Alignment, harmonisation, and accountability in HIV/AIDS

The 2006 International AIDS Conference in Toronto, Canada, ended with a call for universal access for HIV prevention, and care and treatment for AIDS patients. This call marked the culmination of a year of debate and action on how best to achieve these goals following the commitment made by the G8 group of countries in September, 2005, to provide universal access. At the UN General Assembly's request, UNAIDS started several consultations convening thousands of people in more than 130 countries to identify the specific obstacles to scaling up, and to affirm their commitment to take the necessary steps towards universal access in 2010.[1]

As countries stand at the threshold of developing the responses needed for scale-up, they are confronted by two of the oldest challenges in international development: poor alignment of donor strategies with national efforts and poor harmonisation among donor procedures for aid management.[2] These challenges are particularly vexing in AIDS, because of the number and diversity of organisations that have stepped up to address the pandemic. Yet what has been almost completely absent from the many discussions about the universal access process is due acknowledgment of the necessity of alignment and harmonisation to realisation of the access goal.

Inadequate alignment and harmonisation are two critical obstacles that will affect the prospects of scaling-up. In the past 5 years, the number of partners at country level has proliferated. These partners have brought needed resources, but have largely opted for separate and independent approaches to supporting and delivering services in countries. As we seek to attract more resources for a scaled-up response, the numbers of participants and complexity of efforts will increase. Duplication of work and high transaction costs by individual agencies (associated with project-specific planning, supervision, fiduciary arrangements, and monitoring, and assessment), coupled with the absence of important learning exchanges, economies of scale, and synergies, are impeding the speed, quantity, and quality of the response.

These problems have not gone unnoticed. For example, the establishment of groups such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, with its successes in raising substantial sums in its first 5 years, indicate increased recognition of the value of collective action. To address the problem systematically, in June, 2005, the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (GTT) presented a series of recommendations and identified specific actions to improve alignment and harmonisation, building on the principles of the Three Ones. The Three Ones refers to three founding principles for coordinated response at the country level: one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all parties; one national AIDS coordinating authority, with a broad based multisector mandate; and one agreed country level monitoring and evaluation system.[3]

However, the scope for improvement remains vast and urgent. A report to the UNAIDS Board[4] in 2006 on the implementation of GTT recommendations reveals that more than 40% of national AIDS plans are not serving as the framework for contributions by donors. Half of the reporting countries noted low-to-moderate sharing of monitoring and assessment results by international partners, and joint programme reviews of both the government and donors remain rare. With more than 40% of national AIDS plans not evaluated for cost, budgeted, prioritised, or providing sufficient clarity on inputs and outputs, donors remain sceptical about alignment and harmonisation, preferring to engage more directly with countries.

Meaningful progress on alignment and harmonisation depends on meaningful accountability. Consequently, GTT recommended the development of a scorecard to

examine the performance of national and international partners in creating and supporting a strong AIDS response. Although such mechanisms are essential, their effectiveness depends on the willingness of partners to use the results in their yearly programme reviews.

Increased political accountability is clearly required to ensure the use of existing tools. Three groups now need to proactively encourage improved coordination of efforts among international partners, with countries and also with the UN system.

First, civil society must broaden its traditional advocacy focus on access to commodities and services to include processes such as alignment and harmonisation, and must build the national systems on which they rely. The lack of public debate on alignment is a setback for the access agenda; however, activism that has been successful in addressing many other key issues in AIDS response can be used here. Effective processes are the basis for acquiring the right commodities and services quickly.

Second, other non-partisan agencies such as the Global Fund, which command tremendous influence, must also embrace and push alignment activities.[5] For example, the detailed monitoring of Global Fund inputs and fiduciary assessments could be linked to sector-wide monitoring to increase attention and accountability in alignment and harmonisation.

Third, countries must advocate vigorously to press partners to align and harmonise their actions. Although these countries must simultaneously equip themselves to assure partners of their capacity for accountable delivery of programmes, this factor should not be a prerequisite for donors' accountability.

Alignment and harmonisation should act as building blocks, not stumbling blocks, for universal access to HIV prevention and for care and treatment for AIDS patients.

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1 UNAIDS. Towards universal access UNAIDS assessment on scaling up HIV prevention, treatment, care and support. Geneva: UNAIDS, 2006: http://data.unaids.org/pub/InformationNote/2006/200603204_HLM_GA_A60737_en.pdf (accessed Sept 20, 2006).

2 Joint progress toward enhanced aid effectiveness. Paris declaration on aid effectiveness: ownership, alignment, harmonisation, results, mutual accountability. High level forum. Feb 28 to March 2, 2005: http://www.oecd.org/dataoecd/11/41/34428351.pdf (accessed Oct 18, 2006).

3 UNAIDS. Global Task Team on improving AIDS coordination among multilateral and international donors. June, 2005: http://data.unaids.org/Publications/IRC-pub06/JC1125-GlobalTaskTeamReport_en.pdf (accessed Sept 16, 2006).

4 UNAIDS. Effectiveness of multilateral action on AIDS: harmonized support to scaling up the national response. Report for 18th meeting of the UNAIDS Program Coordination board. Geneva, June 27–28, 2006.

5 Sidibe M, Ramiah I, Buse K. The Global Fund at five: what next for universal access for HIV/AIDS? *J R Soc Med* 2006; **99:** 497–500.

What is publication?

The Swedish Two-County trial of screening mammography[1] was instrumental in the introduction of screening. This trial was population-based and the researchers used the Swedish registries for cancer and causes of death. We combined data from the same registries with information on the study population, dates of randomisation, and length of follow-up, and found that the numbers of breast cancers and deaths, both in the primary report from the trial and in two updates with longer follow-up, were much lower than our calculations.

On March 9, 2006, we published our findings in the articles-in-press section on the *European Journal of Cancer*'s website.[2] 3 weeks later the Editor-in-Chief, John Smyth, informed us that his journal had received "comments from a number of sources regarding some of the claims made in the article" and that our article had been removed from the journal's website pending further discussion and clarification.

The Editor did not forward these comments to us but asked for very minor clarifications and changes. We submitted a slightly revised manuscript in which the most important change was that we had deleted a sentence that might have been interpreted (wrongly) as suggesting that the trial authors had deliberately changed the cause of death in favour of screening. We never intended this, hence the amendment to our paper to delete this sentence.

To our great surprise, as our paper had already been published, the revised manuscript was sent out for peer review, and on May 25 the Editor informed us that his decision to withdraw our paper was final. He referred to "the release of new information concerning the randomization process and the trials opening and