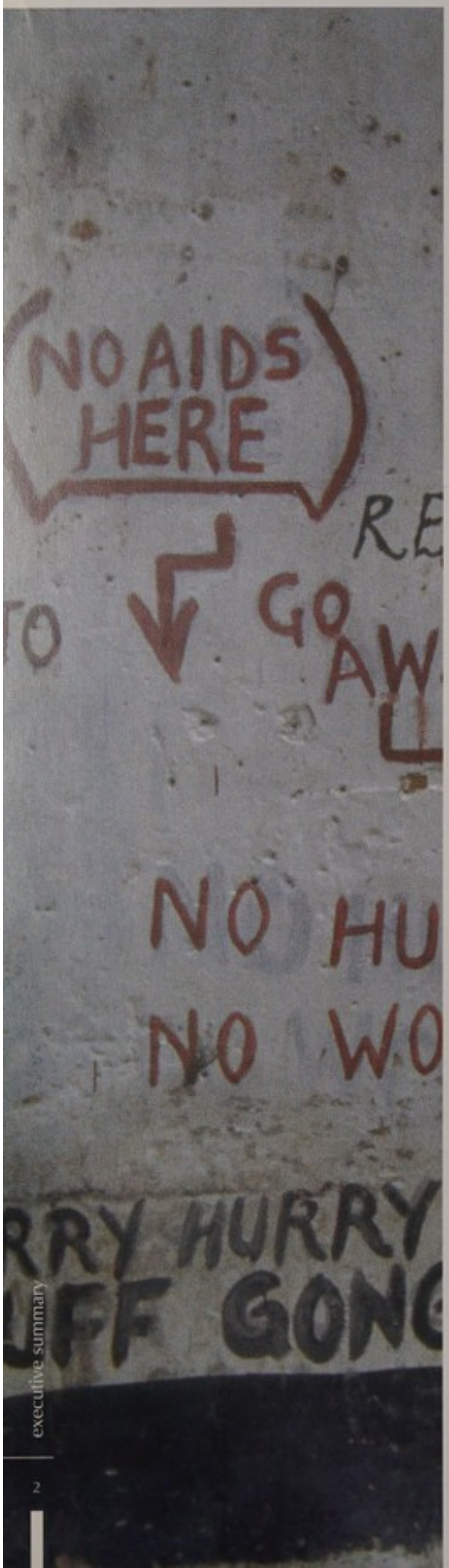
The impact of HIV/AIDS

1 Over the last two decades at least 65 million people have been infected with HIV and 20 million have died. HIV/AIDS is now the leading cause of death in Sub-Saharan Africa where, in some countries, nearly 40 per cent of the population are infected. By 2010, about 14 million children worldwide will have been orphaned by the epidemic.[1]

2 For the poorest countries, in particular, HIV/AIDS can be devastating, depriving them of their most productive people, eroding the capacity of governments to provide essential services and stopping economic growth. The epidemic also jeopardises achievement of the Millennium Development Goals[2] - which aim to halve by 2015 the proportion of the world's population living in extreme poverty. If the Goal to halt and begin to reverse by 2015 the spread of HIV/AIDS is not achieved, that will undermine progress towards all the other Goals. For example, the number of children enrolled in schools in Swaziland has fallen by 36 per cent due to AIDS orphans dropping out of school, eliminating the possibility of achieving universal primary education by 2015.[3]

Coffin-maker's shop, Lilongwe, Malawi

1 *UNAIDS (2002), Report on the global HIV/AIDS epidemic, July 2002; UNAIDS, AIDS Epidemic Update 2003; DFID (2003), UK's Call for Action on HIV/AIDS, December 2003.*
2 *The Millennium Development Goals were adopted by member countries of the United Nations in 2000 and provide global consensus on objectives for addressing poverty. Further information can be found at www.un.org/millenniumgoals.*
3 *United Nations Development Program (undated), Results: HIV/AIDS.*



3 In June 2001, the United Nations issued a Declaration of Commitment on HIV/AIDS[4] in recognition that the epidemic required a multifaceted response on a global scale and set out a roadmap for its implementation. The United Kingdom White Papers on International Development in 1997[5] and 2000[6] highlighted the importance of tackling HIV/AIDS in the interests of eliminating world poverty. The Department for International Development (DFID) leads the United Kingdom contribution, through bilateral country programmes and through multilateral development institutions and international initiatives in the HIV/AIDS field. DFID produced a formal *Strategy* on HIV/AIDS in May 2001[7] and in April 2003, DFID established a multi-disciplinary HIV/AIDS Policy Team to reflect the cross-sectoral nature of the epidemic. In December 2003, the United Kingdom published its *Call for Action on HIV/AIDS*[8] which signalled the Government's intention to intensify its effort to tackle the epidemic. A summary of the *Call for Action* is set out in Appendix 1. A new HIV/AIDS strategy is due to be published in July 2004. This report examines:

- whether DFID had a satisfactory HIV/AIDS strategy;
- how DFID worked through multilateral development institutions and global partnerships to achieve its objectives on HIV/AIDS;
- how DFID's country programmes sought to tackle the epidemic; and
- what use DFID made of research on HIV/AIDS.

DFID's strategic response

4 DFID's 2001 *Strategy* document on HIV/AIDS aims to provide '... a strategic framework for DFID staff on how to approach tackling the HIV/AIDS pandemic'; and 'outlines to a broader readership DFID's priorities and the partnerships [DFID] will be pursuing'. The substance of the *Strategy* reflects international thinking of the time about effective approaches and it compares well with strategies on HIV/AIDS developed by other like-minded donors. It articulates the causes and effects of the epidemic, recognises the importance of international objectives and targets, and highlights the value of working in partnership with others. It helps those outside DFID to understand its broad priorities.

5 The *HIV/AIDS Strategy* was also designed to inform divisional and country-level plans, which set out the detail of DFID's responses. It set out most possible responses to the epidemic, as a starting point for staff - many posted in country - to derive the best set of responses for their circumstances. While responses at a country level need to be driven primarily by country circumstances, the *Strategy* could in some areas have provided further guidance on the relative merits of different approaches.

6 DFID staff also told the National Audit Office that there was a growing need for technical guidance on a number of issues facing them as they sought to develop programmes to tackle HIV/AIDS. DFID had planned to issue a number of guidance notes in the year following publication of the *Strategy* but only two out of seven have been published. There is a continuing demand from country teams for guidance on the most difficult and sensitive issues - such as the merits of funding anti-retroviral drug treatments. DFID plan to issue guidance later in the year, starting with an HIV Treatment and Care Policy, a Sexual and Reproductive Health Position paper and an Access to Medicines Strategy in

4 *United Nations General Assembly, Declaration of Commitment on HIV/AIDS, Special Session on HIV/AIDS, 25-27 June 2001.*
5 *White Paper on International Development (1997), Eliminating World Poverty: A Challenge for the 21st Century, Cm 3789. London, The Stationery Office.*
6 *White Paper on International Development (2000), Eliminating World Poverty: Making Globalisation Work for the Poor, Cm 5006, London, The Stationery Office.*
7 *DFID (2001), HIV/AIDS Strategy, May 2001.*
8 *DFID (2003), UK's Call for Action on HIV/AIDS, December 2003.*

July 2004, followed by a Communications paper in October 2004. The HIV/AIDS web portal is due to be launched in July 2004. In the absence of a DFID position on these issues, staff have recourse to advice from a wide range of other sources, including the extensive UNAIDS 'Best Practice' series of publications.

Monitoring implementation and impact

7 Performance against HIV/AIDS-related targets in DFID's 2003-06 Public Service Agreement will be assessed in 2004 when key data from the United Nations become available in July. DFID has not monitored the implementation or impact of its *HIV/AIDS Strategy* separately from its wider business planning and monitoring processes. Existing monitoring arrangements assess progress against the milestones set out in DFID's Public Service Agreement, Director Delivery Plans and Country Assistance Plans rather than against the objectives set out in the HIV/AIDS strategy.

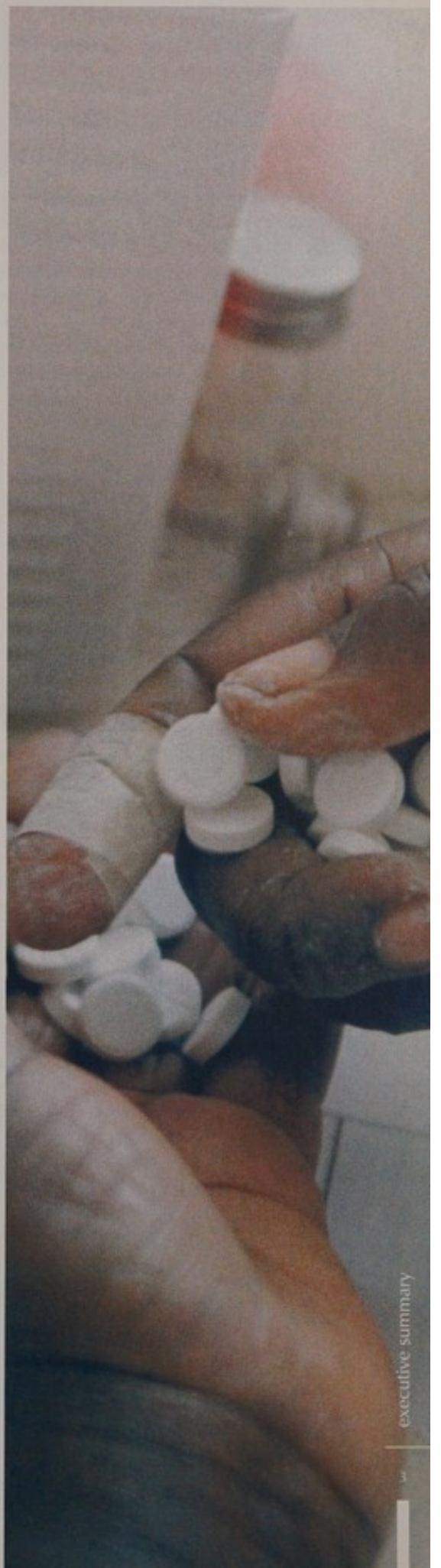
8 Methods of estimating HIV/AIDS expenditure vary. DFID's current definition of HIV/AIDS bilateral expenditure includes sexual and reproductive health spending and generates an estimate of £274 million for 2002-03. If direct budget support and projects that focus principally on sexual and reproductive health are excluded the estimate falls to £169 million for 2002-03. An even narrower approach, which sought to exclude all project expenditure except that focused directly on HIV/AIDS, yielded an estimate of £103 million for 2002-03. This range of estimates reflects the broad-based and multisectoral nature of DFID's HIV/AIDS response, which makes expenditure contributing to HIV/AIDS objectives difficult to isolate. DFID, in common with other donors, has had difficulty in identifying the extent to which general support to a nation's budget is employed on HIV/AIDS issues. DFID has agreed an approach for identifying the extent to which budget support is used on HIV/AIDS based on recipient governments' own expenditure analyses. But more detailed guidance must be prepared before the approach can be applied. DFID has also recently developed a system to use multilaterals' own reported data to estimate how much of its contribution they spend on HIV/AIDS - the first running of the system provides an estimate of £57 million for 2002-03.

9 DFID recognises the need to develop a new strategy. In 2003 it created a multi-disciplinary policy team to lead and coordinate a corporate response to the challenges HIV/AIDS presents to achievement of the Millennium Development Goals. In its *Call for Action* paper DFID announced that it will produce a new HIV/AIDS strategy in 2004 and issue new policy guidance on the role of HIV treatment and care. The creation of the HIV/AIDS Policy Team and this National Audit Office review have led DFID to defer its first comprehensive evaluation of its response to HIV/AIDS.

Working through multilateral development institutions and global partnerships

Multilateral development institutions

10 DFID provides significant sums to multilateral development institutions. DFID seeks to influence the policies and activities of such institutions and has developed Institutional Strategy Papers which describe how DFID aims to achieve its objectives in partnership with these organisations. Institutional strategies are not designed to focus exclusively on HIV/AIDS. But HIV/AIDS has such a bearing on the Millennium Development Goals that it should feature in any strategy relating to those multilateral development institutions which have a clear interest in responding to the epidemic. However, 8 out of the 14 DFID



Strategy Papers for such institutions did not mention HIV/AIDS. One of these was for the European Commission, the largest recipient of multilateral funding from DFID, receiving £851 million in 2002-03.

11 The lack of HIV/AIDS-related objectives in many of DFID's Institutional Strategy Papers reflects in part the high-level nature of these papers. However, it also hampers monitoring of progress. Of the five key multilateral development institutions, one fell below the threshold to qualify for an Institutional Strategy Paper which would have formed the basis of monitoring; two had strategy papers but DFID had not reviewed annual progress; and for the remaining two, annual reviews of progress against strategic objectives did not deal with HIV/AIDS - because there were no explicit HIV/AIDS objectives. DFID has sought to strengthen its review of multilateral development institutions generally with the establishment in 2003 of a Multilateral Finance Allocation Committee whose role is to assess the effectiveness of multilateral bodies as part of decisions about their funding.

Global partnerships

12 DFID also supports a number of global and regional HIV/AIDS partnerships, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the International Partnership against AIDS in Africa (the International Partnership). They provide the potential to focus extra resources on tackling HIV/AIDS alongside more traditional bilateral and multilateral routes. DFID has committed US$280 million (2002-08) and £25 million (2002-05) to the Global Fund and the International Partnership respectively. DFID has been part of the monitoring and evaluation framework working group which is assessing the Global Fund's impact and through this group DFID has contributed towards the development of a robust evaluation framework for the Fund as a whole. However, progress against DFID's own objectives for the Fund has not been formally assessed. Informal monitoring has led DFID to believe that the Global Fund is now overcoming earlier difficulties it faced in slow disbursement of funds to recipient countries. And DFID has been successful in increasing the Fund's focus on poor countries. An external review of the International Partnership in 2003 concluded that only limited achievement of the purposes of the Partnership was possible and that six out of eight outputs should be dropped. However, DFID believes the International Partnership has an

important and continuing relevance alongside the Global Fund and the World Bank's multi-country HIV/AIDS programme for Africa and therefore decided to maintain its support to the Partnership until the end of the funding agreement in 2005.

Tackling HIV/AIDS at country level

National strategies and DFID country plans

13 DFID, like many other donors, has sought increasingly to design its country programmes to support the recipient's national poverty reduction strategy, including strengthening the role and capacity of any national structures for tackling HIV/AIDS. Poverty Reduction Strategy Papers for those countries key to the achievement of DFID's Public Service Agreement targets on HIV/AIDS varied in the degree to which they recognised the importance of HIV/AIDS for poverty reduction. Over a third did not indicate the level of resources set aside for tackling HIV/AIDS and only a third provided measures or targets with which to assess progress.

14 DFID's own country assistance plans do not address the issue of HIV/AIDS consistently. Our review of assistance plans for DFID's key target countries showed that more recent Country Assistance Plans provided greater HIV/AIDS coverage than the Country Strategy Papers which preceded them. But in many plans, the prioritisation to be given to HIV/AIDS within DFID's wider development programme in a particular country was hard to identify. Several plans failed to consider the effect of the epidemic on poverty reduction. Considered assessments of the national capacity to respond; the impact of cultural, political and social factors in a particular country; and the implications of these factors for designing an effective response were often lacking. Many provided little sense of the level of resources appropriate for HIV/AIDS, or did not set out the intended outcomes.

Country level HIV/AIDS programmes

15 DFID country teams support a variety of interventions in the HIV/AIDS field, ranging from direct support to a recipient government's budget to more project-based support to NGOs. The autonomy afforded to country teams and their willingness to consider a variety of ways to tackle the epidemic have enabled DFID to adopt a more flexible and speedy approach than some other donors, which is appreciated by its partners and in line with DFID's decentralisation of country-specific policy-making to the country offices. For example, in Malawi, where government HIV/AIDS capacity is limited, DFID has continued to fund NGOs to deliver local HIV/AIDS services, whilst at the same time working to help strengthen the public sector through technical assistance and support for key systems and institutions.

16 When examining individual HIV/AIDS interventions within the context of their Country Assistance Plans, we found that country teams often took key decisions at an early stage in the design process, based largely on the judgement, intuition and experience of country staff. Once areas for intervention were identified, they were followed up by more formal technical, social, institutional, economic and risk appraisals. In several cases, interventions which represented a continuation of current activities were submitted for funding approval without options being considered. In framing their programmes country teams recognised the importance of learning lessons from elsewhere but they felt they lacked support in identifying relevant information amongst the large amount of technical data available. They also felt that there was insufficient information on how to manage successful HIV/AIDS interventions.

17 The increased emphasis on supporting partner countries' own development plans through use of budget support, in partnership with other donors, gives an opportunity to embed DFID spending in a more sustainable and effective way, but also presents a challenge for DFID to ensure that such funds are used to support recipient governments' own work in tackling HIV/AIDS. Only a few of the Poverty Reduction Strategies for which budget support is provided detailed the level of resources to be allocated to HIV/AIDS, and set out how progress on HIV/AIDS would be measured.

Commissioning and using research

18 The rapidly changing nature of HIV/AIDS and continuing debates over appropriate responses means that ongoing research is needed to maintain and improve the effectiveness of responses. DFID contributes to the global effort by providing funding to international research on developing an AIDS vaccine (£14 million, 2000-04) and on microbicides to kill the virus at point of transmission (£17 million, 2001-06), both of which could provide significant benefits. DFID led the global donor community in providing support for these initiatives and, in doing so, helped generate additional financial support from other donors.

19 DFID also provides £11 million (1999-2006) to support five Knowledge Programmes designed to generate and share new knowledge on HIV/AIDS. The Programmes have generally been successful in changing the climate of opinion. Some work, for example on the effect on the level of HIV transmission of the treatment of sexually transmitted diseases, has had a significant influence on international thinking.

20 These programmes were intended for take up by developing countries and other institutions as well as DFID's own staff. It is to this last audience that research results could have been better disseminated, in particular to those DFID staff working in-country. No regular communication channels exist and some Programmes have experienced problems in engaging with DFID country teams. A review of the Knowledge Programmes carried out in 2003 concluded that they suffered from 'weak operational relationships' with country-based advisers; and that country offices and DFID centrally had done little in guiding, feeding into or feeding back on the use of the knowledge generated. Consequently, the knowledge produced has had little influence on DFID's country-level HIV/AIDS programmes. DFID has recognised the need to improve the dissemination of research results, and to report more regularly and effectively on the impact of its research programmes.

Overall conclusion and recommendations

21 The long-cycle nature of the HIV/AIDS epidemic, variations in the viruses, differences in the main means of transmission and stages of the epidemic between countries, and uncertainty over which responses will prove effective, all pose difficulties for development agencies and national governments in combating the epidemic. DFID has responded with the production of an *HIV/AIDS Strategy*, a substantial increase in HIV/AIDS expenditure and, recently, a multi-disciplinary policy and advisory team, to help coordinate an effective response. It accepts the need to provide greater guidance to country staff and it plans to launch its HIV/AIDS web portal and a number of policy papers in July 2004 to address this. DFID has also recognised the need to revise its HIV/AIDS strategy, and a new strategy is scheduled for publication in July 2004. This reflects recognition that difficulties remain in adequately embedding HIV/AIDS across DFID's planning systems; in securing the information both to plan and monitor effective interventions; in making best use of HIV/AIDS expertise and knowledge; and in allocating appropriate overall resources to combating HIV/AIDS. Given the severe impact of the epidemic on all development indicators, it merits close attention as a key cross-cutting risk to development performance goals. The following recommendations are designed to build on current DFID initiatives and add a degree of impetus to their effective implementation.

22 To help in setting priorities and allocating resources for HIV/AIDS, DFID should:

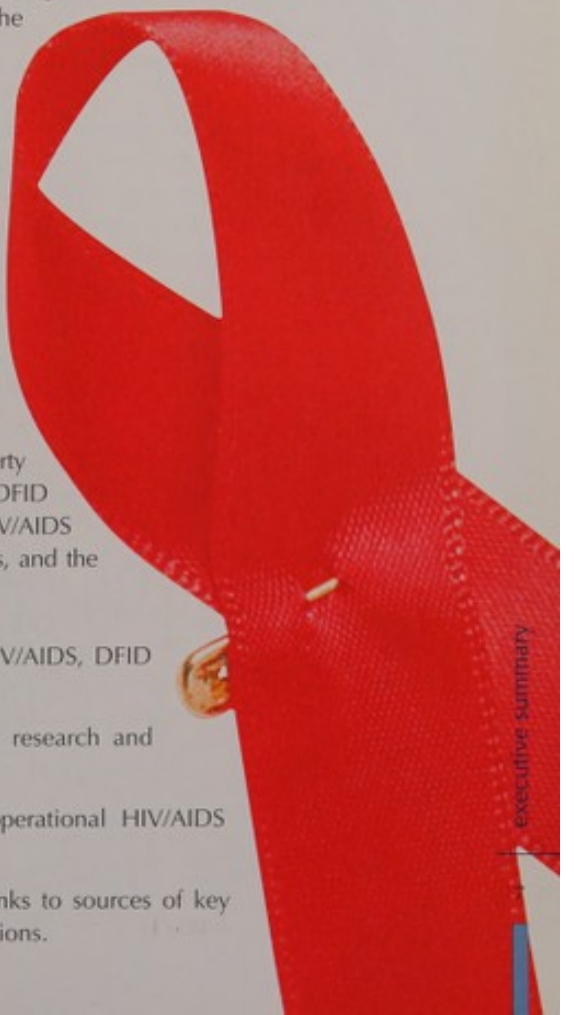
- update, as part of its *Call for Action*, its strategy to provide:
  - a policy statement on responding to HIV/AIDS including the approaches and partners DFID considers crucial to implementation of its strategy; and how it will measure progress;
  - supporting guidance and advice for country teams on key operational issues such as treatment and the use of budget support capable of being updated in the light of research and experience;
- improve its system for providing information on the level and nature of HIV/AIDS activity and expenditure to inform judgements on overall resource allocation and monitoring of progress against strategic objectives;
- measure the effectiveness of its response, drawing on the results of monitoring and evaluation carried out by recipient governments and other donors, and by working with the international community.

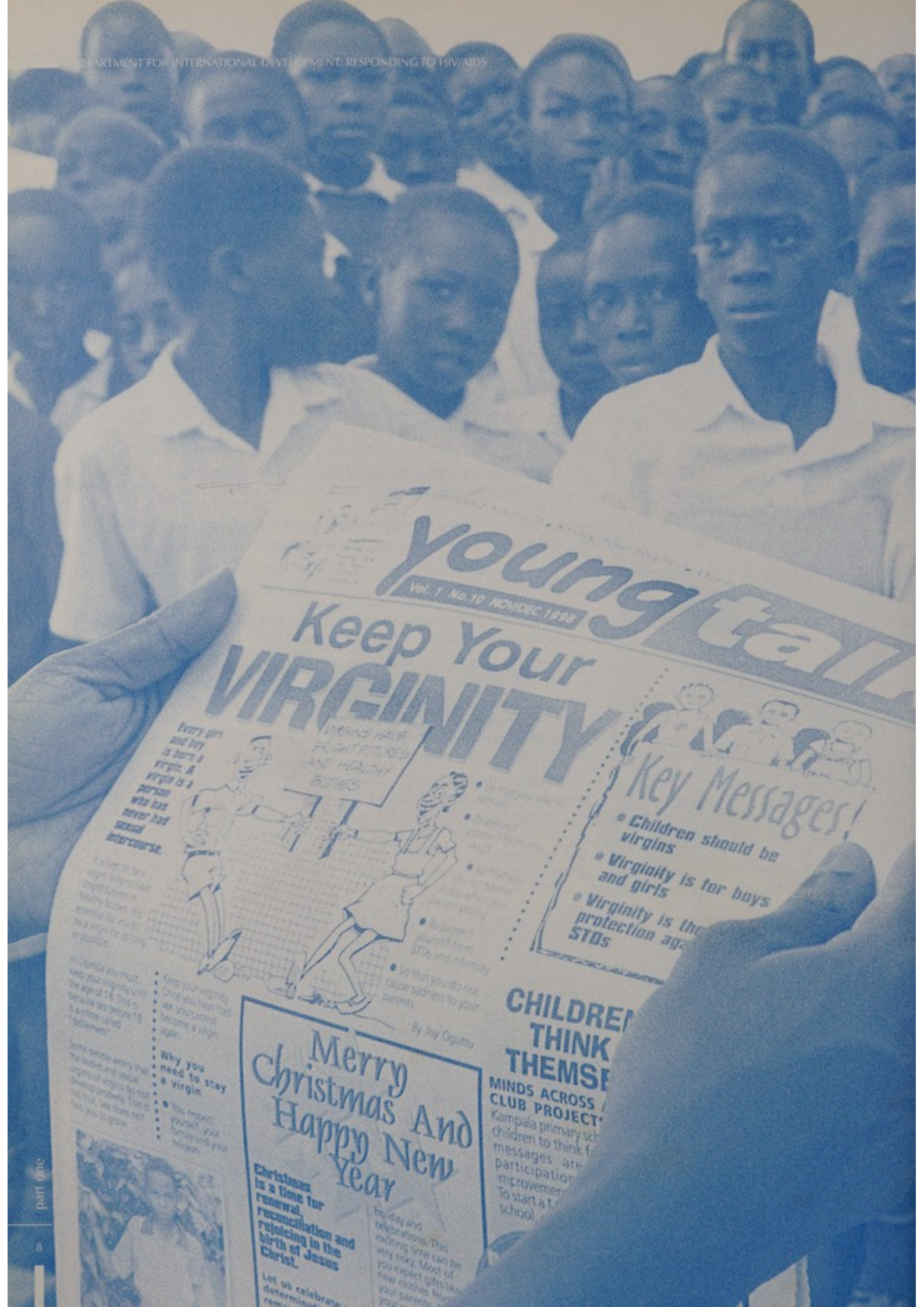
23 To secure maximum effectiveness in tackling HIV/AIDS from its country programmes and multilateral funding, DFID should:

- make sure that its strategies for dealing with those multilateral agencies having an important part to play in combating the epidemic articulate objectives for the institutions' HIV/AIDS policies, activities and results;
- for countries where DFID has HIV/AIDS targets, require country teams to assess, when preparing or updating Country Assistance Plans, the capacity of the country to respond to HIV/AIDS, taking account of factors such as those suggested in Appendix 2;
- where HIV/AIDS is a key risk to general development goals, make sure assistance plans set out DFID's strategy for responding, across all relevant sectors, and associated objectives. And ensure that planned interventions not only fit with the country HIV/AIDS assessment and the strategy, but are sufficient, in combination with partners' efforts, to achieve objectives; and
- make sure that, where general budget support based on a nation's Poverty Reduction Strategy is an important element of DFID's HIV/AIDS response, DFID supports the recipient government to reflect the importance of addressing HIV/AIDS in its strategy, including an explicit focus on resourcing and main activities, and the associated monitoring necessary to provide visibility of progress.

24 To ensure that its programmes adequately reflect current knowledge on HIV/AIDS, DFID should:

- ensure that mechanisms are in place to identify and disseminate key research and knowledge in the field to country teams;
- ensure that Knowledge Programmes take account of the needs of operational HIV/AIDS programmes; and
- make better use of DFID's intranet to summarise emerging research, links to sources of key information and lessons learnt on the management of HIV/AIDS interventions.




Youngtalk
Vol. 1 No. 10 NOV/DEC 1998
Keep Your VIRGINITY
Every girl and boy is born a virgin. A virgin is a person who has never had sexual intercourse.
Key Messages!
• Children should be virgins
• Virginity is for boys and girls
By Joy Oguttu
Merry Christmas And Happy New Year
Christmas is a time for renewal, reconciliation and rejoicing in the birth of Jesus Christ.

Part 1

The challenge of HIV/AIDS

The nature of HIV/AIDS

1.1 Human Immunodeficiency Viruses, or HIV, attack a person's immune system making it less capable of fighting infections. Opportunistic infections increase in frequency, severity and duration until the person dies. It is this presence of many of these infections that is referred to as AIDS (Acquired Immunodeficiency Syndrome). The character of HIV is such that the length of time over which the epidemic develops within a country is certainly around 30 to 40 years and may be as long as 120 years. The epidemic probably began in Africa in the mid to late 1970s. Yet it took the 20 years from 1980 to 2000 for infection rates to rise above 30 per cent in some countries. Thus, even in Africa, a fully-fledged epidemic is only now taking hold.

1.2 AIDS has two important characteristics that make intervening in its transmission difficult. Firstly, in order to be infected, a person has do something (or have something done to them) which exposes them to the virus so that it can pass into the blood stream. HIV is most commonly transmitted through sexual intercourse and drug use. It is hard to intervene in its transmission as this requires intervening in people's private behaviours. Secondly, an HIV-positive person may not look ill but may be highly infectious. They can unknowingly infect other people during this time and others cannot know that they are at risk. Hence, in many cases, transmission occurs in circumstances beyond an individual's control.

The impact of HIV/AIDS on poverty reduction

1.3 In the developed world, an HIV-infected person may live for 10 years before they begin to fall ill. Without treatment, the period from the onset of AIDS to death is thought to be a further 12 to 24 months. But with time from infection to illness and from illness to death appearing to be dependent on local health conditions,[9] research has indicated that timescales are shortened in poor countries.[10]

1.4 At least 65 million people have been infected with HIV over the last two decades and about 20 million people have died of AIDS. In 2003, 40 million people were living with HIV/AIDS and 3 million died in that year alone. By 2010, about 14 million children worldwide will have been orphaned by the epidemic.[11] Sub-Saharan Africa has been the hardest hit **(Figure 1)**.

1.5 The Millennium Development Goals adopted by member countries of the United Nations in 2000 have the overall aim of halving by 2015 the proportion of the world's population living in extreme poverty. Failure to achieve one of these Goals - to halt and begin to reverse the spread of HIV/AIDS by 2015 - will undermine achievement of all other Goals. For example, in Burkina Faso, Rwanda and Uganda, the proportion of people living in absolute poverty will increase from 45 per cent today to 51 per cent in 2015 as a result of HIV/AIDS, instead of falling by half as per the internationally agreed target. And school enrolment in the Central African Republic and Swaziland has already fallen by 20-36 per cent due to AIDS orphans dropping out of school, threatening the Goal of achieving universal primary education by 2015.[12] By 2000 life expectancy had declined by 20-30 years in the hardest hit countries and increased mortality rates threaten the child and maternal international targets.

9 *French, N., A. Mujugira, D. Nakiyingi, E.N. Mulder, J. C. F. Gilks (1999) Immunologic and clinical stages in HIV-1 infected Ugandan adults are comparable and provide no evidence of rapid progression but poor survival with advanced disease, Journal of Acquired Immune Deficiency Syndrome, 22(5).*

10 *Whitworth et al., unpublished Paper presented at the conference HIV/AIDS and Demography, Durban, March 2003.*

11 *UNAIDS (2002), Report on the global HIV/AIDS epidemic, July 2002; UNAIDS, AIDS Epidemic Update 2003; DFID (2003), UK's Call for Action on HIV/AIDS, December 2003.*

12 *United Nations Development Programme (undated), Results: HIV/AIDS.*

1 The global distribution of adults and children living with HIV/AIDS, 2003

Region	Adults and children living with HIV/AIDS	Adult Prevalence %[1]	Adult and child deaths due to AIDS
Sub-Saharan Africa	25 - 28.2 million	7.5 - 8.5	2.2 - 2.4 million
North Africa & Middle East	470,000 - 730,000	0.2 - 0.4	35,000 - 50,000
South & South-East Asia	4.6 - 8.2 million	0.4 - 0.8	330,000 - 590,000
East Asia & Pacific	700,000 - 1.3 million	0.1 - 0.1	32,000 - 58,000
Latin America	1.3 - 1.9 million	0.5 - 0.7	49,000 - 70,000
Caribbean	350,000 - 590,000	1.9 - 3.1	30,000 - 50,000
Eastern Europe and Central Asia	1.2 - 1.8 million	0.5 - 0.9	23,000 - 37,000
Western Europe	520,000 - 680,000	0.3 - 0.3	2,600 - 3,400
North America	790,000 - 1.2 million	0.5 - 0.7	12,000 - 18,000
Australia and New Zealand	12,000 - 18,000	0.1 - 0.1	<100
Total	**40 million**	**1.1**	**3 million**
	(34-46 million)	(0.9-1.3)	(2.5 - 3.5 million)

NOTE

1 The proportion of adults (15-49 years old) living with HIV/AIDS in 2003, using 2003 population numbers. The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information. These ranges are more precise than those of previous years, and work is underway to increase even further the precision of the estimates that will be published in mid-2004.

Source: UNAIDS Epidemic Update 2003

1.6 HIV/AIDS is causing past development achievements to be reversed. As noted by the United Nations Development Programme, the *'impact of HIV/AIDS is unique because it kills adults in the prime of their lives, thus depriving families, communities, and entire nations of their most productive people. Adding to an already heavy disease burden in poor countries, the HIV/AIDS epidemic is deepening poverty, reversing human development achievements, aggravating gender inequalities, eroding the capacity of governments to provide essential services, reducing labour productivity and supply, and putting a brake on economic growth'*.[13] Appendix 3 illustrates how HIV/AIDS can affect all sectors of society.

The global response

1.7 In June 2001, the United Nations General Assembly Special Session issued a Declaration of Commitment on HIV/AIDS, providing a roadmap for a comprehensive, multifaceted response to the epidemic. The Declaration focuses on four core aspects relating to prevention and social mobilisation; access to treatment and supporting people living with HIV/AIDS; reducing vulnerability; and managing and mitigating the impact of the epidemic.

1.8 The United Nations Declaration of Commitment highlighted the fact that the epidemic could no longer just be a health concern. With this has come the challenge for donors and developing countries to fashion a multisectoral response. Whilst there has been widespread agreement about the need for this, there has been less consensus about how this should be implemented in practice. Many developing countries have established national coordinating bodies, often with the support of donors, to oversee the response to HIV/AIDS. And recognition that vulnerability to HIV/AIDS is closely linked to deep-rooted development problems such as poverty; political marginalisation; lack of access to justice and health services; and gender inequality has highlighted the continued importance of grass-roots approaches, often driven by national and local NGOs **(see Figure 2)**. Notwithstanding the current debates, some countries, such as Brazil, have been successful in reversing the epidemic through a multisectoral approach (see Appendix 4).

13 *United Nations Development Programme (undated), Results: HIV/AIDS.*

2 An example of a grass-roots approach - The AIDS Support Organisation, Uganda

The AIDS Support Organisation was founded in Uganda in 1987 by 16 volunteers, 12 of whom were living with AIDS. Its activities include running care and support centres; advocating for the rights of people living with HIV/AIDS; promoting positive attitudes towards people living with HIV/AIDS; promoting safe sexual behaviour; counselling; providing medical treatment; and facilitating nursing care at home. The organisation now has 360 staff and has supported over 86,000 people who have HIV/AIDS. The clinic visited by the National Audit Office saw about 500 clients a week, 95 per cent of whom were living in extreme poverty. Some individuals travelled up to 100 kilometres in order to attend.

Music and dance are used to educate local people about HIV/AIDS, how to live better and longer, and how to reduce the risks of infection. The performers are strong and charismatic which reduces stigma and discrimination against HIV infected people. In 2002, 663 presentations were made to a total audience of approximately 127,000.

Individual 'testimonies' by people who are HIV-positive are also used to encourage others to face up to the reality of HIV/AIDS both for themselves and for friends and relatives. In one such account a woman told of her decision to go for testing and counselling; her reaction to finding out that she was HIV-positive; how she overcame her fears; and her hope for the future, living with and planning for her three children.

The AIDS Support Organisation also provides care, including drugs to treat opportunistic infections which can be fatal for an HIV-positive person.

Source: National Audit Office visit to The AIDS Support Organisation, Jinja, Uganda, October 2003

The United Kingdom response

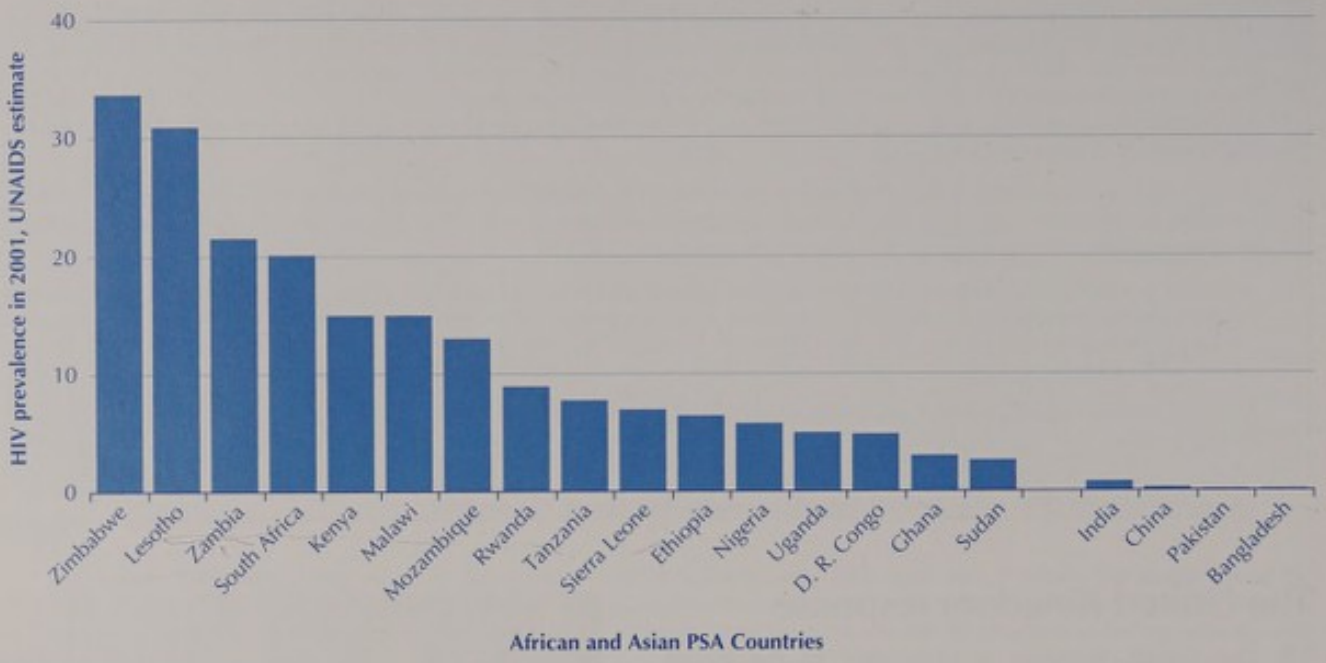
1.9 The United Kingdom is committed to the global response to HIV/AIDS. White Papers produced in 1997[14] and 2000[15] highlighted the importance, amongst other things, of tackling HIV/AIDS in the interests of eliminating world poverty. The United Kingdom also supports the United Nations Declaration of Commitment on HIV/AIDS and in 2003 issued its own *Call for Action on HIV/AIDS*[16] signalling the Government's intention to intensify its efforts to tackle the epidemic (further details are set out in Appendix 1).

1.10 The United Kingdom response is led by the Department for International Development (DFID). It works directly through its own country programmes and indirectly through the support it gives to a range of multilateral development institutions and other global partnerships. DFID's bilateral programmes are concentrated in Africa and Asia, where the greatest numbers of people living with HIV/AIDS are found. This focus is reflected in its Public Service Agreement for 2003-06, which targets a reduction from 16 per cent in the proportion of 15-24 year old pregnant women with HIV in 16 key countries in Africa; and achieving HIV prevalence rates below 5 per cent in 4 key countries in Asia. HIV prevalence rates vary widely across these 20 countries **(Figure 3)**.

Members of a dance group from The AIDS Support Organisation, Uganda.

14 *White Paper on International Development (1997), Eliminating World Poverty: A Challenge for the 21st Century, Cm 3789. London, The Stationery Office.*
15 *White Paper on International Development (2000), Eliminating World Poverty: Making Globalisation Work for the Poor, Cm 5006, London, The Stationery Office.*
16 *DFID (2003), UK's Call for Action on HIV/AIDS, December 2003.*

3 HIV prevalence rates in African and Asian countries in 2001



NOTE

Prevalence rates in Pakistan and Bangladesh are estimated as being less than 0.1 per cent.

Source: United Nations Millennium Development Indicators, 2003

1.11 In 2001, DFID set out its strategy on HIV/AIDS.[17] Following that, in 2003, DFID established a multi-disciplinary policy team on HIV/AIDS in recognition of the need to enhance DFID's corporate effort through promoting a more coherent approach to responding to the epidemic across all DFID's activities. In July 2004, DFID intends to publish a new HIV/AIDS strategy.

The focus of our report

1.12 Responding to HIV/AIDS is a key part of DFID's business. Specifically, this report examines:

- whether DFID's HIV/AIDS 2001 strategy adequately guided its response;
- how DFID works through multilateral development institutions and global partnerships to achieve its objectives on HIV/AIDS;
- the manner in which country programmes seek to tackle the epidemic; and
- the use DFID makes of research and knowledge generation on HIV/AIDS.

As part of our review we visited Malawi and Uganda to understand how DFID develops country-specific HIV/AIDS programmes; and to Brazil where DFID does not work specifically in the HIV/AIDS field but is one of the few countries which has experienced success in reversing the rate of infection. Consultants commissioned by the National Audit Office also examined HIV/AIDS programmes run by DFID in Bangladesh, Nigeria and Tanzania. Further details of our methodology are set out in Appendix 5.

17 *DFID (2001), HIV/AIDS Strategy, May 2001.*

Part 2

DFID's strategic response

2.1 DFID set out its strategic response to HIV/AIDS in May 2001 with the publication of its *HIV/AIDS Strategy*. Its purpose was to provide '... a strategic framework for DFID staff on how to approach tackling the HIV/AIDS pandemic'. It also sought to outline '... to a broader readership DFID's priorities and the partnerships [DFID] will be pursuing'.

The scope of the *Strategy*

2.2 The *HIV/AIDS Strategy* is framed around a number of principles and responses **(Figure 4)**. In considering how to tackle HIV/AIDS and the range of interventions considered to be appropriate under different circumstances, it largely reflects international thinking of the time.

4 DFID's *HIV/AIDS Strategy:* principles and responses

Principles	Responses
■ Involve and support people living with HIV/AIDS	■ Build political leadership
■ Ensure country ownership and leadership of programmes	■ Build national capacity
■ Ensure that the needs of the poorest are met	■ Tackle the underlying causes of vulnerability
■ Address gender inequalities	■ Maximise the contribution of all sectors
■ Support national expertise and institutions in implementing programmes	■ Support HIV/AIDS prevention and care programmes
	■ Support the development of knowledge generation

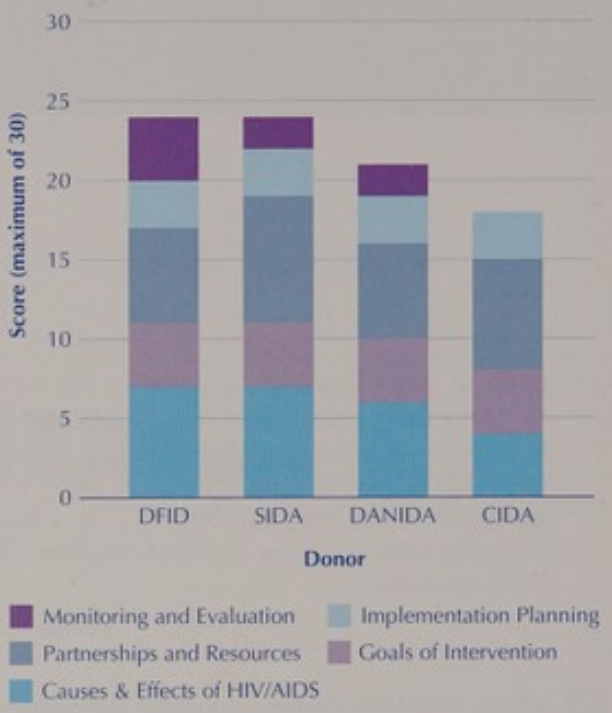
Source: DFID's HIV/AIDS Strategy

2.3 The structure of the *Strategy* is logical, with themes ranging from what the problem is, what has worked in the past, and what needs to be done. It compares favourably with HIV/AIDS strategies developed by other like-minded donors, particularly in articulating the causes and effects of the epidemic; recognising the importance of international objectives and targets; and the value of working in partnership with others **(Figure 5)**.

The use made of the *Strategy* by DFID staff

2.4 The *HIV/AIDS Strategy* provides those outside DFID with a good overview of DFID's understanding of what works in tackling the epidemic; and what needs to be done at international and country level - although it does not set out what DFID thinks are its comparative strengths. The *Strategy* was designed to inform the advisors working in-country of the range of responses that they should consider, depending on the situation in which they worked. DFID country staff we interviewed were aware of the *Strategy*, and welcomed its endorsement of a multisectoral approach, integrated with general development activity. In identifying important elements in tackling HIV/AIDS **(Figure 6)**, the *Strategy* includes most possible responses to the epidemic, a characteristic highlighted by research in 2000 as being common to government AIDS programmes.[18]

5 A comparison of DFID's *HIV/AIDS Strategy* and those of a number of like-minded donors



Source: National Audit Office content analysis of HIV/AIDS strategies

6 DFID's *HIV/AIDS Strategy*: important elements in tackling the epidemic

- Political commitment and leadership at all levels
- Sustained effort over a long period of time
- Effective global and national surveillance
- National resource mobilisation
- National capacity building across all sectors
- Policies and programmes capable of tackling the epidemic at local level
- Early action in low prevalence countries
- Mobilisation of civil society, private sector and faith-based organisations
- Willingness to deal with stigma and discrimination

Source: DFID's HIV/AIDS Strategy

18 *Ainsworth and Teokul (2000), Breaking the Silence, The Lancet, Volume 356 Issue 9223, page 55.*

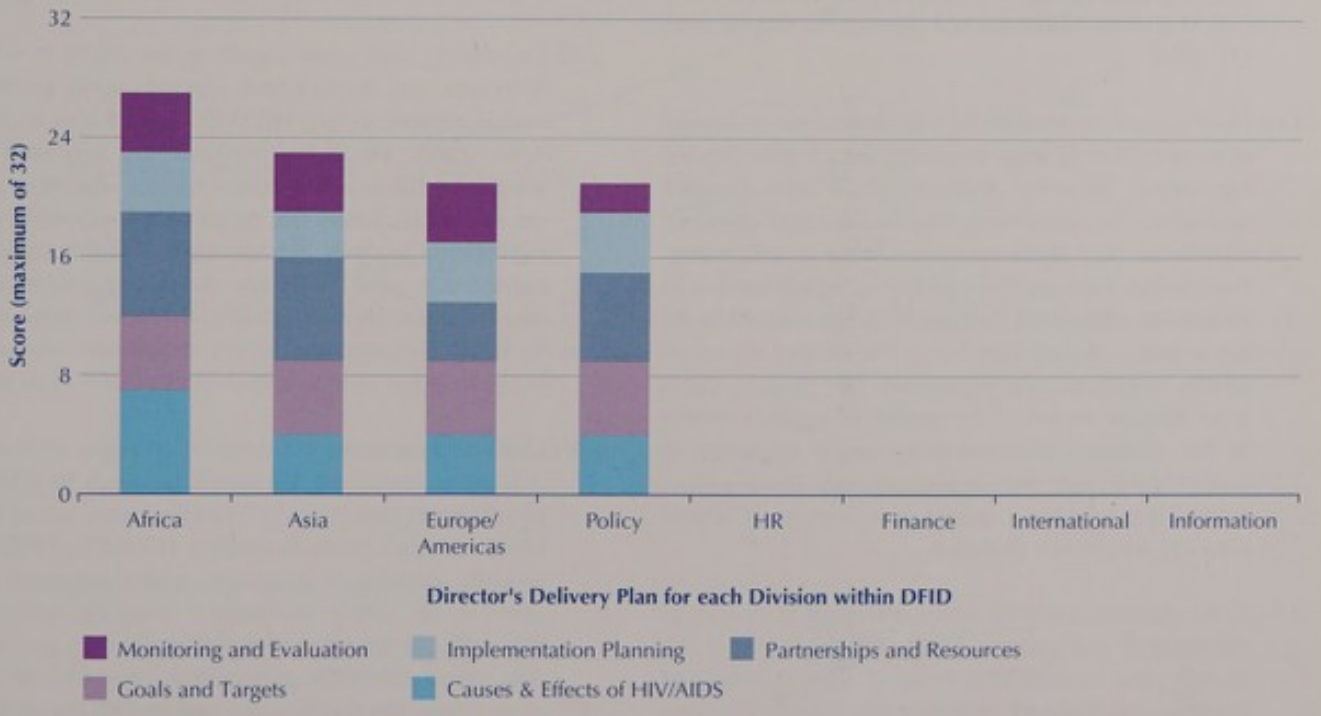
2.5 Consequently DFID country teams considered that any approach they took was likely to fit within the *Strategy* whereas, in practice, suitable approaches in an individual country would need to take account of the stage and nature of the epidemic; national capability and capacity; and the cultural, behavioural and political context. The *Strategy* illustrated the sorts of interventions which might feature in different phases of the epidemic's development in a country. But in general it did not help country teams to identify the circumstances when particular responses would be appropriate. For example, although the *Strategy* recognises the importance of partnership in pursuing DFID's HIV/AIDS objectives and highlights key multilateral organisations involved in the field, it does not identify the circumstances in which support for multilaterals would be the best route for a country team tackling HIV/AIDS. And it does not indicate any DFID policy on issues such as the balance between prevention and treatment. Staff had to form a view on general issues such as these in planning their country responses.

2.6 DFID considers that the *Strategy* is operationalised through other planning documents, such as Director Delivery Plans, Country Strategy Papers, Country Assistance Plans, and regional strategies which sit below its high level strategic framework. The extent to which country plans recognise the significance of HIV/AIDS is considered in Part 4. Director Delivery Plans, which aim to set out how the various divisions in DFID contribute to delivering its Public Service Agreement targets, vary in the extent to which they translate DFID's *Strategy* on HIV/AIDS into operational plans, with only that for Africa making extensive reference to the epidemic (**Figure 7**). The Plan for International Division, with responsibility for overseeing relations with multilateral development institutions, makes no reference despite the importance which DFID ascribes to working with such institutions in tackling HIV/AIDS.

Obtaining technical guidance in support of the *Strategy*

2.7 Some DFID country team advisers told the National Audit Office that there was a growing need for technical guidance on a number of key issues they were faced with as they sought to maintain and develop HIV/AIDS programmes (Appendix 6). When the *HIV/AIDS Strategy* was published, DFID's intention was to follow it up with an initial series of technical guidance notes on issues such as preventing mother to child transmission of HIV; the provision of anti-retroviral treatment; education and HIV; tackling gender inequalities; HIV and sustainable livelihoods; communications and HIV; and success stories.

7 The extent to which DFID's Director Delivery Plans for 2003-06 take account of HIV/AIDS



Source: National Audit Office content analysis of DFID Director Delivery Plans, 2003-06

2.8 To date, only notes on mother to child transmission and education have been produced. In July 2004, DFID intends to publish three other guidance notes: an HIV Treatment and Care Policy, a Sexual and Reproductive Health Position paper and an Access to Medicines Strategy. It also intends to launch its HIV/AIDS web portal in July 2004. A guideline for country programmes on the role of Communications in preventing HIV/AIDS and supporting treatment is planned for publication in October 2004. Country teams felt there was a pressing need for central guidance on issues such as the approach they should take to supporting anti-retroviral treatment, or on how to use budget support to tackle HIV/AIDS, or on supporting impact mitigation. Country offices also felt that guidance was needed on integrating their work with new partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; and a clearer steer on debates such as promoting abstention over and above condom usage. In the absence of a DFID position on these issues and until the planned guidance notes are published, staff have recourse to advice from a wide range of other sources, including the extensive UNAIDS 'Best Practice' series of publications.

Monitoring and evaluating implementation of the *Strategy*

2.9 The overall impact of DFID's *HIV/AIDS Strategy* will be measured against progress in achieving its HIV/AIDS-related Public Service Agreement targets. However, assessing progress against these relies on data from the United Nations which are not planned for release until July 2004.

2.10 DFID has not monitored the implementation or impact of its *HIV/AIDS Strategy* separately from Public Service Agreement, Director Delivery Plan and Country Assistance Plan monitoring. The *Strategy* itself does not identify any key performance measures or milestones. The Director Delivery Plans provide a limited number of milestones - the Africa Delivery Plan has milestones for key events in 5 countries out of the 16 that feature in DFID's Public Service Agreement HIV targets. There is no discrete review of the quality of implementation of the *Strategy* - the extent to which assistance is multisectoral and well-integrated into development activity, for example - except that implicit in overall planning and review processes.

2.11 DFID allocates resources across the range of its work at the regional and country levels and concludes in the *Strategy* that '...as [DFID] move to a more integrated response, tracking and attributing HIV-specific spending will become increasingly difficult and meaningless'[19]. This issue is being reviewed as part of the new strategy, in order to avoid a mismatch developing between spending at regional and country level and that appropriate to achieving DFID's strategy on HIV/AIDS as a whole.

2.12 There is a variety of definitions which can be used to determine HIV/AIDS-related bilateral expenditure. For example, expenditure to treat other sexually transmitted diseases has been shown also to reduce HIV transmission and, for this reason, DFID has previously estimated HIV/AIDS bilateral expenditure using a broad definition of expenditure that included sexual and reproductive health programmes. The most recent estimate using this definition is £274 million in 2002-03. This figure excludes multilateral contributions. If direct budget support and projects that focus principally on sexual and reproductive health are also excluded, the estimate for HIV/AIDS-related bilateral expenditure is £169 million for 2002-03. In line with DFID's broad-based and multisectoral HIV/AIDS response, many projects included in this £169 million address HIV/AIDS in combination with other development objectives. An even narrower approach, which sought to exclude all project expenditure except that focused directly on HIV/AIDS, yielded an estimate of £103 million for 2002-03. However, irrespective of the basis of estimation, expenditure over the last six years clearly rises from a relatively low base in the late 1990s **(Figure 8)**. DFID is aware of the difficulties it faces in arriving at a clear picture of the bilateral support it provides for HIV/AIDS and is considering ways to improve its data collection in this area.

2.13 Uncertainty also exists regarding the extent to which recipients use broad-based support, such as direct budget support, to fund HIV/AIDS-related activity. Since April 2004, DFID has defined an approach for identifying the extent to which budget support is used on HIV/AIDS, based on recipient governments' own expenditure analyses. Implementation of this approach cannot start until DFID has developed guidance for country teams on the method of estimation to be used. So DFID currently has no estimate of the amount of budget support used to further its HIV/AIDS objectives.

2.14 DFID also faces the difficulty, in common with other donors, of identifying the extent to which multilateral development institutions in receipt of contributions from DFID, use such funds in tackling HIV/AIDS. DFID has recently developed a system which estimates the element of DFID multilateral funding spent on HIV/AIDS on the basis of multilaterals' own published data about HIV/AIDS expenditure compared to total expenditure. The resulting estimate for DFID funds spent on HIV/AIDS via multilaterals in 2002-03 is £57 million.

19 *DFID (2001), HIV/AIDS Strategy, May 2001, paragraph 7.1.3.*

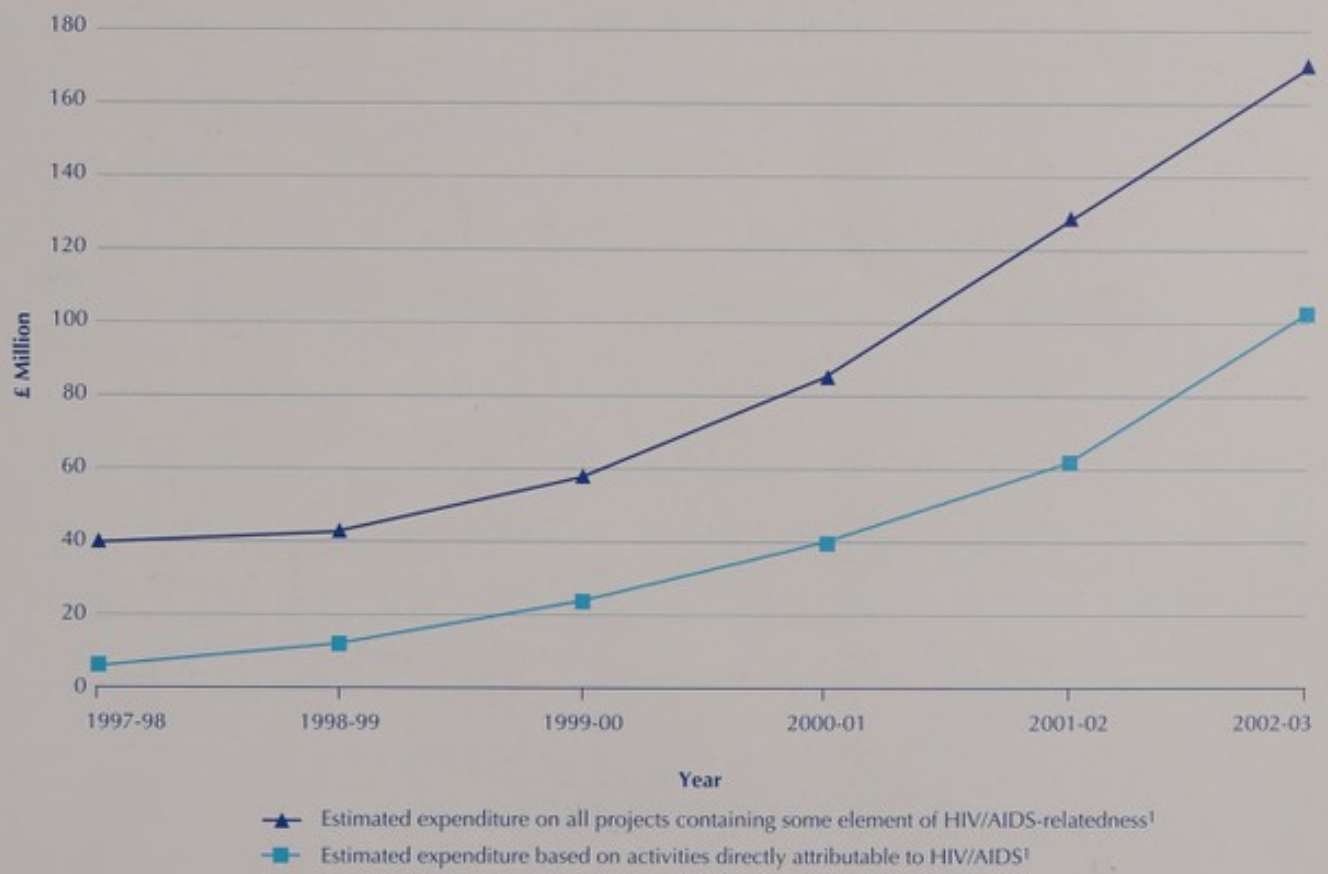
2.15 The HIV/AIDS Policy Team has responsibility for DFID's HIV/AIDS strategy, integrating HIV/AIDS in work across the Department and reviewing the effectiveness of DFID responses. While the Team has objectives and indicators, they are largely descriptive and there are no data systems in place to monitor progress. The extent to which the HIV/AIDS strategy has been adopted across DFID has not been monitored.

2.16 DFID has yet to carry out its first formal evaluation of the impact of its HIV/AIDS programme of work. An evaluation was planned in 2003 but was deferred in the light of this National Audit Office review and the need to allow the new central HIV/AIDS Policy Team to establish its role. Although DFID has carried out reviews at a project and programme level, it has not carried out a sector wide evaluation. However its approach to the epidemic has developed, for example through the establishment of the HIV/AIDS Policy Team.

Improving the strategy

2.17 DFID recognises that its HIV/AIDS strategy needs to be kept up to date. Apart from establishing its HIV/AIDS Policy Team, DFID announced in the *UK's Call for Action on HIV/AIDS* paper in December 2003 that the United Kingdom will formulate a new HIV/AIDS strategy in 2004. This will set out the United Kingdom's planned response to tackle the epidemic internationally and the resources that will be made available. The *Call for Action* also announced that new policy guidance will be issued on HIV treatment and care.

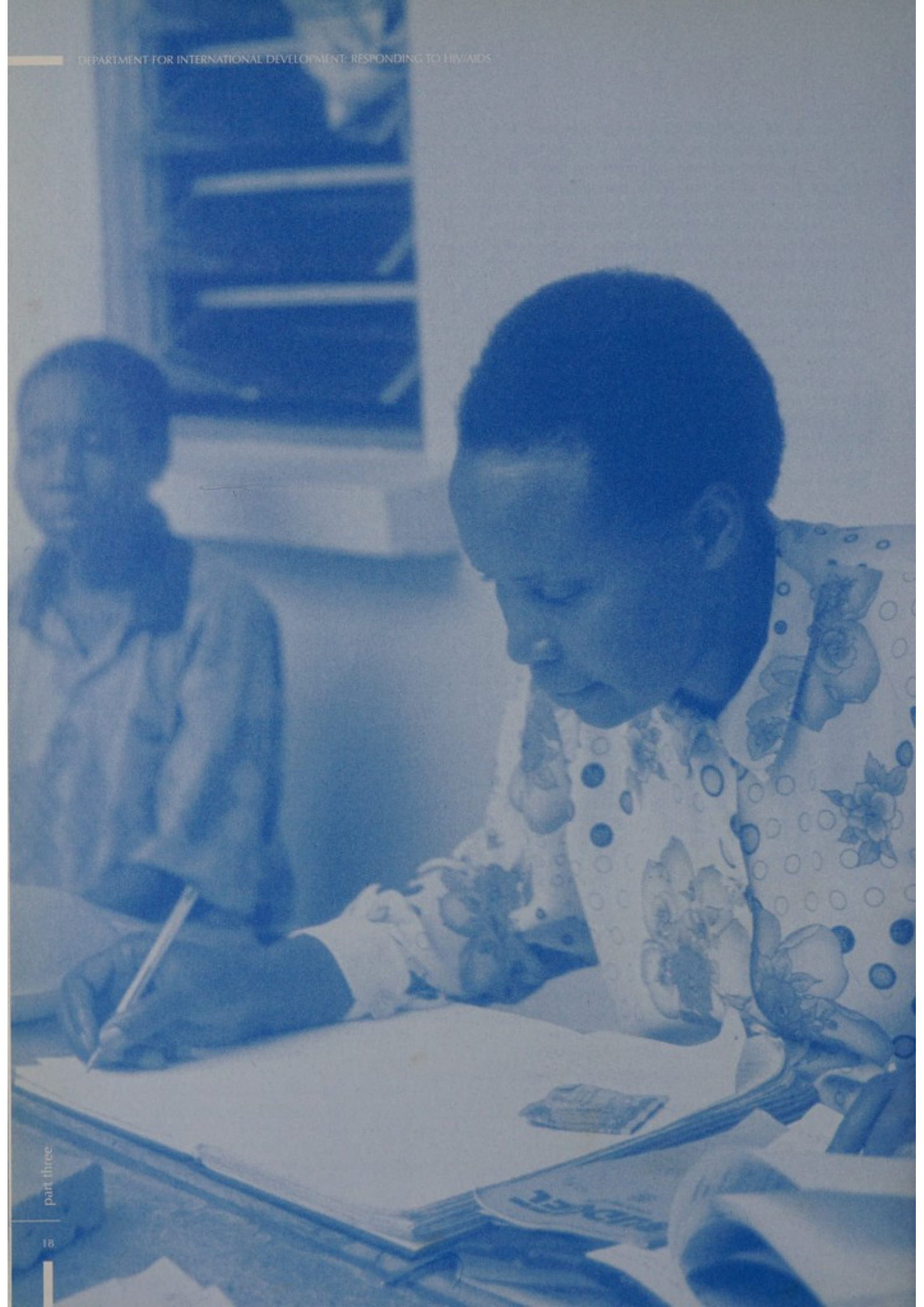
8 The impact of different bases of estimation on HIV/AIDS-related expenditure by DFID, 1997-98 to 2002-03



NOTE

1 Excludes sexual and reproductive health projects and direct budget support.

Source: National Audit Office of DFID data



Part 3

Working through multilateral partnerships

3.1 There are a number of long-established multilateral development institutions, including those of the United Nations, which either focus primarily on HIV/AIDS, or support HIV/AIDS as part of their wider remit. More recently, international partnerships have emerged which focus either on specific diseases, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, or particular parts of the world, such as the International Partnership Against AIDS in Africa. Multilateral bodies provide aid-giving mechanisms which are independent of the aims of any one government and can operate in countries where, for political reasons, DFID is unable to work. They may also offer the opportunity to share fixed costs among the partners, and reduce the burden on developing countries by limiting the number of organisations with which they have to deal.

The range of DFID support to multilateral development institutions

3.2 DFID supports a wide range of multilateral development institutions with the purpose of achieving its HIV/AIDS objectives. DFID considers five of these to be particularly significant given their level of activity in the HIV/AIDS field: the Joint United Nations Programme on HIV/AIDS - UNAIDS; the European Commission; the World Health Organisation; the World Bank; and the United Nations Development Programme. DFID also supports other such organisations including the United Nations Children's Fund, the United Nations Population Fund, the Food and Agriculture Organisation and the World Food Programme which also have a role in responding to the epidemic.

3.3 DFID provides significant sums to multilateral development institutions. Just under half of DFID's annual expenditure is channelled through multilaterals. In 2002-03, £1.4 billion, or 43 per cent of DFID's total expenditure, was spent in this way.[20] Most support is advanced as core funding to support the institution and its main activities, and is not earmarked for a particular purpose. DFID also makes some contributions earmarked to support institutional strengthening, capacity building or specific service delivery. We have not found any such funds earmarked for HIV/AIDS purposes, except £3 million provided to the World Health Organisation to support its '3 by 5' initiative.[21] In addition, DFID country and regional teams sometimes provide bilateral support directly to individual multilaterals working in-country. For example, in 2002 DFID provided US$735,000 to the World Bank for an HIV/AIDS prevention project in Bangladesh.

3.4 More than half of multilateral funding goes to the European Commission (in 2002-03 this was £851 million or 60 per cent of total multilateral funding). However, funding of HIV/AIDS programmes by the European Commission is small in proportion to its total funding of development assistance: it has been estimated that in 2001 under 2 per cent of the European Commission development assistance budget was directed towards HIV/AIDS[22] - in 2003 this equated to expenditure of around £93 million, of which the United Kingdom's share was some £18 million

20 *DFID (2003), Statistics on International Development 1998/99 - 2002/03.*
21 *The '3 by 5' initiative is a global initiative run by the World Health Organisation and UNAIDS to provide anti-retroviral therapy to 3 million people with HIV/AIDS in developing countries by the end of 2005.*
22 *Harinder, J (2003), UK AIDS AID: An analysis of DFID HIV/AIDS expenditure, ActionAid.*

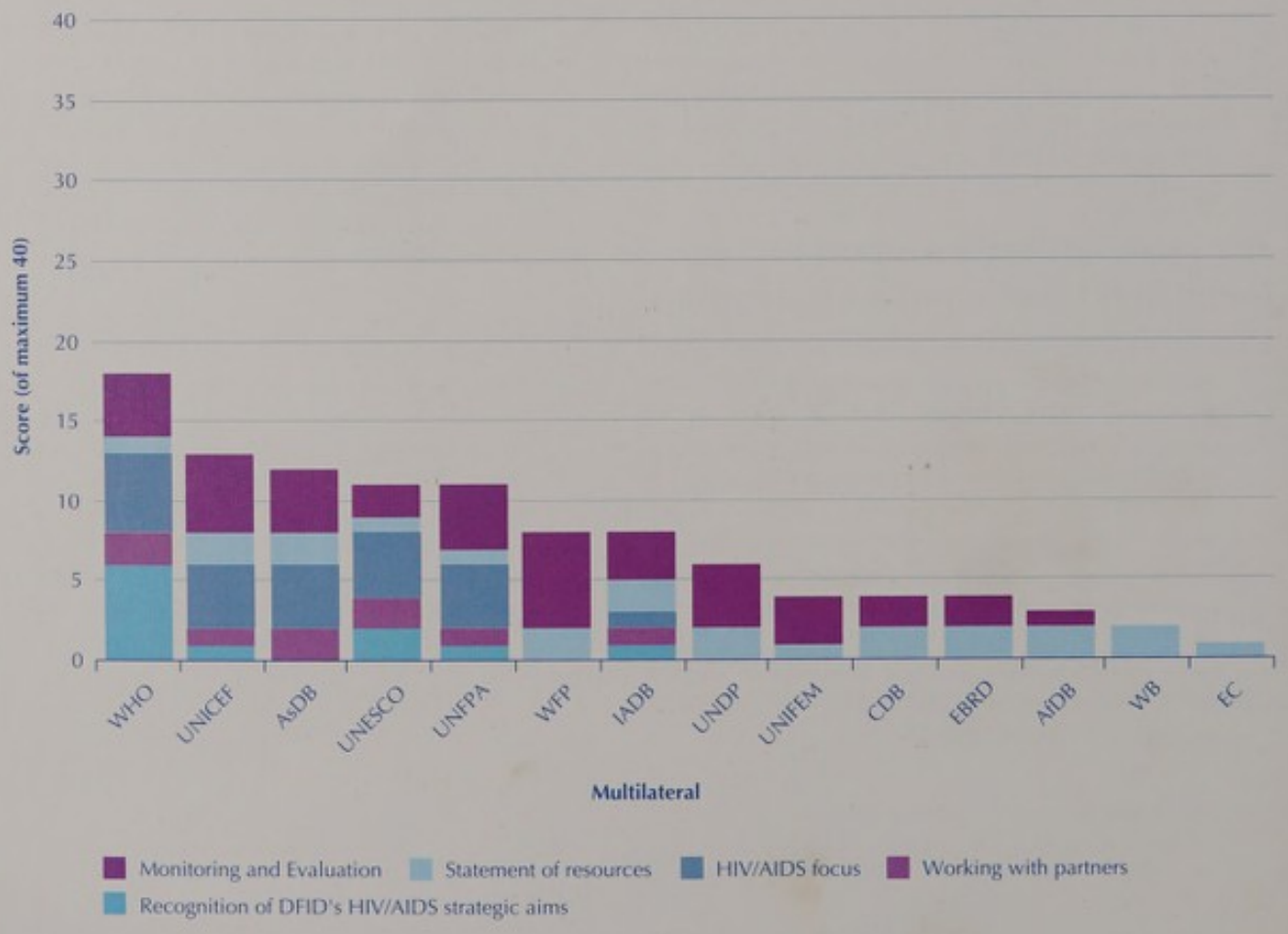
Influencing and monitoring multilateral development institutions

3.5 DFID seeks to influence the policies and plans of multilateral institutions and has developed Institutional Strategy Papers setting out how it aims to achieve its objectives in partnership with these organisations. These strategies cover DFID's overall relationship with the institution, and are therefore not designed to focus exclusively on HIV/AIDS. But the impact of the epidemic on the achievement of the Millennium Development Goals is such that HIV/AIDS is an important factor to consider in any strategy relating to multilateral development institutions.

3.6 Currently only 6 out of 14 Institutional Strategy Papers for multilateral development institutions refer to HIV/AIDS (**Figure 9**), which in part reflects the high-level nature of these papers. Of the five organisations with a significant role in the HIV/AIDS field, the strategy for the World Health Organisation was the only one to refer to DFID's HIV/AIDS objectives. Those for the European Commission, the World Bank and the United Nations Development Programme made no mention of HIV/AIDS. DFID is developing an Institutional Strategy Paper for UNAIDS. The level of funding for UNAIDS, (£3 million in 2002-03) has, in the past, been below that for which DFID requires such a strategy. DFID's view has been that as UNAIDS coordinates the work of other United Nations organisations, for which Institutional Strategy Papers do exist, it does not itself require one.

3.7 DFID seeks to influence and guide the work of multilaterals with respect to HIV/AIDS even in the absence of an institutional strategy or if the strategy does not refer explicitly to HIV/AIDS. In the case of UNAIDS, for example, it exerted influence through being represented on its governing body and supporting evaluations of its performance.

9 An analysis of HIV-related content in Institutional Strategy Papers



Source: National Audit Office content analysis of 14 Institutional Strategy Papers

3.8 Due to the lack of HIV/AIDS-related objectives in many of DFID's Institutional Strategy Papers, DFID has not formally assessed progress in this area. Of the five key multilateral development institutions, no annual reviews had been carried out for three. Where reviews had been done, on the European Commission and the United Nations Development Programme, the Institutional Strategy lacks any HIV/AIDS-related objectives against which to measure progress.

3.9 The justification for the level of funding to the main multilateral development institutions, in support of DFID's HIV/AIDS objectives, was not always well documented. Decisions were not based on an analysis of other options to help determine whether supporting such an organisation was the most appropriate way to achieve the intended purpose. In 2003, DFID established a Multilateral Finance Allocation Committee in order to strengthen its review of the effectiveness of multilateral development institutions and its allocation of resources.

Global HIV/AIDS partnerships

3.10 DFID funds two main global partnerships, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the International Partnership Against AIDS in Africa (the International Partnership). DFID has committed US$280 million and £25 million to the Global Fund and the International Partnership respectively. **Figure 10** provides a comparison of these two initiatives.

3.11 DFID has made a positive contribution to the development of the Global Fund, including:

- being the second national government to pledge financial support;
- contributing to developing guidelines for the Fund's operation;
- taking the lead on governance issues;
- influencing the Fund's focus on poor countries, and the setting up of a fund replenishment system which increases the predictability of cash flows.

10 Comparison of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the International Partnership Against AIDS in Africa

The Global Fund to Fight AIDS, Tuberculosis and Malaria	International Partnership Against AIDS in Africa
Stated aim	
Attract, manage and disburse increased financial resources to reduce infections, illness and death arising from HIV/AIDS, tuberculosis and malaria.	Curtail the spread of HIV, reduce its impact on human suffering and halt the further reversal of human, social and economic development in Africa.
Background	
An international financing mechanism based on an alliance of donors, UN agencies, private foundations, developing countries, civil society, the private sector and people living with the diseases.	A philosophy rather than an organisation which promotes an African-led response to HIV/AIDS. DFID funds work in Ethiopia, Rwanda, Burundi and Ghana.
DFID committed funding	
US$280 million over 6 years: April 2002 to March 2008.	£25 million over 3 years: April 2002 to April 2005.
Justification for funding	
Good. The Global Fund was created to augment existing bilateral and multilateral development assistance by: levering additional funds to address the three diseases; aiding the strengthening of national health systems and ensuring the availability of commodities (drugs, condoms, testing kits etc) at low cost. The reason for funding was considered in depth and justification was well documented.	Africa is the continent most severely affected by HIV/AIDS. The Partnership was created to enable greater coordination of national AIDS activities and to assist national governments in making more effective use of external financial support such as the World Bank's Multi-country AIDS Programme. The reason for setting funding at £25 million is not clear.
Consideration of risks	
Good. There was substantial consideration of the risks surrounding this new instrument and thorough appraisal documents were prepared prior to approval of the funding.	Weak. The documented consideration of risks was limited and potential weaknesses in the design of the programme were poorly considered. Appraisals were brief.

Sources: National Audit Office review of DFID files and interviews with DFID staff

3.12 DFID has yet to formally assess the performance of the Global Fund because it is too early to judge performance against DFID's objectives for the Fund since its funding started in 2002. In determining its support, DFID identified the structure, focus and the way in which it wanted it to develop. It used informal benchmarks to keep track of progress. Informal monitoring suggests that the Global Fund is beginning to overcome some early problems, including the slow disbursement of funds. DFID has been actively involved in developing the Fund's monitoring and evaluation framework in conjunction with other donors, including developing benchmarks for measuring performance against in 2004. This information should be available before donors consider future funding in November 2004.

3.13 The International Partnership has been less successful in achieving its objectives. In 2003, an external review[23] concluded that its purposes were likely to be achieved only to a limited extent and that six of the eight outputs should be dropped. The review highlighted that whilst the Partnership had been successful in building the capacity of NGOs and community based organisations and had provided flexible and timely support to national AIDS coordinating bodies, problems existed, including:

- a lack of quantified targets and milestones by which progress should be achieved, making it difficult to assess the rate of implementation;
- a lack of clarity about which countries were included within the Partnership;
- delays in the disbursement of funds from DFID.

3.14 The International Partnership represented a new approach for addressing HIV/AIDS (see Figure 10). The approach was untested and as a result was relatively high risk. The project was specifically designed to build capacity at the community, national and regional levels, and in particular to facilitate effective utilisation of instruments such as the World Bank Multi-country HIV/AIDS programme for Africa. At the time the funding decision was taken, the Global Fund did not exist. Funding of £25 million was initially agreed in March 1999, but implementation of the programme did not begin until April 2002. In the intervening period, the development of other, larger initiatives, such as the Global Fund, increased the risk that the approach adopted by the Partnership was less relevant. The external review in 2003 noted that 'As the continent-wide funding context has dramatically changed since [IPAA] was launched [IPAA] should be careful to reposition in a strategic manner.' We found no evidence that such a strategic repositioning was performed. DFID's view was that, in being designed to be complementary to the World Bank Multi-country HIV/AIDS programme, the International Partnership had an important and continuing relevance alongside the Global Fund. It was for this reason that DFID did not revisit its funding decision during the period March 1999 to April 2002, nor revise its funding in the light of the 2003 external review. DFID will continue to fund the Partnership until the end of the funding agreement in 2005.

23 *JSI UK (2003), Support to the International Partnership Against Aids in Africa: Output to Purpose Review.*

Part 4

Tackling HIV/AIDS at country level

4.1 At country level, DFID, like many other donors has sought increasingly to design its country programmes so as to support achievement of national poverty reduction strategies. This may include strengthening national capacity to respond to HIV/AIDS and, in particular, supporting the establishment and work of national structures to coordinate a multisectoral response to the epidemic.

Incorporating an HIV/AIDS response into national poverty reduction strategies

4.2 Poverty Reduction Strategy Papers describe a country's macroeconomic, structural and social policies and programmes for promoting growth and reducing poverty. They are prepared by governments through a participatory process involving civil society and development partners. DFID and other like-minded donors are in favour of aligning development assistance more closely with these strategies, or similar national development plans, in order to increase the effectiveness and sustainability of poverty reduction efforts.

4.3 The importance of incorporating HIV/AIDS into poverty reduction strategies was highlighted by the United Nations Declaration of Commitment on HIV/AIDS to 'By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact-mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans'.[24] Our review of poverty reduction strategies for those countries key to the achievement of DFID targets on HIV/AIDS showed that most included a focus on HIV/AIDS to some degree and all contained specific national objectives for HIV/AIDS **(Figure 11)**. However, over a third made no reference to resourcing of any HIV/AIDS response, and only a third contained indicators against which to measure progress. More recent strategies covered HIV/AIDS more comprehensively than earlier ones. Some strategies were 'interim' and contained less detail than 'full' strategies. Poverty reduction strategies for Asian countries were consistently weaker in all these aspects than those for African countries.

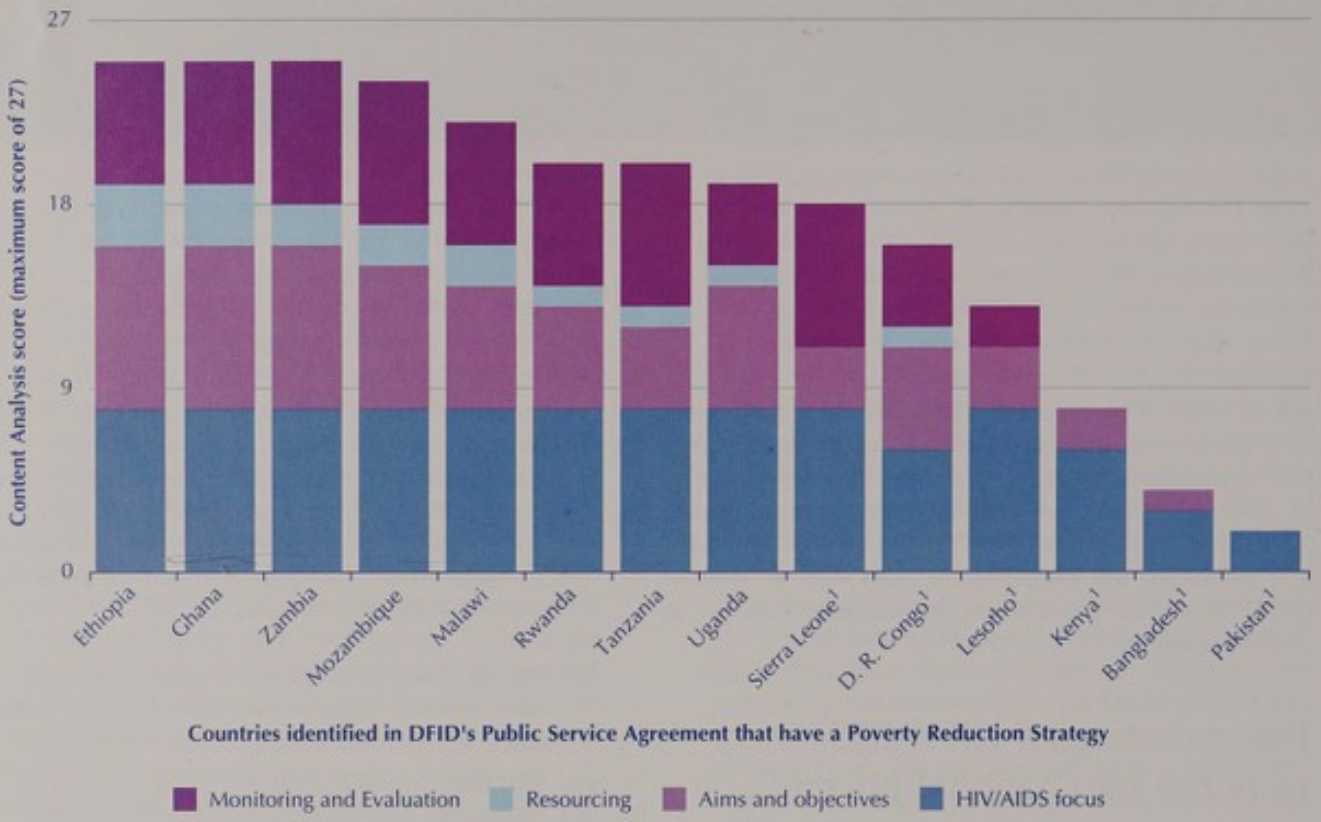
4.4 Increased alignment of DFID's Country Assistance Plans with national poverty reduction strategies makes it harder for DFID to develop its country programmes if the national strategy does not recognise the need for a strong and focused HIV/AIDS response. Therefore, in countries such as Uganda, DFID has sought to increase the recognition of HIV/AIDS as a key factor to be addressed in achieving national poverty reduction objectives. And where national capacity to deliver HIV/AIDS aspects of a national poverty reduction strategy need to be strengthened, DFID has taken steps in some countries such as Malawi **(Figure 12)**, Uganda and Tanzania to support administrative structures designed to deliver a more coherent and multisectoral response to the epidemic.

HIV/AIDS responses in DFID's country strategies

4.5 DFID Country Assistance Plans, and Country Strategy Papers which preceded them, set out its assessment of the country context and prioritise, outline and justify its plans for assisting development. However, plans for those countries central to achievement of DFID's key targets on HIV/AIDS do not reflect consistently the need to respond to HIV/AIDS **(Figure 13)**. Newer plans had a stronger HIV/AIDS focus than older Country Strategy Papers; and those for African countries, where the proportion of the population affected by HIV/AIDS is currently higher, reflected the significance of HIV/AIDS more strongly than those for Asian countries.

24 *United Nations General Assembly, Declaration of Commitment on HIV/AIDS, Special Session on HIV/AIDS, 25-27 June 2001, paragraph 38.*

11 An analysis of HIV/AIDS-related content in Poverty Reduction Strategy Papers[2]



NOTES

1 Interim Poverty Reduction Strategy.

2 20 countries feature in DFID's HIV/AIDS-related targets, but only 14 have either a full or interim Poverty Reduction Strategy, or its equivalent.

Source: National Audit Office content analysis of 14 poverty reduction strategies

12 DFID support to the Malawi National AIDS Commission

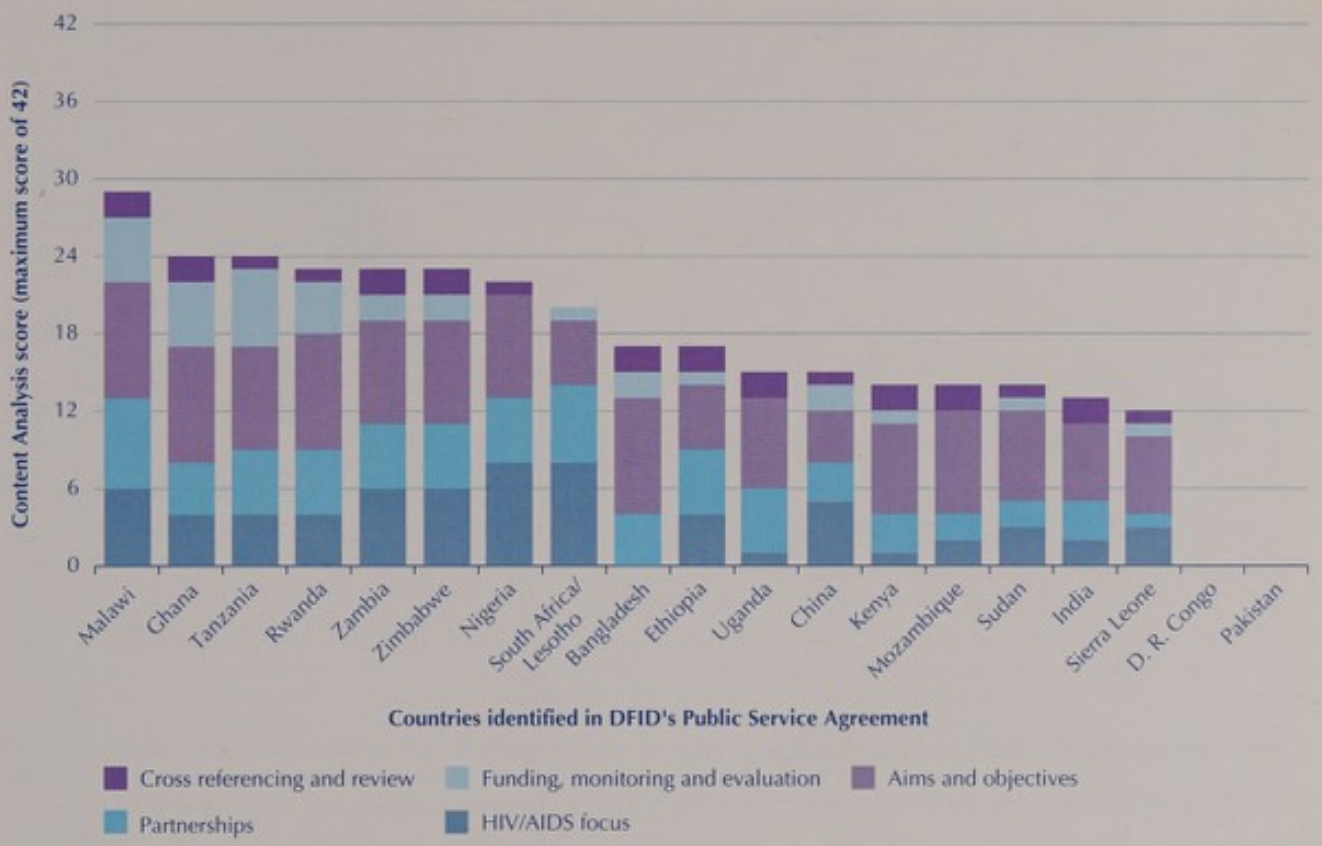
In 2001, HIV prevalence in Malawi ranged from 10 per cent in rural areas to nearly 30 per cent in urban areas. At the end of 2001, UNAIDS estimated that 850,000 Malawians were living with HIV/AIDS. In 2002, life expectancy in Malawi was 38.5 years, whereas it would have been 56.3 in a "no-AIDS" scenario. In January 2002, Malawi's National AIDS Commission reported that HIV/AIDS is the leading cause of death in the most productive age group (20–49 years).

With the help of donors from the United Kingdom, Canada, Norway and the World Bank, the Government in Malawi set up a National AIDS Commission to manage and coordinate a national response to HIV/AIDS. The previous National AIDS Control Program worked from within the Ministry of Health but the National AIDS Commission aims to mainstream AIDS responses in all sectors. Donors are seeking to combine and channel funding through the Commission. This 'basket funding' approach reduces transaction costs and enables Malawi to set up and own a sustainable response.

Malawi's National AIDS Commission described DFID as a 'critical partner' in proposing how to improve the national response; discussing what was needed; in defining a Memorandum of Understanding; and putting together the instruments that make basket funding possible. The Commission told the National Audit Office that some of the most important aid from DFID has been in providing ideas and defining the challenges to be faced, and that these consultations have increased and improved the technical capacity of the Commission.

Sources: National Audit Office interview with National AIDS Commission, Malawi; Garbus, L.(2003), HIV/AIDS in Malawi, AIDS Policy Research Centre; and DFID (2003), Malawi: Country Assistance Plan

13 HIV/AIDS-related content in DFID Country Assistance Plans and Country Strategy Papers



NOTE

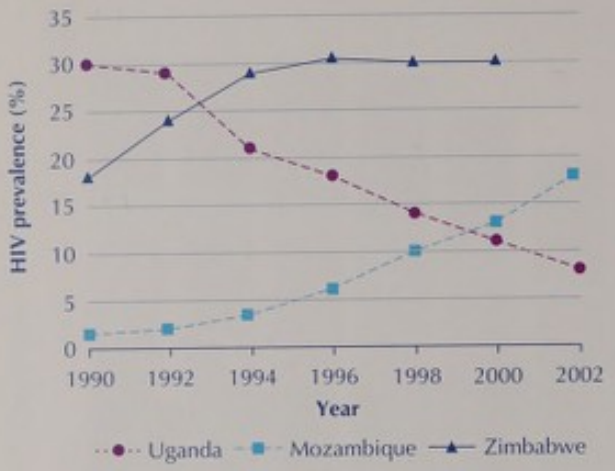
No country strategy existed for Pakistan or the Democratic Republic of Congo. South Africa and Lesotho are covered by a single strategy.

Source: National Audit Office content analysis of 17 country plans

4.6 While all the plans gave some coverage to HIV/AIDS issues, the depth and quality of coverage varied. Some plans omitted information on the nature and status of the epidemic, and its implications for poverty reduction. Considered assessments of the state of the epidemic; the national technical capacity to respond; and the impact of cultural, political and social factors were often lacking. And factors critical to the success of proposed responses - such as development of national capacities or contributions from development partners - were rarely explicitly identified. Of 17 plans examined, 12 did not identify whether a multisectoral approach was planned or what sectoral activities would be relevant to HIV/AIDS, and 11 did not explain how planned responses would contribute to achieving HIV/AIDS objectives. Resourcing of HIV/AIDS-specific plans was often absent. Where plans contained targets against which to measure progress, these tended to focus on prevalence, and omitted targets on impact mitigation, prevention and care.

4.7 The lack of precision in assistance plans partly reflects the nature of the epidemic. Although the prevalence of HIV/AIDS in Africa, for example, is generally rising, both the absolute level and change in prevalence vary widely. **Figure 14** illustrates this point for three countries which feature in DFID's HIV/AIDS target. Country teams face a dynamic environment where a broad range of social, economic and political factors influence vulnerability to the disease - making it difficult to formulate standard responses. In addition, international thinking about the nature of the epidemic and the best ways to tackle it under different circumstances was (and still is) evolving. Given this uncertainty, however, there appeared to be no established process by which country teams could check that their identification of the HIV/AIDS problem and proposed action fell within what DFID, corporately, saw as an appropriate and cost-effective response.

14 Differing trends in HIV prevalence (in urban areas)



Source: UNAIDS Epidemic Update 2003

15 Proportion of DFID country-level HIV/AIDS support by type of intervention, 1997-98 to 2002-03

HIV/AIDS expenditure by type of intervention

Source: National Audit Office analysis of DFID data

Developing country HIV/AIDS programmes

4.8 Notwithstanding weaknesses in longer term planning, DFID country teams developed a range of programmes and activities. In practice, the shape and scope of HIV/AIDS programmes were often driven by the need to react quickly to changing circumstances; and to make the most of opportunities to support the work of others as they arose. DFID country teams support a variety of interventions in the HIV/AIDS field, ranging from direct support to a government's general budget or to the budget of a particular sector, such as health; to more traditional, project-based support, including to NGOs. We looked to see if the pattern of assistance reflected the depth of coverage of HIV/AIDS issues in Poverty Reduction Strategy Papers - which underpin general budget support. We found a weak association between increased use of budget support, relative to discrete HIV/AIDS project support, and the degree to which the Strategies addressed HIV/AIDS. But the analysis is hampered by the inability to distinguish HIV/AIDS issues from more general reasons for using budget support.

4.9 A survey of current DFID HIV/AIDS interventions showed that the main types of identifiable intervention related to prevention, with care, treatment and impact mitigation taking smaller proportions **(Figure 15)**. Capacity building and general support for budgets or institutions accounted for around a quarter of the expenditure. One third of expenditure was not classified by any category. The general pattern of expenditure is built up from differing responses in individual countries, reflecting their differing circumstances. But it is in line with the HIV/AIDS strategy, which has not encouraged expenditure on care and treatment. The high proportion of expenditure unallocated to a type of intervention, however, reduces the value of this information as a means of monitoring the overall nature of DFID's HIV/AIDS response.

4.10 DFID's key governmental and NGO partners told us that they appreciated the flexibility DFID country teams brought to the design of programmes, and the speed with which they were able to develop and implement particular interventions, compared with some other donors. This reflected the decentralisation of country-specific policy-making to country offices. They also highlighted the technical skills of DFID staff and the strengths they brought to encouraging coordination between different players; their role emphasising the importance of monitoring and evaluation; and the influence they had with governments in taking forward national HIV/AIDS strategies.

Assessing the problem

4.11 For DFID country teams, much of the difficulty in identifying the underlying problems was the relatively limited information available. Sometimes organisations that were already directly involved in implementing interventions produced the only available information **(Figure 16)**. Such information, though accurate in itself, may only provide a partial view of the problem. Accordingly, it may be difficult to develop an independent, critical appraisal of the key issues. In both examples shown below, the organisations involved were subsequently selected to be the principal recipient of the final contracts.

16 Examples of HIV/AIDS programming by DFID country teams

Bangladesh - Knowledge and Training Programme

In 1995, an international NGO presented a proposal to DFID Bangladesh to promote empowerment, condom use and the treatment of sexually transmitted infections in brothels and among street based sex workers, and to support harm reduction activities among injecting drug users.

The proposal, costed at £2.4 million for the period 1995 to 2000, was subsequently approved by DFID without other options having been considered, on the grounds that the opportunity existed to keep prevalence low; government capacity to provide such services was weak; and the NGO had a good track record of working with vulnerable groups. The DFID health adviser was particularly impressed by the the NGO's project director. DFID was anxious that the work should develop broader national capacity in Bangladesh to work with vulnerable groups and looked to the NGO to take on the role of mobilising and building the capacity of indigenous NGOs to carry out similar work.

A review in 1999 was generally approving of the NGO's work but concluded that progress in building the capacity of other NGOs had been less successful. However, in 2000, further funding of £3.7 million for the period to 2003 was approved by DFID without the benefit of any formal appraisal of other options. In 2001, another review concluded that although the NGO had been effective in its routine work with vulnerable groups, it had found it difficult to take on the new function of being an 'enabling' organisation. It was not clear that there had ever been serious consideration of whether it was realistic to expect the NGO to take up this role, nor whether there might have been other ways of achieving the objective of building capacity of a wider range of local NGOs to deal with HIV/AIDS prevention.

Nigeria - Condom Social Marketing Programme

DFID approved a £52.8 million, 7 year programme from 2001 to market and distribute condoms which is also supported by USAID. This is an extension of a previous social marketing project. The decision to extend funding was taken by DFID largely on the basis of data generated by the NGO which had led the previous project.

The project represented an opportunity to use funds and see results quickly. The then Secretary of State for International Development had visited Nigeria in 2000 and strongly encouraged rapid scaling-up of HIV/AIDS interventions as part of donors' desire to support the new democratic government with increased funding. Continuing the social marketing condom project, using the established infrastructure of the NGO running the previous programme, was considered by DFID to be an obvious way to do this. As a straightforward condom distribution programme managed by the national affiliate of an international NGO, DFID also saw it as a low risk intervention in comparison to other programmes it had in train or planned. It was also seen as an opportunity to build partnerships with other donors, which was being strongly encouraged within DFID.

There is no evidence, however, that DFID considered other possible responses. Neither does there seem to have been a process of exploring different approaches to increasing condom usage, for example by building up demand for them by developing local markets - a strategy which has been adopted by DFID Nigeria to improve access to malaria bed nets. The proposal continued the supply-driven approach of the previous programme.

Source: Futures Group Europe, for the National Audit Office, December 2003

4.12 In the cases we examined DFID advisers sometimes consulted experts outside their own country team in order to respond to HIV/AIDS most effectively. For example, when seeking to strengthen national capacity in Tanzania, the DFID country team considered that input from DFID's Regional HIV/AIDS Adviser was key to identifying important research and other countries' experiences in tackling similar issues. DFID Russia added a care and treatment component to its five year £25 million HIV/AIDS programme after an exchange visit of a large delegation to Brazil (organised by DFID and UNAIDS) demonstrated, amongst other things, the impact anti-retroviral treatment had on encouraging people to find out their HIV status.

4.13 DFID advisers seeking additional information were often faced with a vast array of technical knowledge on the epidemic from which they found it difficult to extract information which was relevant to their country situation. They felt that more structured support from DFID centrally, such as up-to-date summaries on policies and research, particularly at the early stages of the decision-making process, would be helpful; as would better signposting of where and from whom to get relevant information.

Selecting projects

4.14 Formal approval of funding of all country bilateral programmes is subject to a two stage process:

- a Project Concept Note - providing a basic outline of the project and its total value; followed by a
- Project Memorandum - a more detailed document, setting out the programme design; its rationale; an indicative budget; and technical, social, institutional, economic and risk appraisals setting out different aspects of the country context in which the programme is being developed.

4.15 However, cases we examined showed that key decisions regarding HIV/AIDS interventions were often based by country teams on the judgement, intuition and experience of DFID country advisers prior to the Project Concept Note stage. With incomplete information and the absence of identified critical success factors, interventions were often based on familiar options which had worked in the past (see Figure 16). Consequently, formal appraisals of opportunities and risks at the Project Memorandum stage were less likely to influence the choice and design of a particular programme as they often did not consider alternative options.

Using budget support

4.16 DFID has been using budget support increasingly to fund HIV/AIDS-related activities. Research has shown that it can increase the effectiveness and sustainability of aid. Budget support is normally tied to achievement of a country's national poverty reduction strategy. However, DFID, in common with all donors involved in budget support, cannot control directly where the national government will use such funds although DFID aims to ensure that safeguards are in place to minimise fiduciary risk. And it has formulated a Fiduciary Risk Policy for appraising and implementing direct budget support proposals.

4.17 Many national poverty reduction strategies recognise the importance of HIV/AIDS. However, planned responses are not always clear as many do not identify the level of resources to be allocated to responding to the epidemic. And tracking progress against intended activity is difficult as expenditure and performance monitoring is often inadequately developed. In Uganda and Malawi, for example, there are mechanisms for tracking high-level resource planning, allocation and expenditure. But there is no information that enables the country team to monitor progress on a key cross-cutting topic such as HIV/AIDS.

4.18 In a number of countries DFID is taking steps to improve the control it has over how budget support funds are used. In Tanzania, DFID is working with the Ministry of Finance which is seeking to encourage other ministries to spend more on HIV/AIDS by creating ring-fenced budgets for this purpose. In Malawi, DFID is intending to link its next budget support agreement to performance in key sectors in order to focus the use of such funds in areas most likely to contribute to poverty reduction.

Project outputs and lessons

4.19 HIV/AIDS programmes supported by DFID country teams have generally been fully or largely successful in achieving the specific goals for which they were designed. Where programmes have been less successful overambitious aims and external factors have been two of the causes. **Figure 17** provides examples of HIV/AIDS support provided by DFID, and some of the impacts achieved to date.

4.20 The complex and rapidly changing nature of the HIV/AIDS epidemic places a premium on DFID's ability to identify lessons from its past work and the work of others, and share those lessons as quickly and widely as possible. The establishment of a multi-disciplinary policy team on HIV/AIDS was intended, partly, to facilitate the gathering and dissemination of information from across a number of disciplines; as are other developments within DFID, including the work of the Central Research and Knowledge Sharing Teams.

4.21 DFID staff interviewed by the National Audit Office felt that there was a need to improve the way in which the success or otherwise of HIV/AIDS programmes carried out elsewhere in DFID and by other donors was made known (Appendix 6). This was particularly with regard to the practical management of HIV/AIDS interventions. Whilst much information was available on technical and medical issues there was significantly less information on, for example, ensuring that national governments were given appropriate assistance to take forward their own responses to the epidemic; or the scaling up of the work of NGOs which several of those interviewed recognised as a common problem (see Figure 16). DFID staff also felt that they lacked support in identifying relevant information amongst the large amount of technical and medical information available.

4.22 DFID country teams rely mainly on informal contacts for information gathering; or commission external consultants to carry out research into specific aspects of HIV/AIDS on an ad hoc basis. The results of such ad hoc work are often not disseminated more widely because of the lack of effective mechanisms within DFID to do so. Whilst such approaches can be less resource intensive than more formal dissemination mechanisms, there is an increased risk that country advisers will not be aware of key information. DFID's plan to launch an HIV/AIDS web portal in July 2004 is intended to help address this weakness.

17 Examples of HIV/AIDS interventions supported by DFID

Intervention	Aim	DFID Funding	Achievements
Russian Federation - Open Society Institute Harm Reduction Project	Reduce transmission of HIV among injecting drug users and commercial sex workers in 43 harm reduction sites in the Russian Federation.	£4.2 million (2001 to 2004)	40 harm reduction sites fully operational. Some delay in developing the capacity for monitoring and evaluating harm reduction owing to the reluctance on the part of Russian Federal research institutions to be involved in the evaluation of the strategy. Resource Centre on HIV prevention amongst sex workers started in January 2003. Training programme for journalists on HIV social advertising (radio jingles) delivered.
Uganda - HIV Umbrella Programme	Improved coordination and implementation of multisector HIV/AIDS activities in support of the Poverty Eradication Action Plan and the National Strategic Framework for HIV/AIDS.	£6.2 million (2001 to 2005)	Ugandan AIDS commission strengthening central coordination. Good progress towards mainstreaming HIV/AIDS into all sectors. Support to existing NGOs allowing them to make a valuable contribution to tackling the epidemic.
Malawi - Intergrated Sexual and Reproductive Health Programme through Banja La Mtsogolo	To stabilise and reduce HIV prevalence by promoting safer sexual and reproductive health practices.	£10.6 million (2001 to 2006)	Results include: 29 clinics established in first year; over 6 million condoms distributed; contact made with 351,100 young people; over 8,000 HIV/AIDS tests carried out.

Using music to provide HIV/AIDS education: choir and musicians at DFID-funded Banja La Mtsogolo clinic, Ntcheu, Malawi

Sources: National Audit Office review of DFID documentation and visit to Banja La Mtsogolo, Uganda, October 2003

Part 5

Research and knowledge generation

5.1 Although HIV/AIDS has been recognised since the early 1980s, the viruses are still not fully understood. The medical character of the viruses and the effect of an epidemic on populations and livelihoods are extremely variable across different countries and are only partially appreciated. New approaches to tackling HIV/AIDS continue to be tried, and research is necessary to monitor and conclude on the effectiveness of approaches and to measure the spread of the epidemic.

Medical research supported by DFID

5.2 The rapidly changing nature of HIV/AIDS and its complexity creates a need for ongoing research. DFID contributes to the global effort by funding specific international medical research, including developing a vaccine and into microbicides. Funding of this research involves a high degree of risk because there is no guarantee that it will be successful. The benefits, however, are potentially significant.

5.3 The vaccine initiative aims to develop effective and affordable HIV/AIDS vaccines for use particularly, but not only, in developing countries. DFID carried out a thorough appraisal of risks before committing £14 million between 2000 and 2004. An accessible vaccine could yield substantial benefits by offering long term or even lifelong protection against AIDS. This may be more effective than preventive approaches that require either the repeated use of a product, such as a condom, or consistent changes in behaviour, as in the case of abstinence.

5.4 DFID led the global donor community by providing early support to the vaccine initiative which generated additional financial support from other donors. In 2003, an independent evaluation found that it 'had met or exceeded most of its key goals and has been a very effective and positive force in the development of an AIDS vaccine'.[25]

5.5 Microbicides are chemical compounds which, when applied prior to sexual intercourse, provide protection against HIV infection. Traditional HIV/AIDS prevention approaches in developing countries have promoted sexual abstinence, fidelity, and the use of condoms. However, in poor countries, where women frequently lack social and economic power, they are often unable to insist on condom use or to refuse intercourse. Therefore, a cheap and safe microbicide which can be applied by women could intervene in the transmission of HIV.

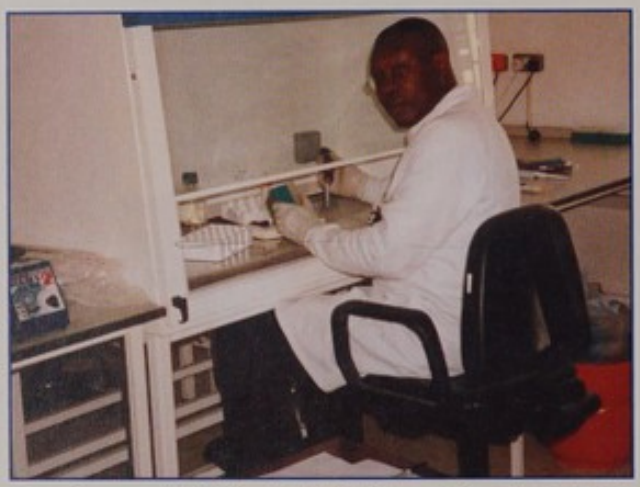
5.6 DFID supports the Medical Research Council (£16 million between 2001 and 2006; see **Figure 18**) in research aimed at, amongst other things, determining the level and duration of protection provided by microbicides and testing potential microbicides to see if they are effective. It also supports the International Partnership for Microbicides (£1.2 million between 2002 and 2006) in fostering partnerships with others working in the microbicides field and to encourage the sharing of knowledge. Early support from DFID helped to encourage other donors to provide funds. But, in contrast to vaccines research, the funding of the International Partnership for Microbicides was not supported by an analysis of risks. An evaluation of the Medical Research Council work, due in October 2003, remains to be done.

25 *Skolnik, R., S. Cornejo, S. Hira, J. La Montagne and J. Turnbull (2003), Independent Evaluation of the International AIDS Vaccine Initiative.*

18 Medical Research Council microbicides research in Uganda

The Medical Research Council began its programme in Uganda 15 years ago, in collaboration with the Ministry of Health and the Uganda Virus Research Institute. Funds from DFID and other donors support various projects, including clinical trials, behavioural and attitudinal research, immunology testing and epidemiological modelling.

For instance, DFID is funding further research into microbicides. In the town of Masaka, a DFID-funded trial is following the progress of 100 discordant couples, where the male is HIV-positive but the female is not. The study will assess the effectiveness of a microbicide by monitoring the HIV status of the women in those couples using the microbicide, and comparing it to women in a control group. Since perception of risk affects sexual behaviour and thus, in turn, the spread of HIV, the study will also assess any changes in the attitudes and behaviour of the couples and the people around them during the trial.



Supporting research: DFID-funded Medical Research Council microbicides development programme at the Uganda Virus Research Institute

Source: National Audit Office review of DFID files and interviews with DFID staff and visit to Entebbe, Uganda, October 2003

Knowledge generation

5.7 DFID funds research, known as Knowledge Programmes, in United Kingdom universities. Their primary objective is to generate and share new knowledge amongst development policy makers and practitioners, (including DFID country teams), developing countries and other donors that will assist in attaining international development objectives. DFID funds two HIV/AIDS specific Knowledge Programmes, and three on sexual and reproductive health which are relevant to HIV/AIDS, each for three to five years between 1999 and 2006. Total funding for the Programmes is £10.9 million. DFID also funds a £2.3 million Knowledge Programme (2001-06) focusing on tuberculosis which is one of the leading causes of death in people with HIV/AIDS. The knowledge generated is available in academic journals, conferences, newsletters and on websites.

5.8 In April 2003, a DFID-funded review[26] concluded that all Knowledge Programmes were 'as a whole, delivering solid outputs, - especially in terms of generating new knowledge'. The review also found they were 'making solid headway (albeit to varying degrees) towards achieving their purpose, (typically expressed in terms of changing the "climate of opinion", or promoting "evidence based decision-making")'. **Figure 19** provides examples of how Knowledge Programmes have led to change in the HIV/AIDS field.

19 Examples of the impact of HIV/AIDS-relevant Knowledge Programmes

Research by the London School of Hygiene and Tropical Medicine found that increasing the treatment of other sexually transmitted diseases reduced the level of HIV transmission by 40 per cent. This finding has had a major influence on policy at DFID, the World Health Organisation and internationally.

The Liverpool School of Tropical Medicine Knowledge Programme in Kenya found a variable quality of service amongst organisations providing voluntary HIV testing and counselling. The National AIDS Commission in Kenya subsequently incorporated the Knowledge Programme's findings into an accreditation system aimed at ensuring consistently high quality services.

Source: National Audit Office review of Knowledge Programme documentation

26 *Allison C., R. Loewenson, and R. Snow (2003), Overview of General Findings from the Triennial Reviews on DFID Funded Knowledge Programmes, DFID Health Systems Resource Centre.*

Disseminating and using Knowledge Programme research

5.9 The Knowledge Programmes generate insights of value to DFID's response to HIV/AIDS, but there have been difficulties in disseminating the results to DFID staff, particularly country teams which were one of the audiences for these programmes. For example, seminars and presentations prepared by these Programmes have not always been well-attended by country teams. The 2003 Knowledge Programme review noted the need for improvement in disseminating findings, for example, by selecting key areas of national evidence for use in influencing international policy. It also concluded that 'weak operational relationships' existed between DFID country advisers and Knowledge Programmes. Country teams did not '...see the Knowledge Programmes as an integral part of their overall policy and programme influencing and support strategies', but there are exceptions, as in **Figure 20**.

5.10 In contrast, Knowledge Programmes were found to have developed closer links with other key stakeholders, national policy makers, national programme managers, NGOs and the private sector, as partners in research, and users of findings. Lack of engagement between the Programmes and country teams increases the risk that country programmes will be based on incomplete information and lead to the funding of inappropriate responses.

5.11 In 2002, an internal review[27] of research and its contribution to poverty reduction recommended that DFID should report more regularly and effectively on the effect of its research. The 2003 review concluded that country offices and DFID centrally had little involvement in directing the Knowledge Programmes. DFID currently relies on voluntary research specialists to monitor and evaluate these Programmes. Knowledge Programme managers interviewed by the National Audit Office confirmed that they received little feedback from DFID about the quality or effect of their research. They considered that the low degree of monitoring by DFID introduced the risk that research may not be as useful to DFID country advisers as it might be.

5.12 DFID's Central Research Team is currently preparing a paper on best practice for the dissemination of research findings which seeks to improve their use. The central HIV/AIDS Policy Team is also considering their role in improving the dissemination and use of research.

20 DFID supported knowledge generation in Russia to inform policy makers

In 2001, Russian Government officials viewed HIV/AIDS as primarily a medical problem which would be confined to intravenous drug users and commercial sex workers. Some officials did not appreciate the risks of a generalised HIV epidemic. However, evidence from Western countries where the HIV epidemic started in a similar way, showed that without intervention the HIV epidemic would undermine economic and social reforms. DFID identified the need for a systematic research programme to create a better understanding of the HIV epidemic in Russia and thereby inform policy development.

This led DFID to set up a knowledge project on the epidemiology and prevalence of the disease that would work in partnership with the Government and scientific communities. DFID engaged Imperial College, who were already participating in the global HIV Knowledge Programme, to undertake a large-scale £1.5 million research programme in three areas: strengthening epidemiological modelling and surveillance activities; social and sexual behavioural research; and the economic consequences of HIV/AIDS. The project, spanning the period 2002-05, will generate information about the potential resource drain, and the economic, demographic and social costs of HIV in Russia, in order to demonstrate the need to invest in prevention, treatment and care responses.

Source: National Audit Office interviews with DFID staff

27 *Surr M., A. Barnett, A. Duncan, M. Speight, D. Bradley, A. Rew, and J. Toye (2002), Research for Poverty Reduction, DFID Research Policy Paper.*

Appendix 1 United Kingdom's *Call for Action on HIV/AIDS*

"The UK Government calls on the international community to intensify its efforts to tackle HIV/AIDS and to achieve real progress towards international targets in the [United Nations] Declaration of Commitment on HIV/AIDS, and in particular:

- 25% fewer young people infected with HIV/AIDS by 2005.
- Three million people - two million in Africa - receiving treatment by the end of 2005.
- One national strategy, one national AIDS commission and one way to monitor and report progress in every country affected by HIV (the 'Three ones').
- On track to slow the progress of HIV/AIDS by 2015.

What we will do: Stronger political direction

- The UK Government will make HIV/AIDS - and Africa - a centrepiece of our Presidencies in 2005 of both the G8 and EU.
- The UK will work with the New Partnership for Africa's Development (NEPAD) and the Africa Partners' Forum to focus on HIV/AIDS.
- We will push for a special session on HIV/AIDS at the United Nations Security Council in early 2004.

What we will do: Better funding

- We will make HIV/AIDS a priority for the extra £320 million the UK will be devoting to Africa by 2006.
- We will press for support for the International Financing Facility to meet the funding gap for HIV/AIDS and other Millennium Development Goals.
- We will work with the Global Fund for AIDS, TB and Malaria to enable it to disburse funds quickly and efficiently.

What we will do: Better donor coordination

- We will step up our coordination with the US and other donors starting in Ethiopia, Kenya, Nigeria, Uganda and Zambia.
- We will double our core funding of UNAIDS.
- We will work with UNAIDS to strengthen their coordination role in countries and to establish an annual forum on donor coordination. We will work with the EU and the UN to support their role in improving donor coordination.

What we will do: Better HIV/AIDS programmes

- We will work with developing countries and other partners to strengthen health systems.
- We will produce a new UK government strategy on AIDS next year. This will define how the whole government will work with countries to establish a stronger response.
- We will issue new policy guidance on the role of HIV treatment and care."

Source: DFID, UK's Call for Action on HIV/AIDS, December 2003

Appendix 2 Key factors relevant to assessing country capacity

Assessing epidemiology and the nature of the risk environment

- How many people in the country are living with HIV/AIDS?
- What are the best estimates of the numbers of AIDS deaths?
- What is the historical trend in HIV prevalence in this country and in neighbouring regions?
- Are there particular groups that have a high risk of becoming infected?
- What are the most common transmission routes?
- Are there situations in which people continue to risk infecting themselves and others?

Preventing infection

Do attitudes and belief systems encourage or discourage protection from infection?

How much control do women and girls have over their sexual activity?

Are high risk groups, such as sex workers, and mobile groups, such as migrant workers and military personnel, targeted for prevention education?

Does the government consider the country at risk from HIV/AIDS?

Is HIV prevalence monitored and evaluated at national, regional and local level?

Is accessible and reliable HIV/AIDS education available?

Is there appropriate access to condoms, clean needles and other commodities which support prevention?

Does the government facilitate the prevention work of civil society and NGOs?

Living with HIV

Are stigma and discrimination associated with HIV?

Are individuals deterred from knowing their HIV status?

Do attitudes and belief systems encourage or discourage medical treatment and care?

Are high risk groups, such as sex workers, homosexuals and drug-users reached by testing and treatment?

Is affordable HIV testing and counselling readily available and accessible?

Does the health sector have the resources to provide treatment drugs (including anti-retrovirals) to HIV-positive individuals?

Living with AIDS

Does the country have adequate governance to make effective use of their own and donor resources?

Does the government have the capability to coordinate a multisectoral response to AIDS?

Does the public health infrastructure have the capacity to reach and care for the increasing numbers of AIDS cases?

Does the health sector have the resources to treat the increasing numbers of opportunistic infections?

As appropriate, are other sectors, such as Education, Transport, Security and Justice, capable of addressing the impacts of HIV/AIDS?

Social and economic impact

Does the country have the capacity to deal with the result of AIDS attrition of key public sector workers (such as the health and education sectors)?

Are child-, women- and grandparent-headed households supported?

Are AIDS orphans adequately provided for?

Has HIV/AIDS undermined civil society organisations' ability to provide social protection measures?

Is the private sector capable and prepared to support the workforce living with HIV/AIDS?

Are rural livelihoods coping with the impact of HIV/AIDS?

HIV programming:

- Map the responses and activities of other donors and multilaterals.
- Learn lessons from what have been effective activities, partnerships and collaborations (bilateral, multilateral, NGO, civil).
- Apply local knowledge and research.
- Consider DFID's comparative advantages and ways of complementing the work ongoing in the country.

Project concepts should fall out of an option analysis generated as a result of this process, during the Country Assistance Plan stage. This should ensure that the reasons for decisions are transparent and the chosen interventions can be monitored.

Appendix 3 The multisectoral impact of HIV/AIDS

Sector	Some examples of the effects of HIV/AIDS
Education	UNICEF estimates that 860,000 children in sub-Saharan Africa lost their teachers to AIDS in 1999. Swaziland has estimated it will have to train 13,000 teachers over the next 17 years to keep services at their 1997 levels - 7,000 more than it would have to train if there were no AIDS deaths.
Health	In Zimbabwe, 50 per cent of all inpatients in wards studied were infected with HIV. In one Tanzanian hospital HIV prevalence among hospitalized patients was 33 per cent; and in Swaziland it has been estimated that people living with HIV/AIDS occupied half the beds in some health-care centres in 2001. Malawi and Zambia are experiencing a five to six fold increase in health-worker illness and death rates. Hospital expenses on drugs, linen, blood and HIV tests have risen by up to 40 per cent.
Governance	HIV infection rates of military personnel have been found to be two to five times higher (during peacetime) than for the civilian population. In Kenya, AIDS accounts for an estimated three-quarters of all deaths in the police force. In Zambia, nearly two-thirds of deaths among public sector managers have been because of AIDS.
Transport	Research among truck drivers at five South African truck stops revealed an overall HIV prevalence of 56 per cent - well above the national adult prevalence rate. 28 per cent of HIV-positive Filipinos and 41 per cent of Bangladeshis have worked overseas.
Agriculture	20 per cent of rural families in Burkina Faso are estimated to have reduced their agricultural work or even abandoned their farms altogether because of AIDS. In Ethiopia, AIDS-affected households were found to spend between only 12 and 16 hours per week performing agricultural work, compared with an average of 34 hours for non-AIDS-affected households.
Private sector	In several Southern African countries the combined impact of AIDS-related absenteeism; reductions in productivity; health-care expenditure; and recruitment and training expenses could cut profits by at least an estimated 6 to 8 per cent. Comparative studies of East African businesses have shown that absenteeism can account for as much as 25 to 54 per cent of company costs. An ING Barings study has forecast that 23 per cent of South Africa's skilled workforce will be HIV-positive by 2005.

Sources: UNAIDS (2002) Report on the global HIV/AIDS epidemic; The UNICEF website: Data Briefs: Progress and Disparity; UNAIDS (1998) AIDS and the Military. UNAIDS point of view

Appendix 4 A coordinated multisectoral response to HIV/AIDS in Brazil

The first cases of HIV/AIDS in Brazil were notified in the early 1980s among people in the major urban areas, among men who have sex with men and people who received blood transfusions. The epidemic began to spread further throughout the country among vulnerable groups such as intravenous drug users, and then among heterosexuals and particularly women. Brazil ranks among the first four countries in the world in terms of the largest number of reported cases.

The number of deaths from HIV/AIDS has dropped by 80 per cent in recent years in Brazil. The United Nations predicted that by 2000 1.2 million Brazilians would be HIV-positive, but by the turn of the millennium only 597,000 people were infected. International experts agree that the substantial difference between actual and estimated numbers of people living with HIV/AIDS in Brazil is due largely to investment in prevention campaigns, alongside treatment and care programmes - especially the production of generic anti-retroviral drugs, and the mobilisation of civilians and the public sector.

In 1998 President Sarney passed state law that HIV/AIDS drugs should be made freely available to all that needed them. This 'right to health' took precedence over intellectual property rights and as a result, Brazil is one of the pioneers in producing generic drugs to fight the disease. President Sarney emphasised this "great cause" would need national collaboration. The National Coordination Unit for HIV/AIDS in Brasilia coordinates a mainstreamed response throughout government ministries. For instance, engaging with the education sector to teach school children about the risks of infection. The management and coordination of ministries of health, justice, education, labour and defence has been critical in developing such a strong response to the HIV/AIDS epidemic.

The Brazilian government has demonstrated a tolerant and accepting attitude towards people living with HIV/AIDS and has set examples of how to incorporate civil society and marginalised groups into policy making. For example, in developing joint government-civil society programmes. Recent research has showed that about 900 NGOs work with the AIDS programme in Brazil. One such organisation called Da Vida is an organising network for the legal and social protection of commercial sex workers across Brazil. The National Coordination Unit for HIV/AIDS and Da Vida have jointly produced stickers and advertising material to alert sex workers to ways of protecting themselves and also pocket sized leaflets for the clients.

Brazil has considerably better health standards than many 'developing' countries, including a universal decentralised health system providing free medical care (including anti-retroviral medications), on which the majority of the population depend. While important distinctions exist between middle and lower income countries, it is hoped that the Brazilian experience of building and sustaining a comprehensive HIV/AIDS prevention and treatment programme can help inform and pave the way for other countries as they start to offer these life-saving medications.

Sources: National Audit Office interviews with Former President Sarney, The National HIV/AIDS Coordination Unit in Brasilia and Da Vida; DFID-Brazil internal documents; Bastos, F. I., and Lowndes, M. (commissioned by DFID 2002), A Critical Review of the Brazilian AIDS programme: Lessons for Others; Szwarcwald, C. L., Bastos, F. I., Barcellos, C., Pina, M. F., Esteves, M. A. (2000) Journal. Epidemiol. Comm. Health 54, 530; Ministry of Health of Brazil secretariat for Health Surveillance National STD/AIDS Programme (2003), Goals of UNGASS: HIV/AIDS The Brazilian Response 2001/2003; UNAIDS (2002), Join the fight against AIDS in Brazil: Menu of Partnership Options

Appendix 5 Study methodology

The main aspects of our methodology were:

Semi-structured interviews

We met with key staff within DFID in the United Kingdom to discuss the general approach to responding to HIV/AIDS.

Country case studies

We visited DFID country teams in Brazil, Malawi and Uganda. During each visit we:

- Undertook semi-structured interviews with DFID staff involved in developing and managing HIV/AIDS programmes.
- Sought to evaluate DFID's response in a broader context by meeting representatives of host nation governments; bilateral donor partners; multilateral development institutions; and NGOs involved in the HIV/AIDS field.
- Examined documentation relating to particular HIV/AIDS interventions to identify how decisions were made concerning their design.
- Visited a number of HIV/AIDS programmes to gain a more detailed understanding of the nature of the HIV/AIDS response; talk to field staff; and to the recipients of HIV/AIDS support about its impact.

Survey of HIV/AIDS programmes

We undertook a survey of DFID country teams operating in 20 countries considered by DFID to be key to achievement of its high level targets on HIV/AIDS. We sought to identify the key aims of each programme and which strategic objectives they were designed to help achieve.

Content analyses

We analysed the following key documents to determine the extent to which they reflected the importance and impact of HIV/AIDS on strategy and planning:

- DFID Director Delivery Plans 2003-06.
- Poverty Reduction Strategy Papers (or equivalents).
- DFID Country Strategy Papers/Country Assistance Plans.
- DFID Institutional Strategy Papers.

International comparisons

We compared DFID's 2001 *HIV/AIDS Strategy* with those of the international development agencies of Canada, Denmark and Sweden.

Consultancy input

We commissioned Tony Barnett (ESRC Professorial Research Fellow, Development Studies Institute, London School of Economics and Political Science) to prepare a scoping paper setting out the background to HIV/AIDS; current thinking on the epidemiology of HIV/AIDS; key emerging issues; and issues and problems faced by those living with HIV/AIDS. A copy can be found at www.nao.org.uk/publications/nao_reports/index.htm#2003-2004

Professor Barnett and Dr James Putzel (Director, Development Research Centre, London School of Economics and Political Science) have acted as reference partners to test and validate the emerging findings and draft report.

We also commissioned the Institute for Health Sector Development to provide a scoping paper, amongst other things, on DFID's HIV/AIDS strategy; how DFID is organised to respond to the epidemic; the nature of that response; and the responses of other donors.

For the main review, we commissioned Futures Group Europe to map the decision-making process for HIV/AIDS resource allocation decisions relating to a sample of HIV/AIDS programmes in Bangladesh, Nigeria and Tanzania.

Appendix 6

Views of DFID staff on the need for technical guidance and learning lessons

On technical guidance

"I think the place where the Strategy falls down is [with] impact mitigation ... it's mentioned but what does it really mean, you know, how far do you go to mitigate?"

"There wasn't anything very focused to draw on, so ... we were very in the dark there about where to go and that was very much related to the reluctance of London to get involved in the Treatment debate."

"There were quite tense debates ... on where we should go, where [the Global Fund] should be focused and we felt, I suppose, a little exposed because there wasn't a clear line from London on it."

"Not getting stuck into the Treatment agenda and starting to do some research and, you know, disseminate some of that, it means we're kind of in the dark to a certain extent."

Source: National Audit Office interviews with DFID country staff

On learning lessons

"I think it would have been nice to have some other people's experiences ... at the beginning, so we wouldn't have made some of the mistakes maybe that we've made."

"If we were serious ... we would be trying to establish some kind of resource centre ... with better access to information of a variety of sorts ... for the whole donor community ... That's what we're lacking in DFID ... if you could get some good information resource there at least that's not going to be a constraint to developing your policies ... or in maintaining standards of professionalism within your workforce."

"We do not spend enough time saying what we're doing, we spend too much time doing it ... We think it's interesting and the people we discuss it with think it's interesting but the greater world doesn't know what's going on."

Source: National Audit Office interviews with DFID country staff

Appendix 7 Glossary of terms

Acronym	Full name
AfDB	The African Development Bank
AsDB	The Asian Development Bank
CDB	The Caribbean Development Bank
CIDA	Canadian International Development Agency
DANIDA	Danish International Development Agency
EC	The European Commission
EBRD	The European Bank for Reconstruction and Development
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
IAVI	International AIDS Vaccine Initiative
IDB	The Inter-American Development Bank
IPAA	International Partnership Against AIDS in Africa
IPM	International Partnership for Microbicides
MRC	Medical Research Council
SIDA	Swedish International Development Agency
UNDP	The United Nations Development Programme
UNESCO	The United Nations Educational, Scientific and Cultural Organisation
UNFPA	The United Nations Population Fund
UNICEF	The United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
WB	The World Bank Group
WFP	The United Nations World Food Programme
WHO	The World Health Organisation

Term	Definition
Anti-retroviral therapies	Drug therapies which suppress HIV, maintain the integrity of the immune system and delay the development of opportunistic infections.
Bilateral aid	Aid provided either, a) for use in a specific country and directed to the government or organisations carrying out an aid function within that country, or b) to institutions, normally based in Britain, working in fields related to international development.
Harm reduction	Activities to reduce the negative consequences to individuals and communities of drug use.
Impact mitigation	Activities undertaken to reduce the effect of HIV/AIDS on individuals and societies affected by HIV/AIDS.
Multilateral aid	Aid channelled via an international agency where DFID does not have direct control over the use and final destination of the funds.
Opportunistic infection	An infection which takes hold when an individual's immune system has been weakened.

Reports by the Comptroller and Auditor General, Session 2003-2004

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Culture, Media & Sport		
Income generated by the Museums and Galleries	HC 235	30 January 2004
The National Endowment for Science, Technology and the Arts	HC 267	25 February 2004
The Royal Parks - An Executive Agency	HC 485	2 April 2004
Cross-government		
Managing resources to deliver better public services - Report	HC 61-I	12 December 2003
- Case studies	HC 61-II	12 December 2003
Increased resources to improve public services: a progress report on departments' preparations	HC 234	28 January 2004
Improving Procurement: Progress by the Office of Government Commerce in improving departments' capability to procure cost-effectively - Report	HC 361-I	12 March 2004
- Case Studies and International Comparisons	HC 361-II	12 March 2004
Defence		
Operation TELIC - United Kingdom Military Operations in Iraq	HC 60	11 December 2003
Major Projects Report 2003	HC 195	23 January 2004
The Management of Defence Research and Technology	HC 360	10 March 2004
Battlefield Helicopters	HC 486	7 April 2004
Education		
Early Years: Progress in developing high quality childcare and early education accessible to all	HC 268	27 February 2004
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English Regions		
Success in the Regions	HC 1268	19 November 2003
An early progress report on the New Deal for Communities programme	HC 309	11 February 2004
Environment, Food and Fisheries		
The UK Emissions Trading Scheme: A New Way to Combat Climate Change	HC 517	21 April 2004
Europe		
Financial management of the European Union: A progress report	HC 529	6 May 2004
Law, Order & Central Institutions		
Youth Offending: The delivery of community and custodial sentences	HC 190	21 January 2004
Criminal Records Bureau: Delivering Safer Recruitment	HC 266	12 February 2004
The Drug Treatment and Testing Order: early lessons	HC 366	26 March 2004
Health and Safety Executive: Improving health and safety in the construction industry	HC 531	12 May 2004
The Management of Sickness Absence in the Prison Service	HC 533	19 May 2004
Asylum and migration: a review of Home Office statistics	HC 625	25 May 2004
Visa Entry to the United Kingdom: The Entry Clearance Operation	HC 367	17 June 2004

		Publication date
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Tackling cancer in England: saving more lives	HC 364	19 March 2004
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Department for International Development: Responding to HIV/AIDS	HC 664	18 June 2004
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The Recovery of Debt by the Inland Revenue	HC 363	24 March 2004
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