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UK AIDS AID

An analysis of DFID HIV/AIDS expenditure

Summary

Whilst NGOs and advocates want a clear baseline on which to campaign for more funding for HIV/AIDS, DFID's systems have not historically provided one. This report collates available evidence to determine how much the UK government is currently spending on HIV/AIDS in developing countries and countries in transition. It points out that a desire to see HIV/AIDS mainstreamed within development work is inconsistent with a desire for clear vertical budget lines. It makes recommendations for future campaign demands and for DFID's statements on its spending.

Executive summary

The level of resources committed to the fight against HIV/AIDS is of great importance to the donor community, people in developing countries and advocates in the UK. This paper collates available information to review the UK government's expenditure on HIV/AIDS through its Department for International Development (DFID).

It is clear that DFID's spending has increased dramatically since 1997, placing it as the second largest bilateral donor of funding for HIV/AIDS work. However, DFID's expenditure systems do not currently provide a single accurate source of more detailed HIV/AIDS expenditure information. Among the reasons for this are different methods of calculating and reporting bilateral and multilateral funding, overlaps with reproductive health work, and integration of HIV/AIDS work into non-health sectors; mainstreaming HIV/AIDS within DFID's wider development work is incompatible with the desire to see clear vertical budget lines.

From available information, the report identifies:

Bilateral spend

Bilateral expenditure on HIV/AIDS in 2002/2003 was at least £132m and up to £286m:

- Health Sector expenditure on reproductive health multi-sectoral responses to HIV/AIDS was less than £93m.
- Expenditure through UK based CSOs with a primary focus on sexual and reproductive health and/or HIV/AIDS was at least £16m.
- £265m of HIV/AIDS programming is planned or ongoing
- Just under £131m of aid had HIV/AIDS as a principal objective.
- About 45% of HIV/AIDS aid was spent in Sub-Saharan Africa.

Multilateral spend

Multilateral expenditure on HIV/AIDS in 2002/2003 was between £63m and £169m:

- Between £22m and £127m was channelled through multilateral agencies.
- Just over £41m was contributed to the Global Fund to Fight AIDS, TB and Malaria

Total Spend

Adding multilateral and bilateral spend suggests that DFID's total expenditure for 2002/03 is likely to be between £195m and £455m. The actual 2002/2003 HIV/AIDS related expenditure figure reported by DFID is £274m, not including their contribution to the Global Fund or to the WHO.

Key recommendations

- Greater clarity from DFID in reporting of its HIV/AIDS commitments and expenditure.
- That DFID recognize the value and need for horizontal *and* vertical funding mechanisms.
- That DFID endeavour to increase the power of its reporting systems.
- That UK CSOs accept limitations of expenditure reporting resulting from mainstreaming and increased funding for integrated projects.
- That UK CSOs attempt to quantify their own HIV/AIDS expenditure.
- That UK CSOs call for increased funding to support mainstreaming, integrated projects and focused interventions.

Introduction

Despite the unprecedented loss of life, millions orphaned, and potential destabilisation of entire regions, only a fraction of the need for resources to fight HIV/AIDS in developing countries is being met. UNAIDS has estimated that the total cost for prevention, care and support programs in low and middle income countries will rise to US$10.5 billion by the year 2005 and US$15 billion only two years later.[1] Current estimated annual global HIV/AIDS funding from all sources (private, national and international) stands at US$4.7 billion.[2] When taken into account that in many countries the bulk of HIV/AIDS expenditure comes directly from the pockets of infected individuals themselves, it is clear that current funding levels are grossly inadequate.[3,4]

In the UK, the desire to see increased levels of HIV/AIDS funding has translated into campaigns such as the Stop AIDS Campaign, calling, in 2002, for US$1 billion from the UK Government for HIV/AIDS work in developing countries. As part of the wider 0.7% campaign, ActionAid called for greater amounts of funding to be allocated to the fight against AIDS in developing countries. To launch effective and targeted campaigns that advocate for increased HIV/AIDS expenditure, however, requires an understanding of existing expenditure levels and allocation of such expenditure by geographic region and type of activity/programme.

The importance of financial monitoring to estimate the total amount and budgetary proportion of HIV/AIDS spending can be underscored for at least three reasons. Firstly, financial monitoring allows for greater transparency and accountability to aid-recipient countries, to domestic oversight bodies (e.g. Parliament) and to the public. Secondly, financial monitoring helps to assess if there is sufficient HIV/AIDS expenditure and if that expenditure is appropriately targeted both to countries with the greatest need and to interventions that are likely to be most effective. This would show whether the costs of tackling HIV/AIDS are being appropriately shared and targeted. Finally, it is important for evaluation; without a clear picture of what is being spent on HIV/AIDS it is impossible to know whether expenditure is having an impact.[5]

Although the need for financial monitoring is clear, the actual process itself is problematic. Two of the main challenges to identifying levels of HIV/AIDS expenditure, both in donor and recipient countries, are posed by the lack of clear HIV/AIDS budget lines within national budgets and the mainstreaming of HIV/AIDS work within wider programme areas such as health, education, and poverty reduction. Donors are also increasingly shifting from more easily tracked project based funding to providing funding through direct budget support (DBS) and sector wide approaches (SWAPs). Funds through DBS go directly into the central budgets of recipient governments and are fungible in that such funding can be spent in any sector. Funds for SWAPs are for a known sector and involve more than one donor contributing funds to a common pool. UNAIDS has highlighted the challenge these issues present to the future monitoring of international and national trends in HIV/AIDS expenditure.[6]

Financial monitoring of HIV/AIDS expenditure by the UK Department for International Development (DFID) is constrained by these same problems. DFID expenditure tracking is complicated by the increased amounts of DFID funding channelled through partnership-programme agreements (PPAs) and direct budget support, [7] and by limitations in DFID's expenditure reporting systems. Despite these limitations, ActionAid believes it is a worthwhile exercise to attempt to review DFID HIV/AIDS expenditure in developing countries and countries in transition, and in particular examine from available data:

1. The annual volume of DFID expenditure on HIV/AIDS in developing countries;
2. The proportion of DFID expenditure on HIV/AIDS allocated by channel (i.e. bilateral or multilateral);
3. The allocation of DFID expenditure on HIV/AIDS by country and region;
4. The proportion of DFID expenditure on: a) prevention; b) treatment & care; and, c) impact mitigation activities and, where possible, a further breakdown of the type of impact mitigation activities; and
5. The proportion of expenditure on HIV/AIDS-specific work and the proportion of expenditure used to integrate HIV/AIDS into existing programmes.

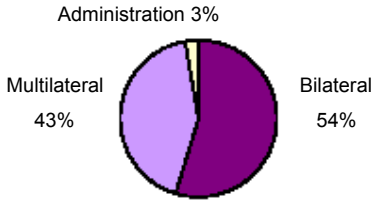
DFID aid instruments and extended PIMS

The main published sources of DFID expenditure data are:

- DFID publications such as its annual *Statistics on International Development* (SID) and *Departmental Report*;
- Development Assistance Committee (DAC) of the OECD publications such as the annual DAC Journal *Development Cooperation Report*; and
- UK Parliamentary Questions.

All DFID official development assistance expenditure in developing countries, including HIV/AIDS expenditure, can be broadly classified as bilateral expenditure, multilateral expenditure, or administrative costs. Bilateral aid is funding "provided to developing countries and countries in transition (those on Part I and II of the DAC list) on a country-to-country basis, and to institutions, normally in Britain, working in fields related to these countries."[8] In other words, the destination of bilateral aid is known as is the intended use of the aid, unlike the more difficult to track multilateral aid, which is "aid channelled through international bodies for use in or on behalf of aid recipient countries."[9] The proportion of aid channelled through each of these channels in 2002/2003 is shown in Figure 1 below.

Figure 1: DFID Aid expenditure by channel in 2002/2003[10]



Two relatively new forms of channelling funding are through PPAs and DBS. PPAs are strategic agreements typically lasting 3-5 years whereby DFID provides funding to UK based civil society organisations (CSOs) for work related to achievement of the Millennium Development

Goals (MDGs). Direct budget support is "funds provided to a partner government to spend using its own financial management and accountability systems."[11] In 2002/2003 just over 3% of DFID's bilateral programme of aid to developing countries and countries in transition was channelled through PPAs while around 10% was channelled through DBS.[12]

An important tool for DFID expenditure accounting is the Extended Policy Information Marker System (PIMS). First introduced in 1993, PIMS measures "the extent to which DFID's projects and programmes are being targeted on key policy areas," with the aim of improving accountability, informing policy debate, monitoring and aid management, and assisting project design.[13] The recently revised system continues to apply to all bilateral commitments with a value of over £100,000. Each eligible programme or project is categorised by which MDG based DFID policy area(s) the work is specific to. Whether the project or programme targets the policy area as a principal or significant objective must also be specified. A principal objective is "fundamental to the design of a programme or project, without which it would not be undertaken," while significant objectives are those which "although important, are not one of the primary reasons for undertaking the activity."[14] The main limitation of PIMS is that if markers are added together, HIV/AIDS expenditure figures become inflated as the same expenditure can be recorded under a range of different objectives.

Sector codes measure the physical inputs into a project or programme. Expenditure recorded through sector codes is more specific than that recorded in PIMS as it usually is representative of minimum expenditure levels. A more detailed explanation of PIMS and sector codes can be found in DFID's 2003 publication *Project Header Sheet Guidance: incorporating Input Sector Codes and Policy Information Marker System*.

With this background on DFID aid instruments and PIMS, we now move to an analysis of DFID HIV/AIDS expenditure.

Analysis

The following analysis of DFID HIV/AIDS expenditure first examines bilateral expenditure and then reviews expenditure through multilateral channels. Bilateral expenditure is further categorised by the source as either PIMS data or input sector code data. Quantifying DFID bilateral HIV/AIDS expenditure is a difficult task further confused by the fact that data sets from different sources may seem to conflict with each other.

A. Bilateral Expenditure

1. Input Sector Code Data

In the 2002 edition of *Statistics on International Development*, HIV/AIDS expenditure is embedded within Health and Population Sector spending. This is a reflection of DFID historically grouping HIV/AIDS work within reproductive health. The limitation of examining HIV/AIDS expenditure by health sector is that not all HIV/AIDS spending will be captured. This is in part due to the mainstreaming of HIV/AIDS work and also because some bilateral aid, such as expenditure on humanitarian assistance, cannot be allocated by sector. In 2002/2003 just under 7% of total DFID bilateral aid is

unallocable[15] whereas according to last year's SID, 56% of DFID bilateral expenditure in 2001/2002 was unallocable.[16] Also there is health expenditure in other sectors such as education sector that would not be reported in health sector expenditure as well. The 2003 edition of SID, unlike its predecessors, shows a breakdown of expenditure within the Health and Population Sector noting reproductive health expenditure. More importantly it takes into account the crosscutting nature of HIV/AIDS work and now lists multisectoral response to HIV/AIDS as an expenditure area. This is shown in Table 1.

Table 1: DFID Health Sector Bilateral Aid Expenditure[17]

Health Sector	Expenditure (£000)				
	1998/ 1999	1999/ 2000	2000/ 2001	2001/ 2002	2002/ 2003
Multi-sectoral Response HIV/AIDS (incl. STD control)	13,113	15,358	15,187	25,970	50,789
Repro. Health (incl. family planning)	32,386	35,775	41,255	37,739	41,222
Total	**45,499**	**51,133**	**56,442**	**63,709**	**92,011**

From Table 1 only a crude conclusion can be drawn about HIV/AIDS expenditure as such work forms just one part of sexual and reproductive health expenditure. **From Table 1 it can be concluded that total bilateral HIV/AIDS expenditure within these two categories was likely less than £93m.**

New in the 2003 edition of SID is a listing of expenditure in Table 1 broken down by region. In previous editions of SID, only total health expenditure was given by region rather than the more detailed breakdown shown in Table 2.

Table 2: DFID Programme: Bilateral Aid for Multisectoral Response HIV/AIDS and Reproductive Health by Region for 2002/2003[18]

Region	Expenditure (£000)	
	Multisectoral Response HIV/AIDS	Reproductive Health
Africa	26,136	18,399
America	14,441	1,592
Asia	2,222	10,752
Europe	854	-
Pacific	25	-
Total	**50,789**	**41,222**

From this table it can be calculated that 48% of the just over £92m (not all of which can be allocated by region) DFID bilateral aid expenditure on multisectoral responses to HIV/AIDS and reproductive health was spent in Africa in 2002/2003.

Examining DFID expenditure through UK-based CSOs that have a primary focus on sexual and reproductive health and/or HIV/AIDS may give an additional snapshot. These totals are shown in Table 3 and are counted under Grants and Other Aid in Kind in SID.

Table 3: DFID expenditure through International Planned Parenthood Federation (IPPF) and UK-based CSOs with a primary focus on sexual and reproductive health and/or HIV/AIDS[19]

Recipient	Expenditure (£000)					
	1997/ 1998	1998/ 1999	1999/ 2000	2000/ 2001	2001/ 2002	2002/ 2003[20]
International Planned Parenthood Federation	5,850	5,500	5,500	5,500	4,500	4,500
Marie Stopes International	3,103	4,235	4,945	5,132	2,554	2,979
International Family Health	1,175	1,151	773	508	628	477[21]
Population Services International	Not given				3,023[22]	4,472
Population Concern	400	114	649	-	476	484[23]
Plan International	Not given					1,847
International HIV/AIDS Alliance	Not given					1,585
Total	**10,528**	**11,000**	**11,867**	**11,140**	**11,181**	**16,344**

Though organisations listed in Table 3 do not limit their work to only HIV/AIDS, Table 3 also does not take into account reproductive health and HIV/AIDS specific expenditure through other UK based CSOs that may engage in such work as only one of their programme areas. **Therefore, it can be concluded that bilateral HIV/AIDS expenditure in 2002/2003 through UK based CSOs was at least £16m.**

2. PIMS Data

SID 2003 also lists HIV/AIDS expenditure commitments mapped in Extended PIMS. Commitment data is given in Table 4 for both projects where combating HIV/AIDS is a principal objective and where it is a significant objective. The degree to which mainstreaming of HIV/AIDS work is successful would be indicated by PIMS bilateral commitments with HIV/AIDS as the significant objective increasing over time.

Table 4: HIV/AIDS PIMS Bilateral Commitments 1998/1999 to 2002/2003[24]

HIV/AIDS Objective	PIMS Bilateral Commitments (£m)				
	1998/ 1999	1999/ 2000	2000/ 2001	2001/ 2002	2002/ 2003[25]
Principal	65.3	66.0	49.4	230.0	265.0
Significant	90.6	138.9	367.1	164.4	33.4
Total	**155.9**	**204.9**	**416.5**	**394.4**	**298.4**

The more pertinent HIV/AIDS commitments data is that with HIV/AIDS as the principal objective. **As committed expenditure cannot be equated with actual expenditure, the conclusion that should be drawn from this table is that in 2002/2003, at least £265m worth of HIV/AIDS programming was planned or ongoing.**

The *expenditure* data provided to MPs during parliamentary sessions often seems to be conflicting as expenditure for the same year can be reported in many different ways. Data shown in Tables 5 and 7 has been extracted from responses to Parliamentary Questions given by Ministers.

Table 5: Estimated range for DFID PIMS Marked (Principal and Significant) Reproductive Health Care, Family Planning and STD control expenditure (including HIV/AIDS).

Reproductive Health, Family Planning and STD Control	PIMS Bilateral Expenditure (£m)				
	1997/ 1998	1998/ 1999	1999/ 2000	2000/ 2001	2001/ 2002
Principal	38.4[a]	45.0[a]	50.5[b]	55.6[b]	62.2[b]
Significant	46.2[b]	45.5[b]	75.5[7a]	124.9[a]	206.6[a]
Total	**84.6**	**90.5**	**126.2**	**180.5**	**268.8**

This table suggests that bilateral HIV/AIDS expenditure under reproductive health care, family planning and STD control in 2001/2002 was a proportion of £63m. This reflects commitments made in earlier years (shown in Table 4).

According to DFID, Table 5 cannot be updated with data for 2002/2003. Instead, the data in Table 6 was provided listing bilateral expenditure marked specifically against the PIMS HIV/AIDS marker.

Table 6: HIV/AIDS PIMS Bilateral Expenditure 1998/1999 to 2002/2003[26]

HIV/AIDS Objective	PIMS Bilateral Expenditure (£m)					
	1997/ 1998	1998/ 1999	1999/ 2000	2000/ 2001	2001/ 2002	2002/ 2003
Principal	20.2	22.3	24.8	27.6	34.5	131.7
Significant	18.2	19.2	31.4	141.3	127.6	136.3
Total	**38.4**	**41.5**	**56.2**	**168.9**	**162.1**	**268.0**

[a] Written answers to questions, UK Parliament. Reply of Clare Short to a question from Chris McCafferty on 15 October 2002.
[b] Written answers to questions, UK Parliament. Reply of Hilary Benn to a question from Mrs. Spelman on 11 April 2002.

Taking the figure for expenditure with HIV/AIDS as a principal objective, and given that some expenditure marked against the reproductive health marker could be seen as HIV/AIDS expenditure as well, **DFID bilateral HIV/AIDS expenditure in 2002/2003 was at least £132m based on Table 6.**

Table 7 shows region specific data presented to parliament on 23 July 2002. These figures exclude regional HIV/AIDS activities and non-region specific work on HIV/AIDS.

Table 7: HIV/AIDS Expenditure by Region[27]

Region	Expenditure (£000)				
	1997/ 1998	1998/ 1999	1999/ 2000	2000/ 2001	2001/ 2002
Sub-Saharan Africa	19,603	22,664	26,692	73,137	129,006
South, South-East and East Asia	7,194	13,869	26,264	39,144	38,032
Europe and Central Asia	0	67	4,125	1,194	1,492
North Africa and the Middle East	0	99	457	1,128	1,027
Latin America and Caribbean	1,051	955	1,630	2,412	2,965
Other	0	33	256	300	424
Total	**27,848**	**37,687**	**59,424**	**117,315**	**172,946**

According to this table, HIV/AIDS bilateral expenditure in 2001/2002 was almost £173m.

The largest proportion of this was (75%) spent in Sub-Saharan Africa.

DFID provided Table 8 as an update to Table 7 but the two cannot be directly compared as the regions are categorised differently.

Table 8: HIV/AIDS Expenditure by Region in 2002/2003[28]

Region	Expenditure (£000)
Europe: Central and Eastern Europe	4,042
Europe: Other	18
Africa: South of the Sahara	128,384
Africa: Unspecified	1,579
America: North & Central	1,932
America: South	2,033
Asia: Middle East	303
Asia: South & Central	42,475
Asia: Far East	10,155
Asia: Unspecified	1,483
Oceania	32
World Unallocated	92,905
Total	**285,341**

It should be noted that this table does not include regional expenditure through multilateral organisations. **From this table, bilateral HIV/AIDS expenditure in 2002/2003 amounted to just over £285m of which 45% was spent in Sub-Saharan Africa.**

3. Comparisons between donors

DAC data is useful in the sense that it allows direct comparison between donors aid programmes and priorities. The Development Cooperation Report does not, however, provide the same level of detail in the relevant areas as do the other expenditure data sources that are included in this analysis. One interesting statistic worth noting in the DAC 2002 report is UK bilateral commitments in Population and Reproductive Health as a percent of total bilateral spending. This data is shown in Table 9 below for the top five net overseas development assistance donors (in descending order).

Table 9: Bilateral Population and Reproductive Health Commitments in 2001[29]

DAC Member	Percent of Bilateral Total	
1. United States	8.5	**DAC Member Average** 2.7
2. Japan	0.1	
3. Germany	1.4	
4. United Kingdom	2.2	
5. France	0.3	

In 2001, 2.2% of total UK bilateral spending was allocated to population and reproductive health work. Although underreporting is likely as DAC reporting only allows a project to be counted in one sector and therefore misses secondary spending. Furthermore, these figures do not include funding through PPAs or DBS. What cannot be overlooked however is that the UK 2.2% is lower than the DAC member average of 2.7%. Also it is significantly less than the United States, the highest proportional spender in this area, at 8.5%.

Specific Bilateral HIV/AIDS Initiatives

- DFID has committed £14 million to the International AIDS Vaccine Initiative (IAVI) over a period of five years. £1.5m of this total was contributed in 2001/02 and £2.25m is planned as a contribution in 2002/2003.[30]
- DFID has committed £16 million over five years to research into the development of

vaginal microbicides, in collaboration with the Medical Research Council and institutions in South Africa, Tanzania, Uganda, Cameroon, Zambia and the UK[31]. Expenditure on this initiative is counted under Knowledge and Research in SID.

- DFID has committed £22.5m to ActionAid over three years (2002-2005) for the Support to the International Partnership Against AIDS in Africa (SIPAA) programme. In 2002/2003, expenditure through this initiative totalled just over £2.6m.

Bilateral expenditure summary

Based on the analysis above, arriving at a single figure for DFID bilateral HIV/AIDS expenditure is complicated. Table 10 shows the conclusions reached thus far.

Table 10: DFID Bilateral HIV/AIDS Expenditure

Bilateral Expenditure 2002/2003		
		Notes
1. Multisectoral responses to HIV/AIDS (Table 1)	Less than £51m	Expenditure data
2. Reproductive Health (Table 1)	Less than £42m	Expenditure data (of which 45% in Africa)
3. UK CSOs (Table 3)	At least £16m	Expenditure data
4. HIV/AIDS Objective (Table 4)	At least £265m planned or ongoing	Commitment data
5. HIV/AIDS Objective (Table 6)	At least £132m	Expenditure data
6. Regional (Table 8)	Less than £286m	Expenditure data

Expenditures 1 and 2 are from the same table and must be counted together (£93m). Given this and that expenditure 3 is likely counted elsewhere and that 4 is commitment data rather than expenditure data this leaves 5 and 6 as the highest and lowest estimates of bilateral expenditure. **In other words, estimated DFID bilateral expenditure on HIV/AIDS in 2002/2003 could have been as low as £132m or as high as £286m.**

B. Multilateral Expenditure

With respect to multilateral expenditure on HIV/AIDS, DFID notes that it is next to impossible to determine the portion of its contributions used for HIV/AIDS work, as multilateral expenditure is not allocated by sector. Multilateral expenditure on HIV/AIDS is perhaps more easily quantifiable with multilaterals involved in reproductive health work and in particular those that have a narrower scope of work such as the UNAIDS Secretariat. Table 11 shows DFID contributions to the five UN programmes and funds that are expected to have the highest expenditure on HIV/AIDS from 2001-05.[32] Contributions to the World Bank, currently the largest funder of HIV/AIDS work, are also shown along with contributions to the European Community (EC).

Table 11: Total DFID Funding to Multilateral Agencies[33]

Recipient	Expenditure (£000)					
	1997/ 1998[34]	1998/ 1999	1999/ 2000	2000/ 2001	2001/ 2002	2002/ 2003
EC	543,262	735,086	739,318	699,845	723,505	851,421
WORLD BANK	189,851	175,254	170,277	276,653	246,672	247,617
UNDP	-	30,850	35,960	41,918	39,826	43,434
UNICEF	9,241	10,461	29,143	2,619	17,500	17,366
WHO	12,099	8,091	20,300	75,110	41,348	34,156
UNFPA	11,500	13,120	15,000	40,050	24,213	9,000
UNAIDS Secretariat	2,300	2,750	3,000	3,000	3,052	3,052
Total	**768,253**	**975,612**	**1,102,998**	**1,139,195**	**1,096,116**	**1,206,046**

From this table it can be concluded that in 2002/2003 total DFID multilateral expenditure was about £1.2bn. As only the contribution to UNAIDS is clearly for HIV/AIDS work, it follows that total DFID HIV/AIDS expenditure through multilateral organisations must be lower. For example, of total EC and World Bank monies in 2001, only 1.8% and 1.6% respectively was reported as financing HIV/AIDS work.[35] A crude application of these percentages to the 2002/2003 figures for DFID contributions to the EC and the World Bank, counting other contributions as 100% HIV/AIDS expenditure, arrives at an adjusted maximum expenditure £127m. Applying the same percentages to the World Bank and EC contributions and only adding the UNAIDS contribution gives a minimum HIV/AIDS expenditure of £22m. From these calculations, it would appear that DFID HIV/AIDS expenditure through multilateral organisations in 2002/2003 was at least £22m and up to £127m.

DFID is also a contributor to the Global Fund to Fight AIDS, TB and Malaria. UK contributions to the Global Fund can be tracked on the Global Fund website and are shown in Table 11 below.

Table 11: Amounts pledged and contributed to the GFATM as of 28/10/03[36]

Year	Global Fund to Fight AIDS, TB and Malaria	
	Contribution (USD)	Pledge (USD)
2001/2002	78,215,278	78,215,278
2003	40,032,750	40,032,750
2004	-	49,751,244
2005	-	54,726,368
Pledge period to be determined		80,000,000
Total	**118,248,048**	**302,725,640**

Source: Global Fund website at http://www.globalfundatm.org

The Global Fund website specifically puts HIV/AIDS expenditure as 60% of total Global Fund expenditure.[37] Applying this percentage to DFID's contribution of just over US$115m (or £69m) in 2001-2003, **leaves £41.4m spent on HIV/AIDS work by DFID through its contributions to the Global Fund**.

Specific Multilateral HIV/AIDS Initiatives:

- As part of its contributions to WHO, DFID supports the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in

Human Reproduction (HRP). In 1999/2000, £1m was contributed to this initiative.

Multilateral expenditure summary

A summary of DFID multilateral expenditure on HIV/AIDS is shown in Table 13 below.

Table 13: DFID HIV/AIDS Expenditure through multilateral agencies/initiatives in 2002/2003

Expenditure (£m)	
Multilateral Agencies	Between £22m and £127m
Global Fund	£41.4m
Total	**Between £63m and £169m**

Total DFID HIV/AIDS expenditure (bilateral and multilateral) summary

Finally, in order to answer our original question, bilateral and multilateral expenditure is combined in Table 14.

Table 14: Total DFID HIV/AIDS Expenditure

Expenditure (£m)		
Bilateral	132 (low)	286 (high)
Multilateral	63 (low)	169 (high)
Total	**195**	**455**

Adding bilateral and multilateral expenditure gives a total DFID HIV/AIDS expenditure in 2002/2003 in the range of £195m to £455m.

Specific expenditure questions

After reviewing the major sources of DFID expenditure data we return to our original five questions and attempt to answer them.

1. The Annual Volumes of DFID Expenditure on HIV/AIDS in developing countries

Based on Tables 1-14 above, DFID bilateral expenditure on HIV/AIDS work in 2002/2003 was between £132m and £286m while multilateral expenditure was between £63m and £169m. Total DFID expenditure was therefore between £195m and £455m. Notably, DFID HIV/AIDS commitments and expenditure have increased exponentially since 1997/1998.

2. Proportion of HIV/AIDS Allocations by Channel

This is not a measure that is found in SID. As there is a range for bilateral, multilateral and therefore total HIV/AIDS expenditure, several possible proportions exist. As such, it is difficult to give even a crude estimate of the proportion of HIV/AIDS allocations by channel through using the figures in question 1 above. Two allocation scenarios, as an illustrative example, are shown in Table 15.

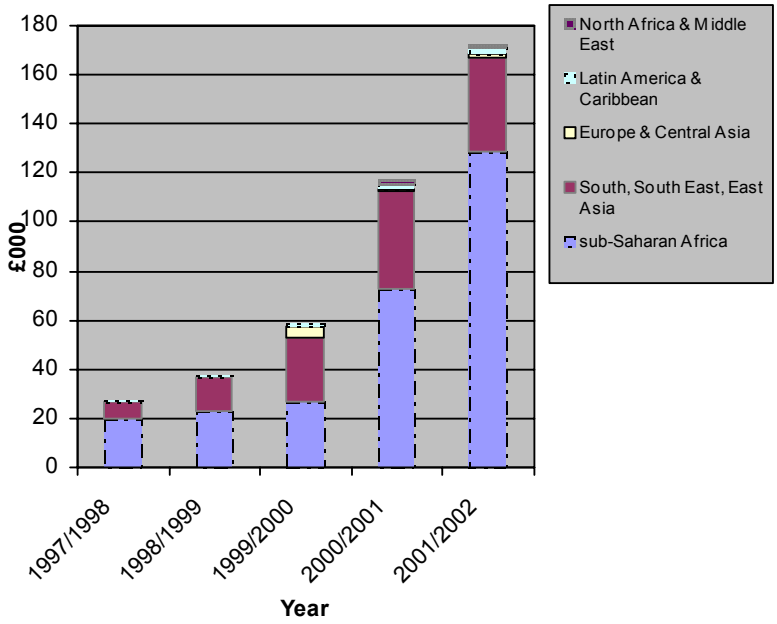
Table 15: Proportion of HIV/AIDS Allocations by Channel

Total Expenditure (£m)	Expenditure Proportion	
	Bilateral	**Multilateral**
£195 (Low)	132/195 = 68%	63/195= 32%
£455 (High)	286/455 = 63%	169/455 = 37%

3. Bilateral Regional and Intra-regional HIV/AIDS Allocation

Just under £286m was spent on HIV/AIDS according to the regional breakdown shown in Table 7. However, to analyse expenditure trends Table 8 can be used and be presented graphically as is done in Figure 2.

Figure 2: DFID HIV/AIDS Expenditure by Region 1997-2002

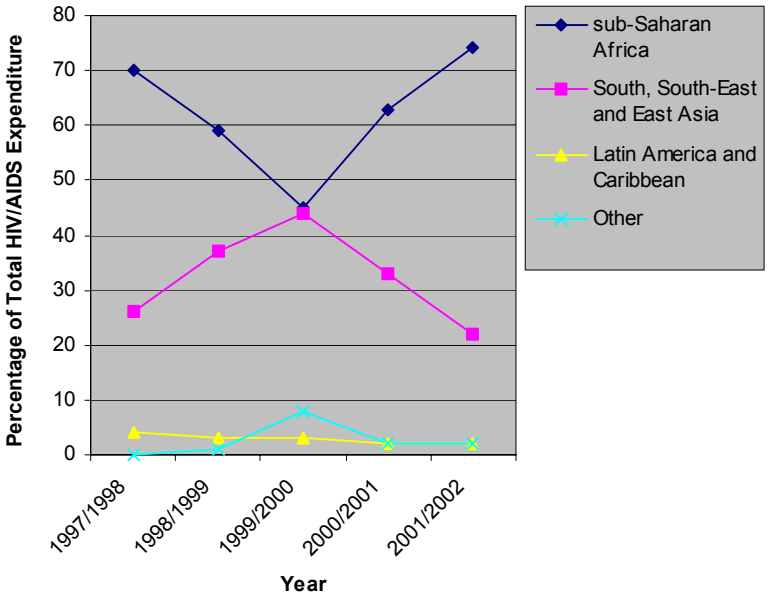


The following regional trends are reflected in this figure:

- DFID support for HIV/AIDS work in sub-Saharan Africa has increased substantially since the year 2000;
- Support for HIV/AIDS work in South, South East and East Asia has increased consistently until 2000/2001, after which it dropped slightly;
- After a slight drop in 1998/1999, Latin America and the Caribbean have seen a consistent increase in DFID funding for HIV/AIDS work; and
- DFID HIV/AIDS expenditure in Europe and Central Asia peaked in 1999/00, after which it dropped to less than a third.

However, if we compare total DFID expenditure by region to the proportion of HIV/AIDS funds each region has received over time, the picture changes substantially. For example, although the volume of HIV/AIDS expenditure to Africa increased annually from almost £20 million in 1997/98 to £129 million in 2001/02, the proportion of DFID HIV/AIDS expenditure going to the region declined from 70% in 1997/98 to 45% in 1999/00, after which it increased again to 63% in 2000/01 and 74% in 2001/02.[38] This is shown graphically in Figure 3.

Figure 3: Proportion of DFID HIV/AIDS Expenditure by Region



4. Allocations According to Types of HIV/AIDS Activities

Based on current information provided by DFID it is impossible to review how much money is spent on prevention, treatment/care or impact mitigation activities as the data are not collected in this manner. Thus, it is also not possible to assess whether there may be a different emphasis in different regions or countries (e.g. Asia more prevention-oriented, Africa more on treatment/care and impact mitigation). DFID does not at present collect expenditure reports at this level and report that to do so would be too labour intensive and therefore not a cost-effective undertaking.[39]

5. Proportion of HIV/AIDS Specific Expenditure and Proportion of Expenditure Used to Integrate HIV/AIDS into Existing Work

Expenditure used to integrate HIV/AIDS into existing work cannot be determined at present and is not a figure that will be available in the foreseeable future.

Discussion

It is only through further consultation with the Statistical Reporting and Support Group at DFID, that one can begin to understand the reasons for the discrepancies between and difficulties with reported DFID expenditure figures. The Group themselves give total spending on HIV/AIDS and Reproductive Health in 2002/03 as being £336m, which falls

in the middle of the estimated expenditure range arrived at through the preceding analysis.[40] This figure includes a £50m contribution to the Global Fund (over 2001-2003) and £12m to the WHO. As both the contributions to the Global Fund and the contribution to the WHO are not true bilateral expenditure, this leaves £274m as DFID bilateral HIV/AIDS and reproductive health spending in developing countries and countries in transition in 2002/03. This is the figure that has been given in recent answers to parliamentary questions.

When interpreting reported expenditure by DFID, one must consider the following:

- **That DFID reports both expenditure and commitments**. It is necessary to keep this in mind as commitments figures can be significantly different than expenditure figures though must balance out with expenditure over time.
- **That figures reported to DAC are based on the calendar year and report total UK expenditure while DFID reports are based on the UK fiscal year (April – March) and report only DFID spending.** DAC figures are constrained by the need to make comparisons between countries. DFID internal figures can be more reliable and capture more complexity, particularly since revision of the extended PIMS.
- **The difference between HIV/AIDS expenditure totals where HIV/AIDS is a principal component and where it is only a significant component.** The PIMS system is an all-or-nothing system. In projects where combating HIV/AIDS is a significant objective, even if HIV/AIDS only comprises 5% of the project, the total value of the project will be counted towards HIV/AIDS expenditure. This leads to potential overestimation of DFID expenditure. For this reason, expenditure data where HIV/AIDS is principal objective is more reliable.
- **That figures reported in parliamentary questions as HIV/AIDS expenditure or commitments most often include funding to sexual and reproductive health activities.** A distinction is not made between the two areas of funding owing to the overlapping nature of the work involved.

Although DFID now has a relatively comprehensive and accurate system of expenditure monitoring and reporting, most available expenditure data is still based on older classification systems. These systems had serious limitations including:

- **That each project could only be given one sector code.** That meant, that until recently, all HIV/AIDS spending was counted under the health and population sector even if the outcomes were not health outcomes. For example, an HIV/AIDS prevention project could either be classified as education or as health but not as both.
- **That all HIV/AIDS expenditure was seen as part of reproductive health expenditure and as such counted as health expenditure.**
- **That budget support could not be quantified at all.** Direct budget support has been included in unallocated expenditure in

the past though now it is PIMS marked and can be coded by sector.

- **That PIMS takes into account only those projects over £100,000.** Commitments valued under £100,000 account for about 50% of projects by number though less than 3% in value.[41] Consequentially, the system cannot track small-scale efforts and trends in HIV/AIDS spending amongst grassroots organisations cannot be determined. Information on such expenditure would provide a useful comparison between the priorities of large international NGOs and their smaller community based counterparts. This limitation still exists in the revised PIMS.
- **That multilateral spending could not be allocated by sector.** Multilateral spending has historically not been recorded by sector however under the revised reporting system, allocation by sector can be recorded if known.[42]

In addition to these limitations, DFID's political decision to shift away from project-based funding will also prove problematic in the future with respect to expenditure tracking. Expenditure through UK based CSOs cannot be allocated by sector and with the introduction of PPAs a larger number of CSOs and greater overall expenditure through CSOs will be seen. Direct budget support often contributes to the achievement of multiple objectives and as such is difficult to measure against individual DFID policy objectives. With the revised reporting system DFID will be able to quantify direct budget support and provide a further breakdown of such expenditure. It is suggested that one way of doing this is to extrapolate from recipient country government budget allocations to specific sectors.

Whilst increased mainstreaming of HIV/AIDS work is a significant step forward, it is also a serious challenge to financial monitoring. Mainstreaming is the inclusion of HIV/AIDS activities as components in integrated programmes and projects that address a set of wider issues. Aid donors, including DFID, are channelling more and more funding through such integrated programming; however, it is difficult to approximate the proportion of such funding that is HIV/AIDS specific expenditure. The mainstreaming of HIV/AIDS into all policy areas also means that the decision over whether or not a project is an "HIV/AIDS" project will be increasingly subjective.

Despite these problems, overall the revised sector and PIMS will provide more detailed HIV/AIDS expenditure data. The new reporting system now has HIV as a crosscutting sector code. In addition to introducing this new code, the revised system allows for multiple sector coding. This means that mainstreamed and multi-sectoral nature of HIV/AIDS work can be taken into account in expenditure reporting. It is important to note that as expenditure tracking mechanisms improve and there is more concerted effort to establish expenditure figures, an artefactual increase in HIV/AIDS expenditure will likely be seen.

In identifying HIV/AIDS expenditure, it is useful to highlight the problems involved with the analysis of reproductive health and/or STI prevention and treatment data. There is much variation at the country level with respect to the programming and services that are included

under the umbrella of reproductive health. Reproductive health services have included, among other services, family planning including abortion, maternity care, cancer prevention, gynaecology, nutrition counselling, legal advice, HIV counselling and testing, STI prevention treatment and control, infertility services, violence against women/female genital mutilation, couples' relationship skill building, and services for high-risk groups. HIV/AIDS prevention, care and treatment is commonly placed within family planning programming and services which in turn are often integrated with reproductive health services. For these reasons, reproductive health care expenditure is a poor indicator of HIV/AIDS expenditure, as HIV/AIDS work comprises only one element of reproductive health care. Furthermore, STI treatment and prevention are also erroneously counted as HIV/AIDS expenditure. It is true that a portion of such services is HIV/AIDS specific but it is not correct to count total expenditure on such services as HIV/AIDS expenditure.[43]

Vertical vs. horizontal funding and implications for the Global Fund

The amounts of aid channelled through "vertical" or "horizontal" funding streams will also have implications for DFID expenditure reporting. Vertical programming has been criticised as being contrary to these broader goals, as such programming is seen by some to be difficult to integrate into country priorities and existing frameworks. Other critiques include that vertical initiatives are not sustainable, do not build country capacities, duplicate other efforts, neglect the broader health system, and disrupt negotiated health reform processes. The trend of channelling health related expenditure through horizontal mechanisms started during the 1990s with donors moving towards sector-wide approaches and DBS in an effort to build health infrastructure and promote the implementation of effective health policy. The strong and commendable push to mainstream HIV/AIDS work has complemented this trend.

The Global Fund to Fight AIDS, TB and Malaria, as a vertical funding mechanism, has been placed at the centre of this debate in the UK. Initially widely welcomed as a disease oriented and target driven mechanism with real potential of improving the lives of the poor, the Global Fund now faces the risk of decline and collapse. Future contributions and pledges to the Global Fund by the UK are in doubt as the Fund is criticised for some of the same above-mentioned problems with vertical funding mechanisms.

ActionAid recognises the limitations of the Global Fund though firmly believes that the Global Fund, and vertical programming as an aid modality, has its place in the fight against AIDS. AIDS continues to be a disease cloaked in stigma, the resolution of which is very much dependent on the prevailing political climate. The Global Fund has raised the profile of AIDS as a global emergency and has mobilized significant amounts of resources to address the epidemic. Furthermore, the Global Fund is one of the few examples of a transparent, democratic, and participatory funding mechanism in which developing countries have the power to set their own priorities. ActionAid agrees that health systems in many countries must be supported and that HIV/AIDS mainstreaming must continue in order to also fully take advantage of resources obtained through the Global Fund. These processes,

however, should be supported through horizontal programming. The nature of AIDS and the scale of the epidemic necessitate that funding for HIV/AIDS work be channelled through both vertical and horizontal programming that works in tandem to launch and support an effective, sustainable and coordinated response.

Recommendations

From this analysis the following key areas can be highlighted for attention:

- That there be greater clarity on the part of DFID with reporting of its activities. Within the existing tracking mechanisms it is important for DFID to be explicit about the nature of the figures it presents. More clarity in reporting is required, firstly, to ensure more consistent reporting and, secondly, to allow DFID to explain where there are justified reasons for the difficulties in isolating support for HIV/AIDS work;
- That DFID endeavour to increase the power of its expenditure reporting systems. This could be done by reviewing the practices and systems of other DAC members and by reviewing the national statistics of aid recipient countries on how DFID aid is received and used.
- That DFID recognize the value and need for both vertical and horizontal funding mechanisms and bodies;
- That DFID consider an audit of expenditure under £100,000 and ensure that its priorities reflect the objectives of work HIV/AIDS work being done at the grassroots level;
- That DFID work with the international community in the development of mechanisms to track HIV/AIDS expenditure within direct budget support. Having promoted the value of direct budget support, and moved towards this, it is necessary for DFID to help to develop mechanisms for tracking HIV/AIDS expenditure within this. In response to the need of many donor countries for such mechanisms UNAIDS plans to develop a methodology for such tracking;
- That UK based CSOs accept the limitations of DFID expenditure reporting that result from the mainstreaming process and increased funding for integrated projects. Mainstreaming allows for the scaling up of responses to the epidemic, addressing of the associated developmental impacts, and launching of effective multi-sectoral responses;
- That taking these limitations into account, CSOs campaigning on HIV/AIDS continue to call for increased funding to support HIV/AIDS mainstreaming, and funding channelled through integrated projects *as well as* focused interventions; and
- That CSOs attempt to quantify their own HIV/AIDS expenditure. CSO HIV/AIDS expenditure monitoring would support attempts by donor governments to quantify HIV/AIDS expenditure, which in turn would assist in the generation of meaningful and accurate global HIV/AIDS expenditure data.

Conclusion

Financial monitoring of HIV/AIDS expenditure is imperative to supporting the launch and evaluation of effective responses to the epidemic. From this analysis, it is clear that several challenges exist to the financial monitoring of HIV/AIDS expenditure not only at

the global level but at the national level as well. As evidenced by the analysis in this paper, limitations of DFID's expenditure accounting system do not allow for the easy retrieval of accurate expenditure data necessary to review whether or not enough expenditure in the area is sufficient and appropriately targeted.

Analysis of current DFID expenditure data shows that bilateral expenditure on HIV/AIDS in 2002/03 was at least £132m and up to £286m while multilateral expenditure was less than £169m, giving a total HIV/AIDS expenditure of between £195m and £455m in 2002/03. What is clear, however, is that DFID HIV/AIDS expenditure has increased substantially since 1997/1998 and this is to be commended.

In recognition of these limitations and the importance of such expenditure DFID is conducting an evaluation to quantify all HIV/AIDS spending over the past five years (1997-2002).[44] This study will attempt to capture funding by all mechanisms and will disaggregate funding both regionally and by activity. The UK National Audit Office also plans on producing a report analysing the DFID response to the AIDS epidemic. These studies will hopefully allow for more complete answers to the specific expenditure questions reviewed in this analysis.

These studies will not, however, address the challenges to HIV/AIDS expenditure monitoring posed by the mainstreaming of HIV/AIDS work and by changes in the way development assistance is provided. As more and more funding is allocated to integrated projects and direct budget support, HIV/AIDS spending will become increasingly difficult to track. Despite the problems in expenditure monitoring caused by these changes, it is important to note that these changes are representative of a growing knowledge base on effective HIV/AIDS programming and the move towards an improved and more comprehensive response to the epidemic. It is essential that DFID continue to work with the international community to respond to the call for improved financial monitoring. It is also essential that UK based NGOs support this process with the recognition that difficulties in HIV/AIDS expenditure monitoring are not exclusively the result of limitations in expenditure reporting systems, but an acceptable result of mainstreaming HIV/AIDS.

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