



Department  
for International  
Development



## Towards Zero Infections - Two Years On

A Review of the UK's Position Paper on HIV in the  
developing world



November 2013

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# Executive Summary

Two years on from the 2011 HIV Position Paper, DFID is making substantial progress against its expected results. Treatment related commitments have already been achieved, and the remaining targets set out in the HIV position paper are largely on track to be met by 2015.

However, major challenges remain in the global response to HIV. In a rapidly evolving context, DFID remains committed to the goal of universal access and targets set out in the 2011 UN Political Declaration. Within this DFID has particular policy priorities to respond to the evolving nature of the epidemic, including key populations; women and girls; and the integration of the HIV-response within sexual reproductive health and rights (SRHR), TB and wider health system strengthening, as well as integration with other development priorities.

The way DFID funds its policy priority on key populations is evolving. A significant amount of direct financial aid has previously been through innovative bilateral programmes for key populations, particularly in the Asia region. As DFID graduates funding from these middle-income countries, it will increasingly work through global and regional mechanisms and partners. In particular, DFID will support civil society such as through the Robert Carr Civil Society Networks Fund (RCNF) and to continue its strong financial and policy support to the Global Fund for AIDS TB and Malaria (GFATM) to ensure that the needs of particularly vulnerable populations are met and human rights protected. DFID continues to support evidence-based prevention, including comprehensive harm reduction for injecting drug users (IDUs).

DFID has committed to putting girls and women at the heart of its development assistance. As well as continuing a focus on women and girls in DFID's bilateral HIV programmes, more work is required to capture, measure and maximise the HIV related benefits of DFID's wider work with women and girls. Global progress on reducing new infections in women and girls remains a priority for DFID.

Promoting integrated health services and supporting overall health systems strengthening are principles that drive DFID's approach. This is evident in the way DFID designs its programmes to align with national health priorities, supporting donor coordination and filling strategic gaps. Enabling strong health systems has been, and will remain, fundamental to DFID's HIV response.

DFID is using a range of mechanisms to achieve its policy priorities. In working through others, DFID recognises the valuable contribution of civil society and the private sector in complementing and progressing achievements. Equally DFID has, and will continue, to use its influence and investments through multilateral partners and in international fora to help ensure policy priorities receive due focus.

DFID will retain its comparative advantage in addressing structural barriers, including stigma and discrimination and gender inequality, which continue to drive the epidemic and inhibit the effective uptake of biomedical interventions. Supporting the generation of new evidence can provide long term, efficient strengthening for DFID's HIV programming. This includes enhancing learning from its own programmes, building-in credible evaluations.

DFID will use the insights, lessons, and recommendations from this review to ensure its investments are responding to the rapidly evolving context to achieve efficiency, effectiveness and equity.

DFID will use the existing HIV Position Paper, priorities and evidence emerging from this review within the post-2015 development process. This will include advocating for the integration of HIV across different sectors. It will mean ensuring that commitments to universal access to treatment, care and support services and 'getting to zero' become a reality.

# 1. List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARROW	Antiretroviral Research for Watoto
ART	Antiretroviral Therapy
ARV	Antiretroviral
BAR	Bilateral Aid Review
BMGF	Bill and Melinda Gates Foundation
CAFOD	Catholic Agency for Overseas Development
CARHAP	Central Asia Regional HIV/AIDS Project
CBO	Community-Based Organisations
CCM	Country Coordinating Mechanism (Global Fund)
CHAI	Clinton Health Access Initiative
COTHAZ	Community-led TB-HIV Advocacy in Zambia
CSCF	Civil Society Challenge Fund
CVCT	Couples Voluntary Counselling and Testing
DALY	Disability Adjusted Life Year
DART	Development of Antiretroviral Therapy in Africa
DFID	Department for International Development
DRC	Democratic Republic of Congo
ESP	Expanded Support Programme
FCO	Foreign and Commonwealth Office
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB and Malaria
GNP+	Global Network of People Living with HIV
GPAF	Global Poverty Action Fund
GTF	Governance and Transparency Fund
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
HRP	Human Reproduction
IAVI	International AIDS Vaccine Initiative
ICAI	Independent Commission on Aid Impact
IDU	Injecting Drug Users
IPM	International Partnership on Microbicides
IPPF	International Planned Parenthood Federation
MAR	Multilateral Aid Review
MNCH	Maternal, Newborn and Child Health
MoU	Memorandum of Understanding
MRC	Medical Research Council
MSI	Marie Stopes International
MSM	Men who have Sex with Men
NAC	National AIDS Council
NFM	New Funding Model (Global Fund)
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
OECD DAC	Organisation for Economic Cooperation and Development – Development Assistance Committee
OPM	Oxford Policy Management
OVC	Orphans and Vulnerable Children
PEPFAR	United States President’s Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PPA	Programme Partnership Arrangement
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis

PSI	Population Services International
RAISA	Regional AIDS Initiative of Southern Africa
RH	Reproductive Health
RMNH	Reproductive, Maternal and Newborn Health
RCNF	Robert Carr Civil society Networks Fund
SACA	State Agency for the Control of AIDS (Nigeria)
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SGBV	Sexual and Gender-Based Violence
SHINE	Sanitation, Hygiene, Infant Nutrition Efficacy Project
SRH	Sexual and Reproductive Health
STBP	Stop TB Partnership
STI	Sexually Transmitted Infection
STRIVE	Tackling the Structural Drivers of the HIV Epidemic
SW	Sex Workers
TB	Tuberculosis
TI	Targeted Interventions
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VSO	Voluntary Services Overseas
WHO	World Health Organisation

## 2. Introduction

In May 2011, the Department for International Development (DFID) published a UK position paper on HIV in the developing world: *Towards Zero Infections*. This restated DFID's commitment to the goals of "universal access" by 2015 and also committed DFID to the vision of "getting to zero" - zero new HIV infections, zero AIDS-related deaths and zero stigma and discrimination. The paper identified three strategic priorities building upon DFID's track record: to significantly reduce infections; to scale up access to diagnosis, treatment, care and support; and to significantly reduce stigma and discrimination. It recognised that DFID would work in fewer countries, focusing HIV-specific support where it is most needed, and working through partners elsewhere. It identified headline results for which DFID would be working. DFID committed to review its progress against results in 2013 and reassess its strategic priorities at that time.

*Towards Zero Infections* is a summary of DFID's diverse and complex HIV response which aims to align to country needs and with government priorities and activities of other development partners. For this reason, there is no standard DFID model of HIV programming. As well as analysing progress against headline results, this review also attempts to reflect the heterogeneity of DFID's response through using a range of good practice examples drawn from different contexts. It is a portfolio 'snapshot' at a specific point in time to help DFID learn lessons and explore opportunities to 2015.

### Methods

The review was conducted as a self-assessment by DFID with support from Oxford Policy Management (OPM) and STOPAIDS (formerly the UK Consortium on AIDS and International Development). Relevant programme documentation was identified by DFID for review by the OPM team. DFID staff provided additional material directly and were followed up by interviews where relevant. An online survey was conducted and three consultative workshops were held with stakeholders, one in the UK and two regionally in Asia and Southern Africa. STOPAIDS helped to facilitate these workshops and collect case-study evidence from civil society stakeholders. This report is the result of a document review (the OPM assessment included 113 programmes), the outcome reports from the consultations, and input from the online survey, as well as extensive discussion and learning from across DFID.

Section 3 briefly summarises relevant changes in the global context of HIV since 2011. Section 4, based on the document review, first outlines the scope of DFID's HIV portfolio and progress against headline results since 2011. It then considers three areas of focus of DFID's HIV response since 2011: Key Populations, Women and Girls, and Integration of the HIV-response within wider health programmes. Three levers DFID uses to implement its HIV work in addition to its bilateral and multilateral programming are then highlighted: building partnerships with civil society, the role of DFID influence, and supporting the generation of new evidence. Section 5 outlines summary messages from the consultations, followed in Section 6 by DFID's response, looking ahead to 2015.

# 3. Changes in Context since 2011

## Multiple Evolving HIV Epidemics

The global context for HIV is changing rapidly. Progress is being made at pace – UNAIDS 2012 data shows that globally there were 1 million fewer infections in 2012 than in 2001 and new HIV infections among children have declined by 52% over the same period. Nearly 10 million people are now on anti-retroviral therapy (ART) and for many HIV is now a manageable chronic condition. In 2012 there were 2.3 million new infections and an estimated 35 million people living with HIV (PLHIV).

However, significant challenges remain. Women remain disproportionately affected by the virus and there are 3.3 million children living with HIV. Due to structural barriers such as stigma and discrimination, and poorly functioning health systems, at least 16 million people in need of treatment are still not accessing services under new WHO 2013 treatment guidelines. In 2012, 1.6 million people died of AIDS-related illnesses.

HIV epidemics are multiple and changing; there is no room for complacency. Twelve countries in East and Southern Africa have ‘generalised’ - whole population - epidemics, accounting for 45% of infections globally. ‘Concentrated’ epidemics are those which predominantly affect certain key populations, including female sex workers (FSW), people who inject drugs (PWID) and men who have sex with men (MSM). Although concentrated epidemics have been the focus of HIV responses outside Africa, recent analyses found that new infections among MSM and other high risk groups are important components of national epidemics in Kenya and South Africa. Progress in addressing the behavioural drivers of sexual transmission of HIV is slowing in some places, with several countries in sub-Saharan Africa detecting decreases in condom use and/or an increase in numbers of sexual partners. Early success in reducing infections has not been sustained in some countries and HIV incidence has been stagnating or even increasing in countries like Lesotho, Uganda and Tanzania. In addition, significant sub-national variations exist. For example, HIV prevalence among the general population in South Africa is 17.9%, but in the province of KwaZulu-Natal, it is almost 40%.

## New Political Commitment

In 2011, the United Nations (UN) General Assembly issued a new political declaration on HIV/AIDS focused on intensifying efforts to eliminate the disease.<sup>1</sup> This included bold new targets for 2015: reducing sexual transmission by 50%; eliminating new HIV infections in children; reducing Tuberculosis (TB) deaths among people living with HIV by 50%; intensifying HIV prevention among FSW, PWID and MSM; eliminating gender inequalities, stigma and discrimination and getting 15 million people on ART. The UK has signalled its strong commitment to the goals of this declaration.

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<sup>1</sup> United Nations General Assembly, Resolution 65/277. *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*, 8 July 2011

## **New Evidence and Technologies**

The evidence base for what works in preventing and treating HIV is growing. There have been major biomedical breakthroughs in terms of antiretroviral (ARV) based prevention, including the demonstrable success of ARVs in preventing mother to child transmission (PMTCT), new evidence around the contribution of ARVs to preventing HIV transmission in sero-discordant couples, and the potential of pre-exposure prophylaxis (PrEP) to prevent HIV infection in high-risk groups.

Male circumcision has been proven to be a highly cost-effective one-off prevention intervention which is now being scaled up in a number of generalised epidemics. The effectiveness of voluntary medical male circumcision will thus be tested and evaluated at population level.

Targeted prevention, such as harm reduction for most at risk populations, is also having an impact in concentrated epidemics.

Although the evidence is as yet limited, there is increased recognition that for biomedical interventions to be effective, it is critical that behavioural barriers are addressed, such as sustained adherence to treatment; that a supportive enabling environment is created through, for example, non-discriminatory legislation and policies; and that the structural determinants driving HIV transmission are addressed, such as gender inequality and stigma.

## **Shift in HIV Financing**

Since 2008, there has been a shift in the financing of the HIV response. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS); funds available from international aid for actions to address HIV have remained largely the same since 2008.<sup>2</sup> Domestic spending on HIV has increased however, accounting for 53% of global HIV resources in 2012. This was estimated to be US\$ 18.9 billion in 2012, US\$ 3-5 billion short of the US\$ 22-24 billion estimated to be needed annually by 2015.

The need for resources is likely to continue to rise as a result of new World Health Organization (WHO) guidelines for antiretroviral therapy, which recommended initiating ART earlier in the course of the infection. This could potentially result in the number of people eligible for ART in developing countries increasing from 17 million to 26 million.<sup>3</sup>

DFID will follow WHO advice and continue to prioritise PLHIV who have a CD4 count of 350 or below. As WHO has identified, it is only appropriate to consider sequencing the treatment of those with higher CD4 counts when the most vulnerable of PLHIV (those with lower CD4 counts) are on treatment. Currently, this is still some way off in many countries.

## **Reform of the Global Fund for AIDS, TB and Malaria (GFATM)**

The period 2011 – 2013 was one of great change and reform for GFATM. In response to reports of financial mis-management and a loss of donor confidence, the GFATM Board commissioned an independent High Level Panel to look at GFATM's fiduciary controls and oversight mechanisms. The High Level Panel's report was a catalyst for a series of progressive and rapid reforms to the institution and its business model, leading to a return in donor confidence and a resumption of funding. Reforms at GFATM over the last two years have included: a new senior management team; a new strategy; refocusing of the Secretariat towards

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<sup>2</sup> UNAIDS World AIDS Day Report 2012

<sup>3</sup> WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection: Recommendations for a Public Health Approach: June 2013

country grant management; a grant by grant risk assessment; and a complete redesign of the allocation and business model – termed the New Funding Model (NFM), which aims to get funds to where they are most needed, spent equitably on the most cost-effective interventions and delivered in a harmonised way.

## A More Strategic Response

Given the shifting financial landscape and improved evidence base of what works in HIV, there has been a growing consensus behind supporting more strategic investments for greater effectiveness, efficiency and equity. This was articulated by a group of experts in a Lancet article on the *Strategic Investment Framework*, published in 2011.<sup>4</sup> It described the centrality of basic programme activities<sup>5</sup> to HIV responses, supported by critical social<sup>6</sup> and programme<sup>7</sup> enablers, while also working with other development sectors to address structural barriers such as gender inequality and violence against women; poverty; weak health systems; and stigma and discrimination.

Strategic investment thinking is influencing the HIV response; national partners are using the approach to better target and prioritise their investments; it is informing the support UNAIDS is giving countries; and it has been embedded in the strategy and design of GFATM's NFM.

## The Developing role of the Private Sector

The private sector is increasingly playing an important role in the provision of commodities and services, through funding and research, influencing governments and delivering focussed programmes to increase access. Workplace programmes that focus on prevention and treatment and tackling stigma and discrimination against PLHIV can also have valuable benefits for staff, their families and the community. Large companies are often well equipped to run these programmes.

Many pharmaceutical and medical research companies are playing a vital role through conducting leading edge research and developing new medicines, diagnostics and vaccines, accelerating access to medicines through pricing policies, developing inclusive intellectual property management strategies and working through public-private partnerships to help ensure sustainable improvements in healthcare delivery.

Quality-assured Indian-manufactured generic medicines account for an estimated 80% of ARVs in Africa, and have underpinned treatment scale-up. It is important that the international policy framework remains supportive of access to quality healthcare. Other priorities include further price reductions for second and third-line drugs, alongside increased efforts for new treatments for pediatric HIV and some co-infections.

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<sup>4</sup> Schwartländer, B. & Stover, J et al. "Towards an improved investment approach for an effective response to HIV/AIDS", *The Lancet*, Volume 377, Issue 9782, pp. 2031 - 2041, 11 June 2011

<sup>5</sup> PMTCT; condom promotion and distribution; programmes with key populations; treatment care and support for people living with HIV; male circumcision; and behaviour change programmes.

<sup>6</sup> Political commitment and advocacy; laws, legal policies, and practices; community mobilisation; stigma reduction; mass media; and local responses to change risk management.

<sup>7</sup> Community centred design and delivery; programme communication; management and incentives; procurement and distribution; and research and innovation.

## 4. Review

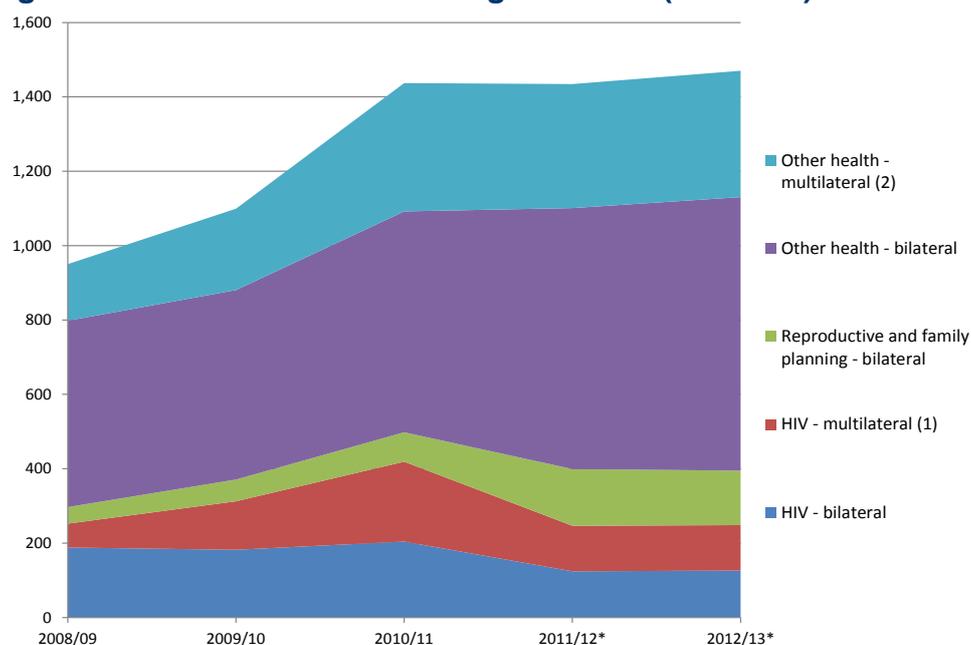
# 4.1 Scale, Scope and Value for Money of DFID's HIV Portfolio

### Scale and Scope of DFID's HIV portfolio

The UK government's expenditure on HIV/AIDS is provided through a number of channels: bilateral programmes (both direct HIV programmes as well as broader support to health systems); contributions to multilateral agencies and global initiatives; support to civil society; and support for research.

DFID's overall HIV spend, including both multilateral and bilateral, has remained stable, averaging at £300 million per year over the last five years<sup>8</sup>. DFID's HIV/AIDS spend as a proportion of overall health funding is illustrated below (Figure 1):

**Figure 1: Estimated DFID Funding to Health (£ million)<sup>9</sup>**



<sup>8</sup> Estimates of total HIV spend shown here do not include support provided through the Civil Society Challenge Fund (CSCF) or the Global Poverty Action Fund (GPAF). Direct HIV spend is the proportion of projects that have been classified under the HIV codes. The actual aggregate spend of HIV prevention and treatment projects will be higher as DFID projects have multiple codes. Estimates therefore underestimate UK support to HIV prevention and treatment.

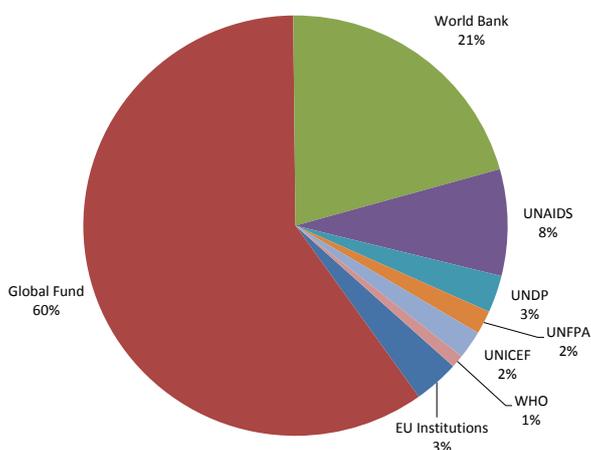
<sup>9</sup> Data source: Statistics on International Development, DFID internal data sources. (1) Imputed multilateral aid to HIV has been calculated using the share of total spend allocated to the prevention and treatment of HIV/AIDS of the main multilateral organisations (Global Fund, UNAIDS, EU Institutions, World Bank, UNDP, UNFPA, UNICEF, UNHCR, UNESCO, WHO). Data sources: Global Fund, [www.theglobalfund.org](http://www.theglobalfund.org); EU Institutions, OECD DAC CRS database, [www.oecd.org](http://www.oecd.org); others, data provided by UNAIDS). (2) UK imputed multilateral aid to health is provided in Statistics on International Development. Provisional data has been used to estimate 2011/12 and 2012/13 imputed multilateral aid to HIV (due to the lags in data).

DFID uses a range of instruments to support the priorities set out in the HIV Position Paper. Bilateral support is channelled through: country programmes targeting HIV; funding the prevention and treatment of HIV by supporting access to, and the quality of, health systems<sup>10</sup>; innovative mechanisms such as UNITAID to increase access to treatments and diagnostics for HIV/AIDS; DFID funded research; and HIV projects supported through programmes such as the Global Transparency Fund (GTF) and Programme Partnership Arrangements (PPA).

DFID’s bilateral spend coded as HIV has decreased since 2010/11 by about £75 million. However, over the same period, DFID’s reproductive and family planning spend, which will impact on HIV outcomes in most contexts, has increased by about £70 million. It should also be noted that the UK brought forward the 2011/12 contribution to UNITAID, which partially accounts for the ‘spike’ in bilateral aid to HIV in 2010/11.

The majority (over 60% over the five year period) of DFID’s multilateral HIV spend is provided through contributions to GFATM. It is estimated that the UK provided around £215 million in multilateral aid to HIV in 2010/11, considerably higher than in previous years, largely due to frontloading of GFATM contributions. For the last two years UK multilateral aid to HIV has remained stable at approximately £120 million, reflecting the level of GFATM contributions in these years. Figure 2 gives a breakdown of DFID’s multilateral HIV/AIDS spend in 2012/13. This shows that the GFATM is by far the largest channel of all UK multilateral support to HIV/AIDS. The World Bank and UNAIDS are also important players in DFID’s multilateral HIV response.

**Figure 2: Estimated UK HIV spend through multilateral contributions in 2012/13**



The UK’s recent commitment of up to £1 billion to the new GFATM 2014 – 2016 replenishment, will see DFID’s multilateral HIV spend increase significantly in future years. Around £500 million of this contribution

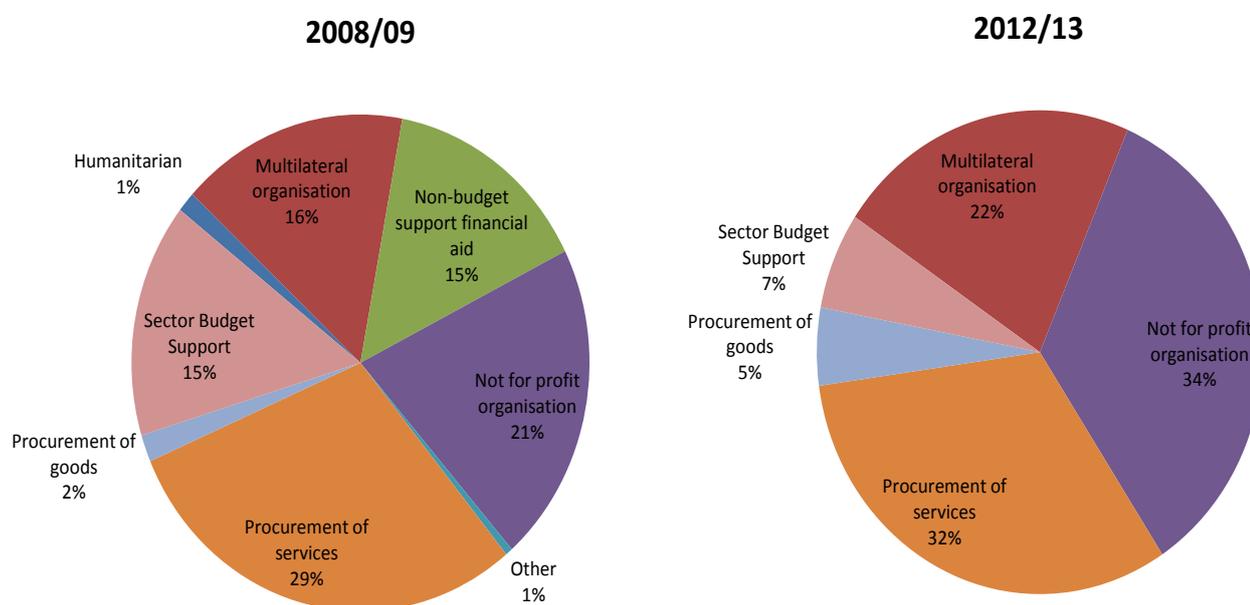
<sup>10</sup> It is estimated that on average just over £20 million per year of the funding to health systems has supported better HIV outcomes. This has been calculated by estimating the proportion of total Disability Adjusted Life Years (DALYs) that are due to HIV in each country. Where DFID has health system spend, a proportion of this spend is attributed to HIV using these estimates. The source of the data is the 2010 Global Burden of Disease (IHME).

will support improved HIV outcomes and this significant investment will ensure that the UK continues to provide a considerable share of the global resources to the prevention and treatment of HIV.

**Country programmes:** In 2010/11 DFID provided bilateral aid<sup>11</sup> to prevent and treat HIV/AIDS in 26 countries<sup>12</sup> (8 in Asia, 16 in Africa and 2 across British Overseas Territories). While regional programmes continued, by 2012/13 the number of bilateral programmes had fallen to 16<sup>13</sup> (5 in Asia and 11 in Africa). This is in line with the direction set out in the Position Paper to work in fewer countries, focusing HIV-specific support where it is most needed and working through partners elsewhere.

Figure 3 illustrates how DFID spends at the country level<sup>14</sup>. The main change since 2008/09 has been the reduction in financial aid (including sector budget support) by 23 percentage points, and an increase in support for not-for-profit organisations, largely through civil society, by 13 percentage points.

**Figure 3: Allocable bilateral HIV funding by funding channel**



DFID funds not-for-profit organisations in a wide variety of ways, including through bilateral programmes, multilateral organisations, and a number of central mechanisms, including project funding, partnership agreements and the Robert Carr Network Fund (see section 4.3).

There are a number of centrally funded programmes that have provided support to HIV projects.

<sup>11</sup> This considers spend classified under HIV codes. Bilateral aid to HIV may be provided as a component of wider health sector support, and it does not necessarily mean that each of these countries had a specific HIV prevention or treatment project.

<sup>12</sup> Bangladesh, Burma, Cambodia, China, DRC, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Nepal, Nigeria, Overseas Territories, Pakistan, Rwanda, Sierra Leone, Somali Republic, South Africa, St Helena, Tanzania, Uganda, Vietnam, Zambia, Zimbabwe.

<sup>13</sup> Bangladesh, Burma, Cambodia, DRC, Ethiopia, Ghana, India, Kenya, Malawi, Nigeria, Sierra Leone, Republic of South Africa, Uganda, Vietnam, Zambia, Zimbabwe.

<sup>14</sup> Analysis of allocable bilateral aid that is coded under HIV/AIDS codes.

- Core funding to civil society is given through **Programme Partnership Arrangements (PPAs)**. Annex B summarises HIV-related PPAs and headline results achieved to date demonstrating strong performance.
- The **Civil Society Challenge Fund (CSCF)** strengthens the role of civil society in reducing poverty among poor and marginalized groups. Since 2010, CSCF has supported 15 HIV/AIDS related projects in 12 African countries with a total value of £6.75 million.<sup>15</sup> Overall these projects have reached nearly four million people.
- The **Global Poverty Action Fund (GPAF)** aims to reduce poverty and contribute towards the achievement of the Millennium Development Goals (MDGs). Since 2012 GPAF has supported 19 HIV/AIDS related projects in 13 African countries<sup>16</sup> with a total value of £17 million.
- The **Governance and Transparency Fund (GTF)** aims to strengthen the capacity of civil society to hold governments to account. The GTF funds three HIV related programmes. Two are small-scale interventions within larger gender-based programmes. The third programme of over £4 million supports the Global Network of People living with HIV/AIDS (GNP+) working in 11 countries.

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<sup>15</sup> Democratic Republic of Congo (DCR), Ethiopia, Kenya, India, Malawi, Mozambique, Namibia, Rwanda, Nigeria, Tanzania, Uganda and Zambia

<sup>16</sup> Republic of Congo, Ethiopia, Kenya, Malawi, Mozambique, Myanmar, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia and Zimbabwe

## Value for Money

DFID has strengthened its approach to Value for Money (VfM), ensuring it is central to multilateral reform priorities and bilateral programme design and management. With regard to its HIV spend, the most considerable results on VfM have been achieved through DFID's market shaping interventions. DFID's focus on VfM is benefitting others through generating global public goods and spearheading strategic investment thinking. The focus on prevention, identified as a comparative advantage for DFID's bilateral work, also contributes to VfM.

### VfM through Multilateral Investments

DFID's multilateral aid review (MAR) in 2011 was a new process established to assess the VfM of DFID's investments in a number of agencies. Progress has been assessed in 2013, and has informed decisions around levels of future funding. Of particular relevance are the assessments made of GFATM and UNAIDS for which good progress has been documented:

**Table 1: GFATM and UNAIDS Value for Money**

Agency	Description of Progress	2011 VfM rating <sup>17</sup>	2013 progress rating	2013 UK funding commitments
UNAIDS	UNAIDS has made progress on aligning human resources with strategic priorities to increase support to countries, improved financial resource management achieving 13% administrative efficiency savings, and articulated a clearer results chain through its results framework. Implementation of the strategic investment approach (with additional catalytic support from DFID) has shown promise in supporting countries make effective, efficient and equitable investment decisions - 29 countries are moving forward with an investment approach.	Adequate VfM	Reasonable progress, good VfM	In 2013/14 and 2014/15 the UK contribution will increase to £15 million core funding per year
GFATM	Significant reforms have been undertaken by the GFATM over 18 months, showing a strong level of commitment to improvement, although it is too early to realise the full benefits at country level. This assessment informed the UK replenishment decision.	Very Good VfM	Reasonable progress	Up to a further £1 billion between 2014 and 2016

<sup>17</sup> DFID 2011 Multilateral Aid Review: <https://www.gov.uk/government/publications/multilateral-aid-review>

## VfM through Market Shaping

There is strong evidence, in particular from ARV markets, that targeted 'market-shaping' interventions for accessing commodities, on both the supply and demand side, can transform the functioning of markets to deliver much lower prices, better quality products and greater security of supply, so allowing for greater availability of essential, quality-assured, medicines for the poor. This offers VfM benefits to donors, as well as access and availability benefits for patients in developing countries. Interventions can include facilitating the entry of new generic suppliers, clarifying regulatory pathways for new commodities, strengthening demand forecasting, using pro-active procurement tactics and supporting countries with faster product introduction and roll-out.

DFID supports a number of interventions in this area. The potential cost savings from work of this nature are enormous and as a global public good they can have far reaching benefits:

- DFID has a programme with the **Clinton Health Access Initiative (CHAI)** worth up to £35m between 2012 and 2015. This work is not restricted to HIV treatment and diagnostics but includes other health commodities, such as vaccines and family planning. The programme follows on from a previous programme that ran from 2008 to 2012 (cost savings have been captured in DFID's headline HIV results, see section 4.2). After six months of project activity under the new programme, it was reported that ART tendering in South Africa, for which CHAI provided technical advice, would result in cost savings of \$260 million over two years. In addition, CHAI policy dialogue with governments in Ethiopia and Zambia over issues of providing ART to PLHIV with a CD4 count < 350 and shifting to option B+ for PMTCT are expected to result in an additional 160,000 people on ARVs by 2015.
- The UK, together with France, is one of the major funders of **UNITAID**, with the UK providing the organisation with £53 million annually. UNITAID has revolutionised the market for paediatric ARVs. As of 2011, more than 400,000 children globally were on ART using optimal AZT-based, paediatric fixed-dose combinations. The cost per patient per year for a leading paediatric antiretroviral medicine was \$130 in 2011 as compared to \$252 in 2006. In addition, children in 57 countries had received more than 1 million curative and preventive anti-TB treatments.
- UNITAID finances the **Medicines Patent Pool** which seeks to ensure that quality medicines, adapted to the needs of people living with HIV in developing countries, are available at prices that these countries can afford. It does this through voluntary licensing of HIV medicines patents. Currently, the Medicines Patent Pool has licensing agreements with the US National Institutes of Health, Gilead Sciences and ViiV Healthcare and Roche. These agreements include licences on the preferred first line treatment regimens for adults and children over three years old, in line with the latest WHO treatment guidelines. A number of sub-licences with manufacturers of generic medicines are enabling more countries have access to more affordable first-line treatments.
- DFID also supports stronger engagement of the innovator pharmaceutical industry in access issues through its support of the **Access to Medicines Index**. This index, which is published every two years, ranks the performance of companies in increasing access to health products. It looks at a range of factors including how they make their products and intellectual property available to developing countries and their complementarity with the health policies of national governments.

Lessons learnt from DFID's market dynamics work are now being applied beyond HIV to other diagnostics and family planning commodities. It is important that intellectual property rights are wisely managed and that TRIPs flexibilities continue to be used wherever necessary to support access, together with proactive efforts to improve access to newer formulations of ARVs.

## **VfM through Bilateral Programmes**

Achieving VfM through DFID's bilateral programming means using strategic investment approaches that are based on evidence of what works where and why to deliver cost-effective interventions that achieve health outcomes for those most in need. VfM is achieved in practice by: ensuring VfM is a major criteria in shaping programme design; rigorously monitoring progress; managing implementation well; taking corrective action where necessary; ensuring partners understand what DFID means by improving results and VfM; and including VfM assessments in evaluations and annual reviews.

By way of illustration of how VfM is being applied to major new DFID programmes, three particular cases are considered – the new HIV prevention programmes in Malawi, Zambia and Zimbabwe. The Zimbabwe programme, in particular, is a major investment over five years, at approximately twice the scale of the Malawi programme. The Zambia programme is somewhat smaller. The summary VfM components are outlined in Annex C. All programmes set out a range of VfM indicators to be monitored throughout the life of the project.

The business cases for all three programmes incorporated modelling in order to estimate the likely outcomes of the proposed packages of interventions, and these cost-effectiveness results fed into an appraisal of options. However, cost-effectiveness was not the only factor when considering VfM. Context matters, and so the domestic political and institutional situation in each country was taken into account.

In all three of the programmes considered, the decision to focus primarily on prevention is justified most strongly by a financing and capacity gap analysis, showing the perceived inadequacy of domestic prevention support in comparison with treatment. This is in accordance with international results over many years showing that proven prevention interventions can be cost-effective, particularly if targeted to marginalised populations in line with the basic programme activities identified by the strategic investment framework.

## 4.2 Progress on Headline Results

Overall, DFID is on track to deliver most of the results forecast in the 2011 position paper. Results have already been achieved for treatment related commitments and therefore new targets will be agreed under follow-on investments to the GFATM and CHAI. Global progress on reducing new infections in women and girls is identified as a priority for renewed efforts.

The position paper identified a number of expected headline results towards which DFID would work. Given the highly contextualised nature of HIV epidemics in the countries in which DFID works, DFID's approach to its portfolio has been responsive to this heterogeneity. DFID-attributable results therefore reflect this diversity, while contributing to global targets.

Progress towards headline results are summarised in Table 2. Results are categorised under the three focus areas of universal access: 1) Prevention, 2) Treatment; 3) Care and Support.

**Table 2: Progress towards headline results in the 2011 HIV position paper**

Scoring is based on an assessment of current levels of results achieved in the light of the results expected by 2015. The following scoring system is used: **Green**: On track, likely to achieve 2015 targets; **Amber**: Progress slow, unlikely to achieve 2015 target without additional effort; **Red**: Limited or no progress, off track

Headline Result	Progress	Data Source	Scoring
<b>Prevention</b>			
We will contribute to reducing new HIV infections in at least 8 Sub-Saharan African countries through scaling up prevention services including TB prevention, strengthening reproductive health services empowering women and encouraging better resource allocation. We will help reduce HIV infections among women by at least an estimated 500,000	Work to reduce HIV infections has been supported in at least 10 African countries, and through a regional Southern Africa programme. These programmes were designed in line with priorities of the national response. According to an assessment of project documentation, the majority of programmes are on track or exceeding projected progress.	OPM assessment of annual review and project completion scores for HIV programmes, summarised in Annex A <sup>18</sup>	On track
	Globally the pace of decline in new HIV infections among women has slowed. In a number of countries where DFID contributes to the HIV response, the decline in numbers of new infections among women has decreased and remains high.	New infections among women 15-49 years (UNAIDS 2012)	Progress slow, unlikely to achieve 2015 target without additional effort
We will focus on reducing HIV infections	Prevention work among key populations has been supported in 9 countries in Asia. Cambodia,	OPM assessment of annual review	On track

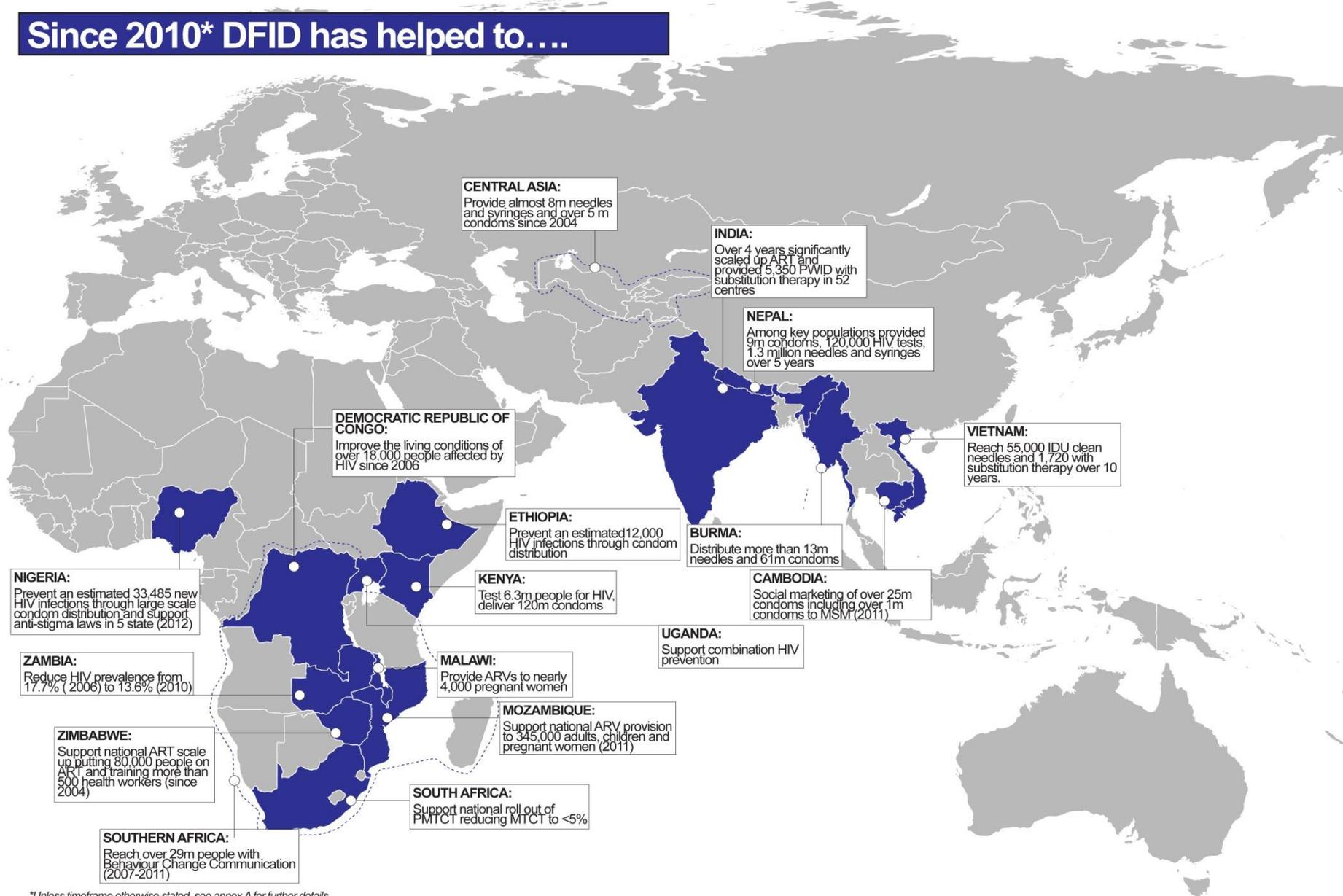
<sup>18</sup> DFID results have been assessed using scoring from programme documentation to identify whether headline results are on track. All existing HIV programmes that were being implemented between March 2011 and March 2013 have been included, as well as any new programmes since March 2011 (see Annex A). A floating baseline has been used depending on programme start date.

Headline Result	Progress	Data Source	Scoring
among most-at-risk populations in at least six countries by improving access to prevention services such as needle exchange and condoms. We will help maintain HIV prevalence below 1% in the general population in these countries	Nepal, Vietnam, India, Burma and countries of Central Asia – Kyrgyzstan, Tajikistan, Uzbekistan. These programmes were designed in line with priorities of the national response. According to an assessment of project documentation, all programmes were on track and delivered expected results or exceeded these. Of particular note was the success of these programmes in sustained scale-up of services for key populations.	and project completion scores for HIV programmes, summarised in Annex A	
	In all of the identified countries, using 2012 data, HIV prevalence among the general adult population remained below 1%. However, national prevalence data masks higher rates within key populations although this data is limited and of varying quality.	HIV prevalence, (UNAIDS 2012)	
We will contribute to the UNAIDS' and Stop TB Partnership's goal of reducing HIV-related TB among people living with HIV by 50% by 2015	Many countries have made considerable progress to address the TB/HIV co-epidemic. Using 2012 data TB mortality among people living with HIV in the 41 WHO priority countries on TB/HIV co-infection, has declined by 37% since 2004. Subject to continuing increase in uptake of ART, progress is on track to meet the goal of 50% reduction by 2015.	UNAIDS/WHO estimates 2012	On track
<b>Treatment</b>			
Through our support to the Global Fund we will give 37,000 HIV-positive women treatment preventing HIV transmission to their babies.  Through our support to the Global Fund we will give 268,000 people with treatment for AIDS.	In 2011 and 2012, the GFATM reported providing ARVs to 700,000 HIV+ women for PMTCT. The UK attribution figure is 9.6% in the 2011-13 replenishment period, meaning 67,200 of these can be attributed to DFID.  Between 2011 to mid-2013, the GFATM report providing ART to a total of 5.3m people, up from 3m in 2010. Using the same attribution rate, this would mean that 508,800 of these can be attributed to DFID.  <i>The UK has committed up to £1billion to the new GFATM 2014 – 2016 replenishment. GFATM, with UK support, has developed new and stretching targets for the 2014 – 2016 period which will be reflected in their Key Performance Indicators.</i>	GFATM reports	Achieved
Our work with the Clinton Foundation to drive down treatment costs will generate enough cost-savings to purchase medicines for an additional 500,000 people by 2015.	Cost savings estimated as \$430m over five years through improvements in manufacturing processes for ARVs and other market interventions. \$75 - \$90m over 5 years through negotiated price reductions with an Indian generic manufacturer for a 2nd line ARV regime. Based on a 50% attribution to DFID funding between 2008 and 2011, these savings are sufficient to purchase ARVs for an extra 500,000 by 2015. An independent assessment evaluated that the	Independent assessment of CHAI 2008-2011 grant	Achieved

Headline Result	Progress	Data Source	Scoring
	<p>programme substantially exceeded the expectation of these results given that cost savings were calculated during the timeframe of the grant only, yet substantial future savings are highly likely under on-going procurements.</p> <p>Under the new CHAI grant (2012-2015) DFID is supporting market interventions that aim to contribute to price reductions for 1st line ARVs from \$169 per person per year to \$90 by 2015, and for 2nd line ARVs, a reduction from \$454 per person per year to \$250 by 2015.</p>		
<b>Care and support</b>			
<p>We will provide cash transfers to poor and vulnerable households in at least five high prevalence countries. These cash transfers will benefit over 1.7 million people, including orphans and vulnerable children. These cash transfers will benefit an estimated 120,000 people affected by HIV.</p>	<p>DFID is supporting cash transfer programmes in a number of countries. These include Kenya, Mozambique, Uganda, Zambia and Zimbabwe. All these countries, in 2012, according to UNAIDS had general adult HIV prevalence &gt;5%.</p> <p>Based on figures to March 2013, at least 1.34m people have benefited from DFID funded cash transfers in these five countries. DFID forecasts that it will be supporting 1.91m people by 2015. Using adult HIV prevalence, an estimate 110,000 people living with HIV are assumed to have benefited from DFID funded cash transfers in Kenya, Mozambique, Uganda, Zambia and Zimbabwe. DFID forecasts that it will be supporting 164,000 people living with HIV through cash transfers in these five countries by 2015.</p>	<p>DFID results framework and UNAIDS 2012 data</p>	<p>On track</p>

Figure 4: Progress on Headline Results

Since 2010\* DFID has helped to....



\*Unless timeframe otherwise stated, see annex A for further details

## 4.3 DFID Support for Key Affected Populations

**Key affected populations have been a policy priority for DFID and significant sustained results at scale have been achieved, particularly in the Asia region. However, the way DFID supports key populations is changing, as its direct bilateral HIV investments in Asia come to an end. DFID is increasingly working through others, with a particular value placed on the role of global and regional civil society networks, demonstrated through the establishment of a new funding model, the Robert Carr civil society Networks Fund (RCNF).**

DFID has spearheaded support to HIV programmes for key populations in a number of countries with concentrated epidemics over a sustained period of time.<sup>19</sup> These programmes have focused on evidence-based HIV prevention services, including the provision of condoms, expanding HIV testing and counselling, provision of sterile injecting equipment and opioid substitution therapy. Alongside this, initiatives aimed at reducing stigma and discrimination experienced by these populations have also been established. Overall, results have been very good with high levels of services provided and documented changes in behaviours, such as use of condoms and sterile injecting equipment (See Annex A).

Although DFID is continuing to support bilateral HIV investments beyond 2015 in Burma, the rest of its direct HIV bilateral programming in Asia and the Caribbean has - or will soon be - coming to an end within the next two years. This does not, however, mean the end of DFID engagement on HIV in these countries, for example:

- In Nepal, DFID now provides budget support to the health sector and some of these pooled funds will be used to support the Ministry of Health to contract NGOs to provide HIV services to key populations.
- In Vietnam, DFID's HIV/AIDS prevention programme will close by December 2013, ending a decade of DFID support as Vietnam's first big donor and pioneer of harm reduction. DFID has advocated for, and facilitated, GFTAM to fill critical gaps beyond 2013 to reduce risks to disruption of activities. DFID has also contributed to the 'One UN Fund' in Vietnam, including earmarking funds for HIV. DFID has actively worked with the Government and other development partners in dialogue to push for increased national budget, mobilisation of new sources of funding, as well as improved efficiency in national programming.
- In India, DFID's engagement since 2012 has been through other partners, specifically multilateral institutions funded at the global level; UNAIDS, UNICEF, WHO, World Bank and GFATM – who all continue to support the current phase of the national AIDS control programme. DFID is the second largest donor to the World Bank which is focusing support on prevention amongst high risk groups in India. DFID continues to work with the GFATM Country Coordinating Mechanism (CCM) through the bilateral constituency, keeping oversight of the grant portfolio. DFID's broader investments in women and girls, education and social protection, will also contribute to the HIV response.

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<sup>19</sup> Burma, Cambodia, India, Nepal, Vietnam and countries in Central Asia and the Caribbean

DFID is responding to the evidence which highlights the increasing relevance of key populations in HIV transmission in Africa, and their experience of unacceptable levels of stigma and discrimination. DFID's new programming in the southern Africa region is seeking to improve the evidence base for what works for key populations, with a focus on sex workers in Zimbabwe and prisoners at the regional level (See Box 1). Alongside this, DFID has increasingly worked with the Foreign and Commonwealth Office to highlight and challenge punitive and discriminatory laws and other human rights abuses affecting key populations, particularly LGBT people.

#### **Box 1: DFID's new focus on key populations in Southern Africa**

Through its investment in the National Sex Work Programme in Zimbabwe, DFID will contribute to reaching 22,000 women by 2015 with a range of SRHR services, including provision of HIV testing and counselling, legal support and assisted referral to HIV services for FSW who test positive. As part of this programme, DFID is also supporting a collaborative research project to determine the cost effectiveness of providing ART for FSWs both for prevention (in the form of PrEP) and for treatment and care. This research will document the uptake and acceptability of ART provided through sex worker clinics; adherence to ART; uptake of a repeat testing program; uptake and acceptability of PrEP offered to HIV-negative FSW; adherence to PrEP; patterns of PrEP use; incident HIV infection; proportion of those taking ART or PrEP with drug resistance; and proportion lost to follow up. The results will be directly applicable to the debate around the feasibility of implementing treatment as prevention approaches in the region more broadly.

At the regional level in Southern Africa, DFID will be supporting research on innovative mechanisms for HIV prevention in prisons and among adolescent girls, as well as addressing the human rights of vulnerable groups. This will be commissioned through a regional research fund which will competitively allocate funds based on promising proposals for interventions on how to address the particular needs for prevention in prisons. The programme will also work through civil society organisations on how to make prevention in prisons (e.g. through condoms) politically more acceptable in Southern African countries.

As an essential complement to its bilateral work, DFID works through others to support key populations this ensures broader coverage in countries where it does not have a direct presence or where its bilateral footprint is changing. DFID's partners include:

- **GFATM:** GFATM is becoming the UK's principle financing mechanism for HIV and TB, including support for most-at-risk populations. In the first half of 2012 alone, GFATM-supported programs delivered 4 million community-based prevention activities targeted at most-at-risk populations, although it is recognised that coverage in sub-Saharan Africa is limited.<sup>20</sup> The future of Global Fund support in some middle-income countries with concentrated epidemics is uncertain and therefore requires a robust debate a strategy which the UK will be pursuing with the GFATM and partners. The GFATM's new strategy includes an objective focused on proactively promoting human rights in the programmes it finances, while through the new iterative review process, countries are being challenged to be more responsive to key population needs and to better target performance. In Indonesia, for example, a lack of progress among sex workers was identified, leading to a reprogramming of the grant to refocus interventions and geographical focus.<sup>21</sup> This resulted in an increased coverage of key populations and improved intervention mix.

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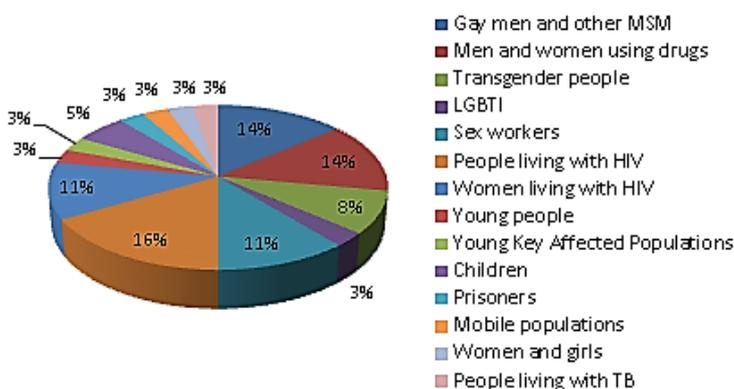
<sup>20</sup> GFATM 2012 Results Report

<sup>21</sup> Example from Grant Review papers

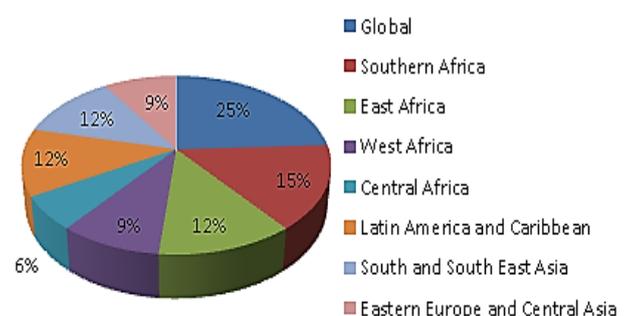
- Other multilateral agencies:** DFID is supporting work on key populations through its core support to UNAIDS and other agencies. For example, in 2011 the United Nations Population Fund (UNFPA) worked with governments, communities and NGOs to support HIV prevention and Sexual and Reproductive Health (SRH) services for sex workers in 81 countries. In 2010, the United Nations Office on Drugs and Crime (UNODC) began interventions among women who inject drugs and the female sexual partners of men who inject drugs in four states of India. Services now regularly reach 400 women who inject drugs and 700 female sexual partners of men who inject drugs. They include provision of female condoms and initiatives to prevent mother to child transmission of HIV.
- Civil society:** DFID has provided direct support to global and regional civil society networks. DFID has funded the Global Forum on MSM (MSMGF) and the International Harm Reduction Association (IRHA) over the past four and six years respectively. Their work has contributed to improved policies for key populations. For example, MSMGF partnered with WHO in 2011, to develop and launch its first-ever guidelines for the prevention and treatment of HIV and other sexually transmitted infections (STI) among MSM and transgender people. For health ministries and HIV service organisations at the country level, the guidelines filled critical gaps in knowledge. This provided the evidence-base necessary for the delivery of appropriate prevention and treatment services to MSM and transgender communities. DFID’s investments have also been catalytic in supporting underfunded key population groups. IHRA successfully enabled the start-up and sustainability of five new networks and leveraged further harm reduction funding from other donors through DFID’s grant. IHRA developmental support for these new networks has helped secure approximately \$17 million USD for harm reduction NGOs from non-UK sources over the course of the grant, a return on investment of approximately \$3 for every dollar of DFID investment in IHRA.<sup>22</sup>

Although direct support to these networks has ended, in recognition of the important role that regional and global networks play, DFID joined with the United States President’s Fund for AIDS Relief (PEPFAR), the Norwegian Government, and the Bill and Melinda Gates Foundation (BMGF) as a founding donor of the Robert Carr Network Fund. DFID has committed up to £4 million between 2012 and 2015. As figures 5 and 6 illustrate, in its first round of funding, grants were given across all major regions and included a diverse range of populations inadequately served by the current HIV response. The first round also demonstrated, however, that there was significantly more need than could be met from current resources available for the fund.

**Figure 5: RCNF 2012 grantees by inadequately served population**



**Figure 6: RCNF 2012 grantees by region**



<sup>22</sup> DFID Project Completion Reviews for MSMGF and IRHA

## 4.4. DFID focus on Women and Girls

The empowerment of women and girls is at the heart of the UK government's development assistance. In all of DFID's new bilateral HIV programmes since 2011 there has been a sharpened focus on women and girls. Good practice examples of gender approaches in other sectors that also include HIV benefits exist. However, the failure to make more progress in preventing infections among women and girls is alarming: a systematic approach to mainstreaming and measuring cross-sectoral HIV-related benefits is still required.

This section first explores how women and girls have benefited from HIV initiatives supported by DFID, before considering the HIV-related benefits of DFID's action for girls and women in line with DFID's 2011 strategic vision for girls and women.<sup>23</sup> It was beyond the scope of this review to comprehensively assess HIV-related benefits of cross-sectoral programmes. However, examples of good practice have been identified in those sectors where HIV linkages are considered to be particularly important.

### 4.4 (a) Benefits for women and girls of HIV initiatives supported by DFID

The case for a focus on women and girls is clear - they comprise 57% of people living with HIV in sub-Saharan Africa, and globally, young women aged 15-24 are most vulnerable to HIV, with infection rates twice as high as young men, accounting for 22% of all new HIV infections.<sup>24</sup>

DFID has responded to this need using a combination of policy approaches:

- **Building a programmatic focus on women and girls:** Since 2011, DFID's new HIV programmes have been designed with an increased focus on reducing infections among women and girls within DFID's HIV project portfolio. This focus includes targeting those women and girls vulnerable to infection, including adolescents in Southern Africa, Malawi, Zambia and Zimbabwe; and engaging with men and boys in order to improve outcomes for women and girls, for example through scaling up male circumcision in Zimbabwe, couple counselling and testing in Zambia, and involvement of men in PMTCT in Malawi.
- **Increased participation of women living with HIV:** DFID is supporting initiatives to promote the meaningful involvement of women living with HIV in issues that affect them and the RCNF provides a new channel through which global and regional networks of women living with HIV have been able to access resources.
- **Building the evidence base on what works for women and girls:** DFID funded research has a strong emphasis on gender issues. Gender-disaggregated data is used to improve understanding of the ways in which gender issues can influence outcomes. Section 4.8 outlines DFID support for the development of female initiated prevention technologies and research into how gender inequalities are reinforced and condoned by norms and social structures. DFID's new regional programme in Southern Africa supports research on specific and innovative interventions for prevention of HIV infections among adolescents with a focus on young women. The programme sees adolescents as a critical group for halting the epidemic in this region where intergenerational sex is a major driver and recognises that adolescents have particular reproductive health needs, which require more specific prevention services.

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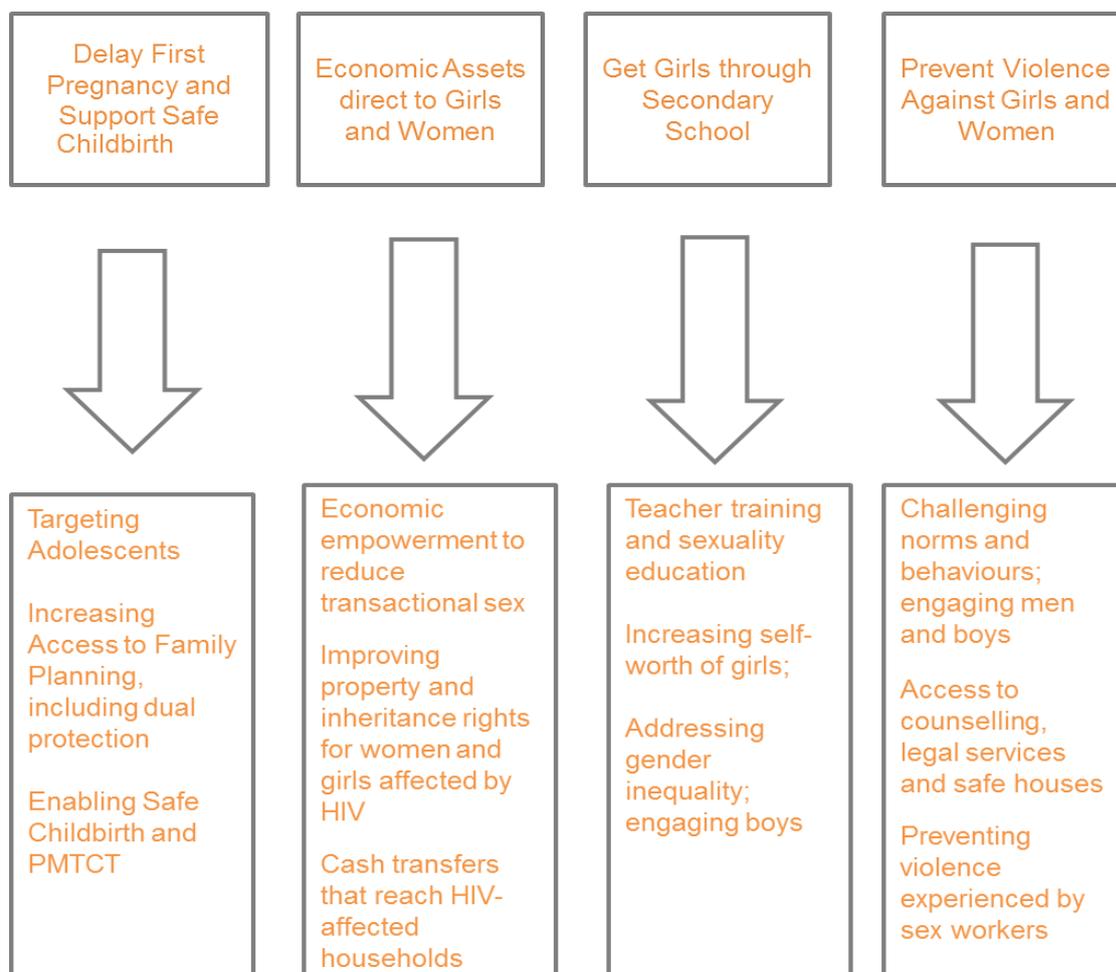
<sup>23</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/67582/strategic-vision-girls-women.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67582/strategic-vision-girls-women.pdf)

<sup>24</sup> UNAIDS, 2013

## 4.4. (b) HIV-related benefits from DFID's broader action on women and girls

The HIV-related benefits arising from DFID's broader action for women and girls are analysed according to the four pillars of DFID's strategic vision.<sup>25</sup>

**Figure 7: Examples of HIV-related actions undertaken within the Four Pillars of the Strategic Vision for Women and Girls**



### Pillar 1: Delay first pregnancy and support safe childbirth

The majority of actions within this pillar which have an impact on HIV are set out in DFID's Reproductive Maternal and Neonatal Health (RMNH) framework for results *Choices for Women*.<sup>26</sup> This framework recognises that addressing the specific sexual and reproductive health needs and rights of women at risk of HIV infection, or women living with HIV, is part of a comprehensive approach which includes targeting adolescents, increasing access to contraception, and enabling safe childbirth.

<sup>25</sup> DFID, *A New Strategic Vision for girls and women: stopping poverty before it starts*, 2011

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/67582/strategic-vision-girls-women.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67582/strategic-vision-girls-women.pdf)

<sup>26</sup> DFID, *Choices for Women: Planned Pregnancies, Safe Birth and Healthy Newborns: The UK's Framework for Results for improving Reproductive, maternal and newborn health in the developing world*, December 2010

The evaluation of the RMNH Framework for Results will examine linkages and integration with the HIV position paper through country case study analysis, a review of DFID programmes, and review of DFID's multilateral and influencing approach.

### **Targeting Adolescents**

DFID recognises adolescent girls as a group requiring particular attention. DFID seeks to implement holistic programmes that not only address the SRH rights, desires and needs of adolescent girls, but also seek to address social and economic gender inequalities that can increase girls' vulnerability (see Box 2).

#### **Box 2: Supporting Adolescent Girls in Zambia**

DFID Zambia has been supporting the Adolescent Girls Empowerment Programme since November 2011 (£10.4 million over 6 years to 2017). The programme aims to empower 10,000 vulnerable adolescent girls through acquiring social assets through a mentor, economic assets through money management and access to savings accounts, and health training and vouchers for accessing services, all of which can be drawn upon to reduce vulnerabilities and expand opportunities, thereby increasing school completion, delaying sexual debut, reducing early marriage, unintended pregnancy, risky sexual behaviour, HIV transmission and giving girls greater negotiating power in sexual relationships.

The programme has a significant research component, including a four year longitudinal study which will follow girls for two years after the intervention in order to test the longer term impact of the programme on the empowerment of adolescent girls. The programme will test girls at baseline for HIV and other sexually transmitted infections through the use of bio markers.

### **Increasing Access to Family Planning**

In order to prevent sexual transmission of HIV and prevent unintended pregnancy, increasing choice and access to a broad family planning method mix is critical. The UK hosted the Family Planning Summit in 2012; FP2020. Meeting the pledges made at FP2020 - including making contraceptive information, services, and supplies available to an additional 120 million women and girls in the world's poorest countries by 2020- is a UK government priority. Within this context DFID has provided support to UNFPA for a £17m female condom procurement to provide dual protection from HIV and other STIs, and unintended pregnancy. In addition, work will ensure that all women, including women living with HIV, realise their right to make decisions about their sexual health and support them in realising their fertility intentions.

DFID has social marketing programmes in a number of high burden HIV countries. Distribution of male condoms at scale has resulted in significant numbers of HIV infections averted (for example in Nigeria), and in Ethiopia the programme includes an explicit focus on vulnerable women (See Box 3).

#### **Box 3: Social Marketing in Ethiopia**

DFID support to social marketing in **Ethiopia** has to date resulted in the provision of almost 80 million condoms which have averted an estimated 12,000 HIV infections. The programme includes a focus on providing reproductive health supplies to vulnerable populations including sex workers, university students and women in remote, underserved areas, such as Afar and Somali. The programme reported training 2,444 sex workers as peer educators, exceeding its target by more than 50% with benefits including increased acceptability of demanding condom use with fee-paying partners and improved availability of affordable and attractive condoms.

## Enabling Safe Childbirth and Preventing Mother to Child Transmission (PMTCT)

HIV is the leading cause of death for women of reproductive age worldwide.<sup>27</sup> DFID recognises the need to support women living with HIV to access their sexual and reproductive health and rights, including through the integration of PMTCT of HIV within Antenatal Care. It supports scale up of PMTCT through its bilateral programmes (see Box 4) as well as through support to UNAIDS, WHO and UNICEF, leading the Global Plan to eliminate MTCT. However, reducing new infections in women is a central element of the Global Plan but progress remains slow, highlighting the critical need for continued prevention efforts.<sup>28</sup>

### Box 4: Preventing MTCT in South Africa

DFID provided support to **South Africa's** 'Accelerated Plan for PMTCT' (the A-plan) which combined tried-and-tested strategies to improve the quality of PMTCT at facility level with social mobilisation strategies to increase community demand and utilisation of services. A successful pilot phase in 2009 covering 161 facilities in six priority districts delivered impressive gains: the percentage of women seeking early antenatal care increased from 37% to 42%, and the percentage of pregnant women with a CD4 count below 200 being referred for, and starting ART, increased from 22% to 55%. DFID continued to support the A-plan as it scaled up nationally in 2011 and ensured improved harmonisation with other development partner efforts including PEPFAR, UNICEF and GFATM. These efforts have contributed to significant progress - between 2009 and 2012, South Africa has seen the number of new infections among children decrease by 63%.<sup>29</sup>

## Pillar 2: Get economic assets directly to girls and women

Women who lack access to and control over economic resources and opportunities, are potentially more at risk of HIV infection, particularly through transactional sex and lack of household decision-making power. DFID is working to support initiatives to enhance girls' and women's access to economic opportunities in a number of ways, including through support to financial inclusion, skills development, jobs matching, investment climate programmes and social protection mechanisms – the Adolescent Girls' Empowerment Programme in Zambia highlighted above is a good example.

However, it is often a challenge to measure the HIV-related benefits of these broader programmes. For example, DFID is contributing £17.5 million to a school fees assistance programme targeted at Orphans and Vulnerable Children (OVCs) in Zimbabwe. In 2012, 337,301 beneficiaries from 5,415 primary schools throughout the country were supported, and more than 50% were girls. Although it is not possible to state how many AIDS-related OVCs were reached given identification could increase HIV-related stigma, in a hyper-endemic context where there are an estimated 900,000 AIDS orphans<sup>30</sup>, the benefits to HIV affected children can be inferred.

The potential impact on girls is significant - studies show that HIV infection rates are at least twice as high among young people who do not finish primary school as those that do, which is especially true for girls who, with each additional year of education, gain greater independence, are better equipped to make decisions affecting their sexual lives and have higher income earning potential<sup>31</sup>.

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<sup>27</sup> World Health Organisation, 2013

<sup>28</sup> Global Plan Progress Report, 2013

<sup>29</sup> UNAIDS *Progress Report on the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive*, 2013

<sup>30</sup> UNAIDS, 2012

<sup>31</sup> Educate Girls, Fight AIDS, UNAIDS 2011.

### **Pillar 3: Get Girls through Secondary School**

Lower education outcomes for girls are associated with decreased levels of economic empowerment and higher rates of HIV infection. In Malawi 46% of all new HIV infections occur among young people, with young women three times more likely to be HIV positive than their male counterparts. DFID's Keeping Girls in School Programme drew on a World Bank evaluation of a conditional cash transfer experiment among teenage girls and young women in Malawi to keep them in school. It found that the stipends lowered HIV prevalence by 60%.<sup>32</sup>

DFID is a major donor of the Global Education Challenge Fund (GECF), funding six projects with a specific focus on HIV positive girls or girls affected by HIV, and eight projects that include HIV prevention activities, raising girls' awareness through teacher training and mentoring, girls clubs and specific HIV/ AIDS clubs (see box 5).

#### **Box 5: Theatre for a Change, Malawi**

With nearly £1.5 million through GECF, this project aims to improve the sexual and reproductive health of young Malawian girls to improve the learning outcomes of over 7300 marginalised girls, including HIV/ AIDS double orphans, or those with disabilities. The project trains teachers to run single sex after school AIDS Toto clubs each week. These are safe environments for girls to develop strong relationships, build their self-confidence, develop the knowledge awareness and skills to protect their SRH and improve their literacy and numeracy learning outcomes. Weekly mixed AIDS Toto Clubs include boys and focus on improving cooperation and communication between boys and girls, improving awareness about SRH and explicitly promoting gender equality. The messages are reinforced through radio listening groups.

### **Pillar 4: Prevent Violence against Girls and Women**

Violence against women and girls (VAWG) is a significant contributor to women's vulnerability to HIV. Studies show that women who experience physical or sexual violence by a partner are more likely to acquire HIV and STIs, as compared to women who have not experienced partner violence.<sup>33</sup> HIV positive women are also particularly vulnerable to, and have more lifetime experience of, violence than HIV-negative women.<sup>34</sup>

As outlined in the 2011 position paper, DFID seeks to promote the ability of women and girls to protect themselves from both violence and HIV transmission. DFID continues to scale up programming on VAWG, with targeted programmes in over 20 country offices, including in those countries particularly affected by HIV such as Malawi, South Africa, Zambia, Nigeria, Mozambique, Kenya, Uganda and Zimbabwe (see box 6). DFID is also on track to help 10 million women access justice through the courts, police and legal assistance, and is exploring new research and innovative programming to help end early and forced marriage which increases vulnerability to HIV.

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<sup>32</sup> World Bank Malawi Study: In Malawi, Money in Girls Hands Boosts School Enrolment. Jan 2010

<sup>33</sup> Jewkes et al, 2010; Weiss et al, 2008; Zablotska, 2009

<sup>34</sup> Maman et al, 2002

**Box 6: Integrating SRHR, HIV Prevention and VAWG in Zimbabwe**

DFID's integrated SRHR programme in Zimbabwe includes support for family planning, HIV prevention and VAWG. It is designed to improve health outcomes for the poorest and most vulnerable populations in Zimbabwe focusing on women and adolescent girls in particular. The VAWG component includes establishment of safe houses and referral pathways, access to counselling and legal assistance, as well as a behaviour change campaign to educate on women's rights and gender responsive laws, as well as address social norms that drive gender based violence. Some early results from the first year of implementation (mid 2012-mid 2013) include: 413 people (community leaders, health workers, police, etc) trained on GBV management and referral; 1,115 survivors provided with legal aid; 10,252 people exposed to messages on masculinity, gender responsive laws, women's rights, and gender norms, through community dialogues.

## 4.5 DFID focus on Integration of HIV with other Health Programmes

**Promoting integrated health services and supporting overall health systems strengthening are fundamental principles that drive DFID's approach. This is evident through both the way DFID structures its human resources, most DFID country health advisers work across the health sector, rather than on disease specific initiatives. It is equally evident in the way it designs its programmes to align with national health priorities, supporting donor coordination and filling strategic gaps.**

Integrated services provided through strong health systems are believed to be an important way to improve efficiency, reach more people and build the capacity and resilience of services to meet the changing needs of a community. Integration is important from the perspective of people that use services who may view their health in a holistic way, rather than as a set of individual health problems, although attention must be paid to rights-sensitive approaches to service delivery, particularly for PLHIV and key populations. This section first considers approaches to health system strengthening and then gives specific examples of how HIV services have been integrated with TB and RMNH.

### **Integration of HIV within the overall health system**

DFID has long recognised that strong health systems are needed to deliver effective HIV programmes. DFID has a significant focus on strengthening health systems in the countries in which it works, as articulated in its health position paper.<sup>35</sup> OPM found in their analysis of 113 programmes with HIV related spend, that nearly 50% of annual funding included support to strengthening reproductive health services, improving resource allocation for health and strengthening health systems. Since 2011, a number of DFID programmes such as those in Mozambique, Nepal and Kenya, have switched from directly targeting HIV to incorporating HIV within broader health programmes, sector-wide approaches or budget support. Box 7 illustrates this transition in Kenya and how DFID has remained engaged in the HIV response through its broader programming, GFATM contribution and advisory support.

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<sup>35</sup> DFID *Health Position Paper: Delivering health results*, July 2013  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/227184/Health\\_Position\\_Paper\\_final\\_for\\_matted\\_version.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/227184/Health_Position_Paper_final_for_matted_version.pdf)

### **Box 7: The UK's evolving role in Kenya's HIV response**

The national HIV/AIDS programme in Kenya is mainly off budget (80%) and largely funded by donors (98%); the US Government contribution is the largest by a considerable margin. This has resulted in a multiplicity of partners supporting a variety of different programmes, outcomes, funding channels and processes at all levels. The UK has been supporting efforts to tackle HIV in Kenya since at least 1997. A decision was taken by DFID in 2010, during the Bilateral Annual Review (BAR) process, not to continue funding a separate vertical HIV project, but to exploit DFID's comparative advantage by supporting greater harmonisation of approaches to deliver the results of the Kenya National AIDS Strategic Plan (KNASP). Since that time DFID has focused on ensuring HIV is addressed through its existing and emerging broader health systems strengthening, maternal health and family planning interventions. DFID also gives advisory support for critical policy work such as ensuring HIV is addressed as a cross cutting issue in national health planning processes and engaging in the development of the new HIV strategy. DFID attends the HIV working group, co-chairs development partner coordination meetings, and is an alternate representative for the bilateral donor constituency on the GFATM CCM. GFATM support in Kenya is focused on procurement of ARVs, improving the quality of diagnosis and treatment of TB, addressing TB/HIV co-infection particularly in vulnerable populations, including prisoners, people living in informal settlements, and mobile populations.

### **Integration of HIV with Tuberculosis**

TB is a major cause of death among PLHIV. In 2011, UNAIDS estimated that 430,000 people with HIV die of TB each year. DFID is supporting the integration of TB and HIV largely through civil society and multilateral channels.

DFID provides core funding to the Stop TB Partnership (STBP). In July 2010, STBP signed a joint Memorandum of Understanding (MoU) with UNAIDS to improve coordination at a strategic level to catalyse scale-up of TB/HIV and work towards ending deaths from TB among people living with HIV. Following an external evaluation, this was renewed in November 2012. Their joint efforts have contributed to increased HIV/TB collaborative activities. The impact of this can in part be seen in the 13% reduction in tuberculosis (TB)-associated HIV deaths between 2010 and 2012 and the increase in the numbers of people with HIV and TB co-infection accessing antiretroviral therapy (ART) - a 45% increase between 2009 and 2011.

Under the NFM of GFATM, practical guidance on TB/HIV interventions was developed alongside support to countries with high co-infection rates to put together concept notes for both TB and HIV. In 2013, GFATM provided around US\$ 200 million of new funding for TB spread over 25 grants.

Through civil society, DFID has supported a number of small-scale integrated HIV/TB projects. For example, the Southern African Catholic Bishops Conference AIDS Office has trained caregivers in South Africa to conduct screening for TB and rapid HIV testing in local communities. This resulted in a fourfold increase in the number of people initiated on TB treatment. A number of international NGOs, such as Christian Aid and the International HIV/AIDS Alliance have used their partnership agreement with DFID to integrate TB and HIV services. DFID is currently finalising plans to work with the World Bank to address TB and HIV in mining communities in Southern Africa.

DFID has also played a significant role in supporting the product development, policy development and scale up of new rapid diagnostic test for tuberculosis and rifampicin resistance - Xpert® MTB/RIF, a rapid molecular diagnostic test. Evidence to date has shown that it could double the number of HIV-associated TB cases diagnosed in areas of high rates of TB and HIV. UNITAID has been successful in market shaping for Xpert® MTB/RIF, reducing costs by over 40% and driving increased VfM for DFID's other TB-HIV investments.

## Integration of HIV with SRHR and MNCH

At the global level, DFID has been engaging in policy discussions to try to better define and measure integration in relation to HIV and SRHR. HIV and SRHR integration was part of the agenda of the FP2020 summit. Through its membership of the International Agency Task Team on HIV and SRHR linkages, DFID has been supporting a process to identify high quality indicators to measure linkages. This will feed into the accountability framework of FP2020.

At country level, DFID is supporting the provision of integrated HIV, SRHR and MNH services, some of which have already been highlighted in section 4.4 on women and girls. Donor cooperation in Zimbabwe between DFID and USAID has been central to the promotion of integrated of SRH and HIV services. As a result, it is now reported that most clinics in Zimbabwe have services that provide HIV testing and counselling and family planning together. Zambia is another example of a new DFID programme seeking to improve integration (see Box 8).

A number of civil society organisations are using their DFID PPA funding to support integrated approaches (see Annex B). For example, the International HIV/AIDS Alliance and Marie Stopes International (MSI) have used DFID PPA funding to establish a strategic partnership, resulting in the development of an SRHR-HIV integration tool, used by MSI partners globally to assess the readiness, quality and level of integration of their services.

### **Box 8: Scaling-up Integrated Voluntary Couples Counselling and Testing with Family Planning Services in Zambia (2013 – 2016)**

In Zambia, DFID is seeking to support increased demand for, and access to, integrated HIV prevention and SRHR services. Support is being given for scaling up couples voluntary counselling and testing (CVCT) with couples family planning counselling (CFPC) and provision of long-acting contraceptives (LARC). This is an integrated approach that has not been tested at scale which addresses the prevention of heterosexual and perinatal HIV transmission as well as unwanted pregnancy. In the first six months of implementation, the programme has provided integrated CVCT and CFPC services to 16,200 couples. As evidence on the benefits of integrated SRHR services is still limited, this service model will be carefully monitored to contribute to the evidence base of what works in a generalised epidemic context.

# 4.6 DFID Partnership with Civil Society

**Civil society organisations (CSOs) have been important partners in implementing DFID’s HIV portfolio. Through their programmes, they have complemented and extended what DFID has been able to achieve in implementing the position paper.**

This section presents areas in which the contribution of CSOs, supported through DFID, adds value to the HIV response. These areas are illustrated with brief examples from performance reporting through DFID’s civil society funding mechanisms and the case studies submitted as part of the consultation process.<sup>36</sup>

## Reaching Community Level

A significant comparative advantage of civil society is their ability to reach the community level. This can be done through promoting community ownership in planning and managing programmes, involving community members in the demand and delivery of integrated services, and supporting communities to participate in formal structures to hold local and national government to account. DFID has supported CSOs to reach communities through direct funding, building their capacity and gathering evidence on the added value of such approaches.

In Zambia, for example, TB Alert launched the Community-led TB-HIV Advocacy in Zambia (COTHAZ) project which trained 100 volunteers, many of whom are living with HIV themselves, to provide outreach visits to local communities. Through communicating accurate information, they are challenging myths and stigma surrounding both illnesses. The volunteers are also trained to identify symptoms and to refer to appropriate local services for TB and HIV testing. To date the volunteers are estimated to have reached over 3.3 million people.

## Reaching ‘Hard to Reach’ Groups

CSOs are especially well-placed to reach marginalised populations affected by HIV. This is particularly important in countries where governments criminalise or discriminate against specific groups, creating significant barriers to accessing services and protection of human rights. CSOs are pioneering work among groups often overlooked by conventional HIV programmes, such as disabled people and indigenous populations. CSOs not only provide services directly to these populations but they also seek to influence government to provide these services themselves, advocating on some of the structural barriers such as legal and policy reform and the protection of human rights.

A good illustration of this approach is the HIV/AIDS Alliance’s work through partners in India to support HIV services to 450,000 men who have sex with men, transgender people and hijras. Through training transgender and hijra advocates, there has been a greater understanding of the needs of these populations among local government. As a result, for the first time, the new national AIDS strategy includes a separate HIV prevention strategy for transgender people and hijras.

## Engaging with People Living with HIV

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<sup>36</sup> <https://www.gov.uk/browse/citizenship/international-development>  
<https://www.gov.uk/government/policies/improving-the-health-of-poor-people-in-developing-countries/supporting-pages/preventing-and-treating-hiv-and-aids>

HIV programmes are more effective when PLHIV are meaningfully involved. DFID has supported the Global Network of People Living with HIV (GNP+), the World AIDS Campaign and the Network of African People Living with HIV to work with networks of PLHIV in 15 countries. Christian Aid support to a local network of PLHIV in Sierra Leone resulted in the creation of 500 support groups, with over three quarters of membership consisting of women. The creation of these support groups has improved referrals for testing, treatment, care and support, as well as supported efforts to address stigma and discrimination through working with local chiefs to sensitise communities.

Catalytic DFID funding to the International Planned Parenthood Federation (IPPF) supported an international partnership with UNAIDS, GNP+ and the International Community of Women living with HIV and AIDS (ICW), to develop a Stigma Index. This has since been used by people living with HIV to carry out more than 70 studies of stigma and discrimination involving over 24,000 PLHIV, sharing their experiences and increasing their engagement on issues around local legislation and rights to service access. In India, the use of this index has resulted in a network of PLHIV taking on a watchdog role.

### **Transformative, Integrated Approaches to Addressing Gender Inequality**

CSOs are pioneering approaches to transforming gender norms that go well beyond simply providing services to women and girls. These approaches are beginning to address the root causes of vulnerability to HIV. For example, In the Eastern Cape of South Africa, DFID has supported a GNP+ project to protect young girls from Ukuthwala (forced marriage). Evidence on sexual and reproductive rights was used in campaigns targeting law enforcement agencies, and to develop a television documentary to raise national and international awareness. As a result, changes in the attitudes of local communities and law enforcement agencies led to the establishment of a one-stop centre for rape survivors, 12 arrests for practicing Ukuthwala and zero reported abductions of underage girls for forced marriage in the Eastern Cape.

### **Innovation**

CSOs are well placed to trial innovative ways of working, often incorporating new technologies. In Mozambique, Absolute Return for Kids successfully used text message appointment reminders to improve adherence to HIV treatment in urban areas. The use of hand held clinical support tools by the Desmond Tutu HIV foundation in South Africa enabled streamlining of consultations and speedier dispensing of medicines and family planning commodities.

### **Promoting Accountability**

CSOs play a critical role in holding governments to account, including promoting the human rights of key populations and PLHIV, and addressing the stigma and discrimination they experience. Civil society organisations have used many policy dialogue and advocacy mechanisms to achieve this including promoting the participation of affected populations, targeting decision makers, building and sharing evidence, and strengthening the capacity of institutions to respond to HIV.

For example, Help the Hospices has worked alongside local and national government officials in both India and Malawi to advocate for improvements in policies relating to hospice care for children with life-limiting illnesses, including HIV/AIDS. This has led to the improvement of children's palliative care services and entitlements reaching over 7,300 beneficiaries to date. Voluntary Services Overseas (VSO) Regional AIDS Initiative of Southern Africa (RAISA) has supported the development of care giver policies in seven countries through research, advocacy and lobbying for change. In Zimbabwe, this work has supported the development of a national policy which has improved the coverage and quality of care for PLHIV, and has resulted in increasing the number of male caregivers, with the aim of reducing the burden of care on women and girls.

In the UK, DFID funded STOPAIDS until 2012, to support the development of policy positions around HIV and AIDS, especially in relation to gender equality, family planning and post-2015.

# 4.7 DFID Influencing Beyond Financing

**DFID exercises influence, in addition to its financial investments, to strengthen the HIV response and maximise VfM. Examples of DFID influence include technical support, policy influence, political lobbying and negotiation, working with others and reforming institutions.**

This section illustrates a number of examples highlighted by DFID staff where different types of influence are perceived to have made a notable contribution to the HIV response. The examples were verified independently through stakeholder interview analysis and comments have been incorporated below.

## Technical Support and Policy Influence at National Level

At the country level, DFID staff have an influencing role through building relationships and trust with national governments and other stakeholders. They participate in sector wide approaches, National AIDS Councils (NACs) and GFATM CCMs, contributing to evidence-informed policy discussions and offering technical support on reform priorities.

DFID support to HIV in India is one example of this form of influence. DFID's HIV programme concluded in March 2012 as a result of DFID's transitioning aid relationship. With this ended a long term partnership with India on supporting very effective initiatives<sup>37</sup> which informed the policy and strategy of successive national HIV control efforts. Besides playing a strategic role in India's effort to contain HIV, DFID's value has been in influencing policy direction and coordinating stakeholders. DFID brought definite leverage in areas such as building capacity for scale up of interventions for the high risk groups including sex workers, IDU and MSM.

Stakeholders have raised concerns about the perceived declining influence of DFID in contexts where it is exiting from direct HIV programmes, which may have negative impacts in the future, in particular for support to harm reduction which has historically been DFID's comparative advantage.

## Political Lobbying and Negotiation at Global Level

The UK harnesses its Ministerial influence to play an active role in setting global priorities for HIV and lobbying for ambitious international targets. The UN High-Level Meeting (HLM) has been described by stakeholders as a "high-water mark" for DFID influence, and for the quality of consultation and cooperation with civil society. The UK mobilised support to secure some important outcomes, critically a recommitment to universal access with a goal of 15 million people on treatment by 2015, and recognition that prevention must be at the heart of the response including for key populations at higher risk of infection. Working with STOPAIDS as a member of their delegation, DFID provided a platform for representatives of civil society including key populations to make their voices heard.

More recently, as co-chair of the Post-2015 High-level panel, the UK has helped to facilitate a strong outcome which included health goals incorporating HIV.

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<sup>37</sup> Support included generating evidence regarding transmission-dynamics of the epidemic and developing programmes based on mapping of high risk groups and working with communities; support for the establishment of networks of People living with HIV AIDS; taking harm reduction to scale; Surveillance systems including analysis of survey results; Evaluation of Targeted Interventions which informed the prevention strategy.

Stakeholders felt that despite strong thought leadership, DFID's political influence around HIV is now becoming more limited due to a reduction of staff, and therefore technical capacity, within the organisation. Stakeholders also highlighted that opportunities to have high level ministerial statements which link HIV to government priorities around women and girls, transparency and economic growth could also be better used to shape the global dialogue on HIV.

## **Participation and Accountability**

DFID has showed a strong and systematic willingness to work with civil society more generally in the framing of policy and strategy, with robust support for key populations. Amongst civil society groups, stakeholders suggest DFID is known for being comparatively easy to work with through a team approach, open to frank conversations and, if need be, willing to have back-channel conversations that will facilitate negotiations in international meetings and forums.

The UK is a strong advocate for the involvement of populations affected by HIV to be represented in international and national policy fora. The UK has been a strong supporter of NGO delegations and representatives of PLHIV on the UNAIDS and GFATM boards, and has established positive working relationships with these groups. DFID's founding role in establishing the RCNF was seen by stakeholders as instrumental in reforming and building the capacity of civil society groups to participate in policy discussions both internationally and locally.

DFID, as a large scale donor, has had to work through large international and national organizations who have been described as 'brokers' of DFID's work and influence. Although it would increase DFID's transaction costs to work directly with national and local civil society groups, it was considered important to recognize and be sensitive to the complexities of these relationships, and to increase its involvement with established community watchdog functionaries and groups.

Stakeholders commented that DFID's preparations for high-level global and regional meetings tend to be late in the day, resulting in less time for DFID to consult and work with civil society in the run-up.

## **Reforming and Building the Capacity of Institutions**

The UK has played a critical role in pursuing reform of the international aid architecture, based on rigorous evidence-based analysis through its MAR. Since 2011, the GFATM has been a significant focus for the UK's reform efforts on HIV, TB and malaria. The UK not only provides finance to the GFATM, but also support through membership of its governing bodies. The UK sits on the GFATM's Finance and Operational Performance Committee, and has been very active on the Board, including in the provision of an interim Chair in 2012 and 2013. DFID country offices provide a range of complementary funding and support to national health plans and GFATM supported programmes.

DFID have also supported UNDP, UNFPA, UNICEF and UN Women using performance indicators of the UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) in their new Strategic Plan and Results Framework for 2014-2017 to help monitor progress in addressing HIV and AIDS and maximise the coherence, coordination and impact of the broader UN response to AIDS.

Stakeholders commended the role DFID has played in ensuring reforms are embedded, although civil society felt that DFID could play a stronger role in urging GFATM to support critical key population interventions in middle-income contexts. Stakeholders mentioned the role of DFID in demonstrating support for the GFATM in public fora and through quiet advancement of funds when needed most. Stakeholders also commended DFID for the global leadership and influencing displayed through its recent replenishment announcement. Stakeholders felt that DFID played an important role (through funding, as well as technically) in supporting the development of the Strategic Investment Framework (SIF) at UNAIDS. Support for a pilot project to build capacity to apply the SIF at national level was seen as critical, and contributed to the adoption of the principles of the SIF by GFATM within the NFM.

## 4.8 DFID Support to the Generation of New Evidence

**DFID has supported the generation of new evidence to inform its programmes and to provide global public goods for the wider HIV response. Alongside significant investments in research, including new support for studies on the structural drivers of the epidemic, DFID has conducted a number of HIV evaluations since 2011.**

DFID's research related to HIV has focused on:

1. Development of new technologies for HIV prevention (product development research);
2. Cost-effective ways of providing treatment for people living with HIV and AIDS (clinical trials);
3. Evidence to strengthen HIV programming (long-term research programmes)

### **Development of New Technologies for HIV Prevention**

DFID has supported the development of female initiated methods of prevention through its continuing support to the International Partnership on Microbicides (IPM). DFID was an early funder of research into the development of a viable AIDS vaccine and continues to support the International AIDS Vaccine Initiative (IAVI). DFID's funding for IPM will amount to £35 million between 2009 and 2018 and £45 million for IAVI over the same time period. DFID's support to WHO's Special Programme on Human Reproduction (HRP) also offers opportunities for research related to HIV acquisition.

DFID also supports product development research for TB, including the development of new vaccines, drugs and diagnostics. New diagnostics are required to identify and treat those infected with TB as early as possible, in order to reduce the spread of the disease. New TB drugs are required to effectively treat people co-infected with HIV, as existing TB medication interacts with commonly used ARVs, complicating treatment. Similarly, research into new vaccines is required as existing TB vaccines are not suitable for use with infants infected with HIV.

### **Cost-effective Ways of Providing Treatment for Adults and Children Living with HIV/AIDS**

The DFID funded Development of Antiretroviral Therapy in Africa (DART) and Antiretroviral Research for Watoto (ARROW) trials have shown that it is safe and effective to provide ART to both adults and children without the need for routine laboratory toxicity testing. For the same amount of funding up to one third more people can be treated. DFID continues to provide support to the Medical Research Council (MRC) Clinical Trials Unit for moving DART implementation forward into policy and practice in Africa. The Lab-Lite study is investigating ART delivery in remote rural settings, where health infrastructure is limited and there is no previous research experience.

DFID is also supporting the Sanitation, Hygiene Infant Nutrition Efficacy (SHINE) trial focused on the causal relationship between sanitation and child stunting. HIV-exposed but negative children have particularly challenging nutritional needs. SHINE will study enteric disease, gut damage and iron levels in all HIV exposed babies identified in the trial.

## Evidence to strengthen HIV programming

DFID has supported a number of long-term research programmes to generate evidence for improving HIV programming. Between 2006 and 2012, DFID supported research on HIV treatment and care (£3.8 million) and the social context of HIV (£3.8 million). The two programmes produced a wide range of evidence, including on the packages of treatment and care services that can be delivered in different settings, to different groups (such as PMTCT with a focus on HIV positive women, not just their infants); ART delivery in remote areas; the mental health needs of PLHIV; how to take account of the needs, and remove barriers for PLHIV with disabilities; ways to measure the psychological, social and economic impacts of HIV; and how to increase access to services for OVCs.

Most recently, DFID has invested £6 million in a long-term research programme Tackling the Structural Drivers of the HIV Epidemic (STRIVE) (2011-2017). It is investigating the social norms and inequalities that drive HIV, based on the need for more evidence on how such structural forces increase vulnerability to HIV and on the interventions to address these drivers that work in practice. Its research includes the impact of conditional cash transfers designed to keep young women in school; the impact of alcohol especially related to intimate partner violence and high risk sexual encounters; gaining a stronger understanding of the drivers related to transactional sex; modelling the impact of stigma and discrimination, particularly related to PMTCT; and developing tools to more accurately determine the root causes of transmission.

## Generating New Evidence through Evaluation

DFID is also generating evidence from the evaluation of its programmes. Since the 2010 Bilateral Aid Review (BAR), it is a requirement that all new DFID programmes consider evaluation as part of their design. A number of HIV-related independent evaluations and two Independent Commission on Aid Impact (ICAI) reports have been published since 2011, evaluating both country programmes (Zimbabwe, Burma, India, Sierra Leone) as well as multi-country studies on behaviour change and community responses (summary findings are summarised in Annex D). Publication of HIV-related evaluations in South Africa and Vietnam are due next year. Along with other internationally supported HIV-related evaluations, DFID supported a process to synthesise the learning from these evaluations. Evidence on HIV prevention was drawn from this work and was published by OECD DAC.<sup>38</sup> It is also being used to influence the work of the UNAIDS Monitoring and Evaluation Reference Group, of which DFID is an active member, in particular in promoting the use of shared indicators to monitor the global AIDS response, and strengthening evaluation practice. UNAIDS will shortly launch a global Evaluation Repository to improve access and uptake of evidence.

DFID is increasingly collaborating with the World Bank to conduct HIV-related evaluations which are underway in multiple countries, including:

- Southern Africa - evaluating the effectiveness of incentives to reduce risk behaviour among young adults to improve HIV prevention impact; strategies to improve adherence to ART; different implementation strategies to create increased demand for male circumcision;
- Zimbabwe - evaluating programmatic efficiency and effectiveness of the Government's programmes on integrated HIV and sexual reproductive health services; estimating the impact of the Combination HIV Prevention Strategy;
- Uganda - evaluating the effect of scaled-up combination HIV prevention, including the effect of local hot spot 'targeting' of HIV prevention interventions in a generalised population setting.

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<sup>38</sup> See OECD/DFID, The DAC Network on Development Evaluation "Preventing HIV: Lessons from Evaluation", *Evaluation Insights*, Number 7, November 2012  
[http://www.oecd.org/dac/evaluation/Evaluation%20Insights%207\\_preventing%20HIV%20final%20reformat.pdf](http://www.oecd.org/dac/evaluation/Evaluation%20Insights%207_preventing%20HIV%20final%20reformat.pdf)

## Applying Evidence in Practice

There are several examples where evidence generated from research, evaluations and other sources have been used in DFID-supported programmes and more widely. DFID's use of evidence to advocate for, and implement, scaled-up harm reduction programmes in Asia is a notable example – evidence was used in India to establish opioid substitution therapy in 52 centres across 15 states providing services to more than 5,000 people by November 2011. Examples of how the findings from evaluation of the community response to HIV have been used are outlined in Box 9.

### **Box 9: Evaluation of the community response to HIV: Examples of evidence being used in practice**

In India, the findings provided further evidence that Community Based Organisations (CBOs) and empowerment of groups at high risk of infection can positively affect the course of the epidemic. These findings persuaded the government and joint donor investments (World Bank/DFID) to fund CBOs to implement structured interventions, targeting high risk groups.

In Kenya, the findings were used by government to operationalise the community response pillar of the national HIV strategy, and address gaps in the prevention programme such as the lack of CBO referrals. Findings were also used by CSOs for advocacy purposes.

In Nigeria, the presentation of the results of the community evaluation created strong interest on the part of the Federal government. A series of policy briefs for each of the six states involved in the evaluation were developed to inform resource allocation decisions by the State Agency for the Control of AIDS (SACA) for funding to CSOs.

In Senegal, it was found that CBOs have a strong positive effect on both voluntary counselling and testing, and post-testing outcomes. This was used during the GFATM negotiations to include on-going support for CBOs, preventing the closure of HIV testing sites. The government also decided to reverse its decision to replace social mobilisation with peer-mentoring after the impact evaluation found that each approach was particularly effective with different groups. CBOs are now combining both approaches.

In Zimbabwe, the findings provided evidence that the community response is an important factor behind the behaviour changes that had taken place, providing strong justification for maintaining support to community groups.<sup>39</sup>

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<sup>39</sup>See DFID, HIV/AIDS Evaluation Synthesis Report, 2012 [http://r4d.dfid.gov.uk/pdf/outputs/hiv\\_aids/61077-SynthesisingInternationalEvidencefromHIV-relatedEvaluations\\_FullReport.pdf](http://r4d.dfid.gov.uk/pdf/outputs/hiv_aids/61077-SynthesisingInternationalEvidencefromHIV-relatedEvaluations_FullReport.pdf)

# 5. Summary of messages from the Consultation Process

The consultation process comprised three workshops and an online survey. The workshops all involved CSOs, academic institutions, multilateral organisations and other development partners.<sup>40</sup> The workshops were conducted throughout June and July 2013 in London and two regional hubs - Johannesburg and New Delhi. The online survey was live during this consultation period.

## Aims of the Consultations

The aims of all three workshops and the online survey were four-fold:

1. To **understand** the evidence available and reflect with DFID partners on results achieved to date (May 2011-May 2013) under the 2011 HIV Position Paper, as a contribution to inform the review;
2. To **situate** the results in the context of evolving local, regional and global context and evolving priorities and provide insight to the Parliamentary Under-Secretary of State on how DFID is responding to HIV and AIDS;
3. To **identify** successful strategies, examples of best practice and outcomes to inform the development of a Theory of Change to guide and strengthen implementation of DFID commitments on HIV in the future; and
4. To **develop** strategic recommendations as to how DFID can be more efficient, effective, provide better value for money and maintaining its comparative advantage for the remainder of the Position Paper's mandate, based on its existing footprint.

## Main Points Raised

The following summary outlines the main points raised during the consultation process, within general themes. This section was written by OPM who summarised comments directly from the workshop consultation reports.

### Historical Role and Comparative Advantage of DFID

DFID is well regarded by most stakeholders, praised for the flexibility of its funding, its technical expertise, its historic political and technical role in the HIV response, and its support for civil society and institutions such as the Global Fund. Nevertheless, stakeholders commented that DFID needs to ensure that it continues to act where it has a comparative advantage, perceived to be primarily in the following areas:

- Advocacy and programming beyond biomedical prevention interventions, particularly associated with addressing **structural drivers** of the epidemic;
- Thought leadership particularly in terms of rights-based approaches to HIV and support **for key populations**;
- Catalytic investments in harder to measure areas – such as legal reform and human rights – particularly through small-scale but influential support to CSOs;
- An important political position to influence the actions of multilaterals.

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<sup>40</sup> See separate workshop reports for further detail

## Structural Drivers and Critical Enablers

Stakeholders commented that DFID has taken seriously the need to address the 'critical enablers' identified in the UNAIDS Strategic Investment Framework. DFID is perceived to have shown leadership on this by investing in networks and organisations which undertake activities such as policy advocacy, policy and law reform, civil society strengthening and community mobilisation. All of which are essential to the success of HIV prevention, treatment and care, particularly for key affected populations.

## Key Populations

DFID is seen by stakeholders to have an impressive track record in investing in activities to further the rights of key affected populations. However, many commented that both coverage and access for marginalised groups remains inadequate and there is a need to consolidate the gains achieved. Some participants expressed concern that DFID is in danger of losing its comparative advantage in the area of key populations. In particular, there was concern about the scope for DFID to retain its support for civil society post 2015, and about the loss of DFID's voice and influence.

There was a view that DFID can enhance the effectiveness of its interventions in the workplace by supporting trade union action directed at eliminating stigma and discrimination. Trade unions, in partnership with employers, are in a position to play a decisive role in a comprehensive strategy with regard to eliminating discrimination and stigma, but also for prevention, treatment, care and support.

Some participants felt DFID could be doing more in taking a tougher, more vocal stance on some of the more controversial issues such as criminalisation. A stronger partnership with the Foreign and Commonwealth Office (FCO) on these issues was also proposed. Caution was however expressed about how quickly accountability and national ownership can be achieved on such issues, especially with regard to key populations, where there is an on-going need for non-stigmatizing, non-judgemental environments in which they can access services.

Some participants pointed out that the focus on key populations can result in young people, especially girls, being overlooked. It was felt that DFID's approach, which includes gender analysis and a critical appraisal of women's needs, can inform innovative programmes that are deliverable within the context of competing and challenging priorities. Stakeholders commented that DFID can bring a wealth of international and national expertise to designing and testing delivery models.

## Treatment, Care and Support

While DFID may have a comparative advantage and focus on prevention, some stakeholders felt that it should not see prevention and treatment as competing options, but rather intricately linked. It was stressed that DFID has a critical role to play in promoting structural prevention interventions but must also have a voice on treatment as prevention and the new treatment guidelines. This could include a role in monitoring drug manufacture and Trade-Related Aspects of Intellectual Property Rights (TRIPS), particularly in the context of India. Simultaneously, some stakeholders wanted DFID to continue to invest in care and support, including physical and psychosocial support and palliative care, in tandem with gender and HIV-sensitive social protection. These are all areas needing more global attention and it was felt that DFID could have a strong voice.

## Integration

Integration was identified as an area where DFID is increasing its effort, but stakeholders felt more work is needed to maintain momentum. This includes going beyond health to integrate HIV within broader development sectors in recognition of the complexity of people's lives and the cross-cutting issues that affect them, such as gender inequality, stigma and discrimination.

## Research

Stakeholders mentioned how DFID has historically been an 'early mover' on innovative HIV research or programming, and has played a leadership role in terms of international policy. However, concerns were raised regarding DFID's continued visibility and influence and there was a call to step up its leadership in the field of HIV research again.

There was recognition that results are critical for donor organisations but that DFID could also be playing a better role in disseminating and encouraging uptake of research findings, for example in relation to support for community organisations to better document evidence of impact.

## **Capacity Building and Civil Society Strengthening**

Stakeholders spoke about how DFID's investments in civil society have shown the catalytic effect of seed funding in nascent or emerging civil society networks and organisations, with high returns for DFID investment. Many participants expressed support for the Robert Carr Fund in particular, and called for increased DFID investment, but participants cautioned that DFID should be doing more to support national and local networks as well as the regional and global networks supported by the Fund.

It was felt that DFID's investments have built infrastructure and increased capacity not only amongst health care workers, but also communities. Nevertheless, there were concerns that civil society remains fragile in many countries, but there were calls for a need to maintain and increase support, through direct funding where necessary.

## **Multilateral Influence**

Participants acknowledged that the UK government has maintained its political leadership in the HIV response globally – leveraging the support of other donors and being a vocal leader of progressive good practice in HIV programming. In this respect, there were several calls to ensure that GFATM is adequately funded, and that its track record justifies increased UK investment. Participants were keen to understand how DFID would increase its influence through its funding of multilateral partners (such as the EU, Global Fund and World Bank). Participants wanted to know how DFID would position itself as a future partner in countries transitioning from direct overseas assistance.

## **Private Sector Engagement**

Participants were interested in DFID's emphasis on private sector engagement within development; seen as an important new mechanism for achieving future sustainability. They asked if DFID would use this influence to open channels of communication between the harder to reach communities in partner countries and the UK private sector.

## **Need for New Strategy**

There was a view from stakeholders that the current HIV position paper is outdated due to significant technical and programming innovations since its publication and so it is unable to adequately guide DFID's HIV investments. The review document, while welcome, was anticipated by some to be inadequate in filling this gap. A renewed position or strategy was called for by some participants to ensure that DFID investment harnesses all the latest innovations which can have a significant impact on the course of the HIV epidemic, particularly for marginalized groups. Concern was also expressed about the lack of measurability associated with the Position Paper and the lack of a baseline or of a theory of change. DFID were encouraged to put these in place for future activities.

It was pointed out that scope exists for regional and global learning across DFID programmes, either separately or in partnership with other donors (for example, the BMGF). Applying the learning from how India and other countries have partnered key populations with sub-Saharan African actors was mentioned several times.

## **Post-2015 Agenda**

DFID was encouraged to draw on lessons from the response to health and HIV in shaping the post 2015 agenda. It was felt that the final report should also 'read' from a post-2015 perspective in order to get the best from it.

It was felt that DFID should work to ensure that the progress made under MDG 6 is not lost. Participants felt that DFID should push for a target focused on protecting human rights through the repeal of all punitive and discriminatory legislation and the enforcement of anti-discrimination law. This would benefit not just the HIV response, but all aspects of development and poverty eradication.

# 6. DFID Response: Priorities to 2015

The HIV landscape continues to rapidly change. It is characterised by multiple epidemics involving different populations which have evolved and matured, presenting new opportunities and challenges in each context. The rapid scale up of ARVs has had a dramatic impact on prolonging life (maintaining prevalence levels), and to some extent reducing new infections, but high incidence levels will remain a critical challenge into the future, particularly among women and girls and key populations. New evidence and scientific advances create promising opportunities to further accelerate progress, alongside addressing behavioural and structural barriers such as stigma and discrimination, gender-based violence and gender inequality. DFID therefore remains committed to the three strategic priorities set out in *Towards Zero Infections* - to significantly reduce new infections; to scale up access to diagnosis, treatment, care and support; and to significantly reduce stigma and discrimination. Over the next two years, DFID will focus its efforts in the priority areas outlined below.

## **Shifting the balance: ensuring investment and influence through bilateral and multilateral channels are complementary and play to DFID's comparative advantage**

### *Bilateral approach*

As stated in the HIV Position Paper, and evidenced by this review, DFID's bilateral footprint on HIV has shifted significantly over the last few years to a more focused approach in fewer countries where the need is greatest and where we can add value.

Since 2010, DFID has focused its new bilateral HIV investments in the region hardest hit by the epidemic – southern Africa – with an emphasis on addressing prevention gaps. On-going HIV prevention investments in sub-Saharan Africa focus on countries with resurging epidemics (e.g. Uganda) or large numbers of infections (e.g. Nigeria). This includes working increasingly with key populations in Africa, as the epidemic changes, as well as improving the way we serve girls and women.

DFID has prioritised direct bilateral HIV funding for critical prevention gaps given the urgent need to reduce new infections, particularly for women and girls. Integrated modes of delivery for these services are being increasingly supported. DFID sees its comparative advantage in supporting not only biomedical prevention strategies, but also addressing structural barriers that drive the epidemic and inhibit effective uptake of biomedical interventions, such as stigma and discrimination and gender inequality. DFID will actively seek to apply the evidence emerging from the STRIVE research consortium to its own programming as well as use it to influence others through evidence-informed debate. It will also use the evidence from its HIV-related evaluations to inform future programming and share lessons across countries through establishing a multi-country DFID HIV evaluation reference group.

Indirect bilateral programmes focused on broader health outcomes in high burden HIV contexts include activities that play to DFID's comparative advantage through encouraging greater domestic financing for basic services; donor coordination and alignment to national plans; health systems strengthening; engaging on governance and economic issues; innovative approaches, particularly for reaching the hardest to reach; research and evidence; and data collection and analysis.

### *Multilateral approach*

Multilateral organisations can work and help achieve impact in many more countries, and at a larger scale, than the UK can reach on its own. This is why the UK recently announced up to £1 billion commitment to GFATM for the 2014 – 16 replenishment. This amounts to more than doubling of UK support and will help GFATM roll out the NFM and support countries scale up cost-effective, high-impact interventions to fight the three diseases. It is estimated that 50% of GFATM funds will go to HIV. As the UK's principle financing mechanism for HIV and TB, and in most countries the only mechanism through which DFID funds ART scale-up, this is an important complement to DFID's bilateral programme.

Given this significant commitment, it is critical that DFID continues to play an influencing role on the GFATM's board and committees to ensure policies and ways of working are effective and achieving maximum impact. In particular, DFID will monitor progress on improved coverage and retention of HIV and TB treatment, including PMTCT; increased number of programmes which respond to gender-based violence; credible and sustainable graduation of middle-income countries; scaling up of investments to the most at-risk populations; and implementation of the gender equality strategy, including systematic reporting about the impact of its programmes on women and girls. As the UK graduates from middle income countries, it will ensure a robust debate around addressing the needs of key populations in these countries with the GFATM and other partners. DFID will also support its country office network to work with GFATM on the ground to ensure proper monitoring and accountability.

In addition, the UK sees the role of UNAIDS and the Stop TB Partnership as critical during this replenishment. They must intensify their support to countries to develop credible, evidence-based, national strategies from which GFATM grant applications are drawn, and ensure appropriate participation of PLHIV, women, and other key affected populations in country dialogues. DFID will urge UNAIDS to support quality strategic investment approaches at the country level, and intensify technical engagement in GFATM processes. UNITAID's ability to impact on the availability and affordability of essential medicines will continue to be a strategic lever in DFID's response.

### **Maintaining key populations as a policy priority and the role of civil society as an important partner moving forward**

Key populations remain an HIV policy priority for DFID both from a public health and human rights perspective, and we will continue to advocate for neglected groups within international and national fora. Our ultimate vision for key populations is that their rights and health are recognised, respected, and responded to by the governments of the countries in which they live.

DFID will use its influence with multilaterals, particularly UNAIDS and GFATM, to push for greater monitoring, leadership and investment in key populations, to increase involvement of those affected in shaping and strengthening the response, and to hold UNAIDS co-sponsors and member states accountable for their response. DFID will do this through its influence on boards as well as monitoring specific progress on key populations through performance management frameworks (the UNAIDS UBRAF and GFATM's Key Performance Indicators).

The UK will continue to address stigma, discrimination and criminalisation on the grounds of sexual orientation and gender identity through efforts led by the FCO to build support for LGBT rights. The FCO's clear message is that human rights are universal and should apply equally to all people. The UK works through international organisations such as the EU, UN and the Commonwealth, as well as bilaterally through our Embassies and High Commissions, on human rights issues, including LGBT issues. DFID will continue to raise concerns with Governments bilaterally through UK ministers and officials (whether this is done publically or in private is guided by the context) and will consider partner governments' respect for human rights through its Partnership Principles – principles that govern the UK's direct financial aid to countries. The UK's broader efforts to strengthen the rule of law, improve access to justice, build capacity on human rights and support civil society are also critical to the response.

The way DFID funds key populations is, however, evolving. We recognise that a significant amount of direct financial aid has previously been through innovative bilateral programmes for key populations, particularly in the Asia region. As DFID graduates funding from these middle-income countries, it will increasingly work through global and regional mechanisms and partners. Tracking GFATM investments to key populations, including through critical core support to national networks and holding national governments to account, will help to ensure these groups are not left behind. Civil Society are another essential partner through which DFID will invest. Civil society has a particular comparative advantage in supporting key populations and addressing related critical enablers (such as policy influence, legal reform, civil society strengthening and community mobilisation) pivotal to a successful response. Funding for global and regional networks for this work is seen as a strategic gap, not covered by the GFATM or national programmes. DFID has sought to address this gap in becoming a founding supporter of the Robert Carr Fund. DFID sees this as an important channel for its response, and will consider options to support this kind of work in the future, subject to review of results and VfM.

### **Strengthening our focus on women and girls affected by HIV through increasing integration of HIV with health and broader development priorities**

Although HIV remains a public health priority for DFID and part of a human rights response, it must not be treated in isolation if women and girls are to benefit. DFID's approach will be to increasingly address HIV alongside other health and social problems. This can be achieved through routine health services and by integrating HIV prevention into broader efforts to work with communities to promote and protect their own health and rights. DFID plays an important role in helping countries to develop their national health systems in ways that address problems of access, equity quality and coverage across a range of health problems, including HIV, in order to accelerate progress towards universal health coverage.

Although there are undoubtedly challenges and context-specific dimensions to integrated delivery, the body of evidence is growing around the benefits of integrating HIV within broader health systems as well as with specific health services. DFID will continue to contribute to this evidence base so that high quality HIV-related services are appropriately provided and integrated within primary and secondary health services, with a particular focus on women and girls. Evidence will be generated through programme learning, and investing in operational and implementation research to identify ways of strengthening health and community systems. DFID funded research will have a strong emphasis on gender, tracking gender-disaggregated data, to improve our understanding of the ways in which gender norms and dynamics influences the outcome of interventions and programmes. There will also be a specific focus on integration as part of the Reproductive, Maternal and Newborn Health (RMNH) framework for results evaluation.

Understanding the HIV benefits of wider investments not only applies to health programmes, but also to broader development priorities for women and girls in high-burden HIV contexts, such as violence against women and girls, social protection and livelihood programmes. Although there are many examples of DFID's broader programming in these contexts, HIV benefits are not always clearly tracked. In addition to continuing its work internationally to improve the measurement of HIV and SRHR linkages, DFID will work to improve the way it delivers integrated programmes and measures gender disaggregated HIV related results. DFID will explore a number of specific programmes that, through programmatic course corrections, could improve integrated outcomes. These will focus in particular on approaches for adolescent girls as a critical group in danger of being left behind in the HIV response but in need of a cross-sectoral gender transformative approach to prevention.

DFID is currently developing a new programme on sexual and reproductive health in emergency response and recovery, with the aim of building resilience in countries so that they can be better prepared. This will include services to reduce the transmission of HIV. The highest maternal mortality and worst reproductive

health is in countries experiencing crisis. In emergencies girls and women are more vulnerable to rape and transactional sex.

## **Supporting sustainable, comprehensive HIV responses for prevention, treatment, care and support that deliver effectively, efficiently and equitably**

DFID recognises that a major challenge for the HIV sector moving forward is durability of the response. This will require HIV responses to be effectively managed within the context of broader health services and other development sectors, and concrete solutions found to sustainable financing.

DFID will continue to support greater VfM in the HIV response, particularly through its role in shaping market dynamics to bring down the cost of drugs, improve the effectiveness of drug regimens, and tackle the challenges of potential drug resistance. Working with the private sector to achieve these goals is crucial. VfM will also be central to DFID's approach to working with multilaterals, applying research and evidence and rigorously monitoring the progress of our investments, managing implementation well, and taking corrective action where necessary.

DFID welcomes the shift towards greater shared responsibility for HIV with many countries increasing domestic resources. DFID will use global, regional and national platforms to advocate for national governments to contribute their share in resourcing HIV and health. These resource flows need to be sensitive to meeting the needs of the poorest and marginalised, deliver a comprehensive response balancing investment across prevention, treatment, care and support, and recognise and support the on-going role of civil society in ensuring an effective HIV response.

DFID follows the advice of the new WHO treatment guidelines, recognising that they may present countries in resource-constrained environments with challenging decisions over the immediate costs of scaling up ART in the context of their overall health expenditure and other pressing development priorities. DFID therefore strongly emphasises the recommendation that as a priority, ART should be initiated in all individuals with severe or advanced HIV clinical disease and individuals with CD4 count  $\leq 350$  cells/mm<sup>3</sup>. Where there are resources and capacity to further roll out treatment at higher CD4 cell counts, DFID will work to help ensure that this does not have negative impacts on other HIV spending priorities, the broader health system, or the access of poor people to the treatment they need. DFID will also work to ensure that implementation occurs in a context of informed consent, confidentiality and respect for human rights.

Although there are numerous mathematical models documenting the cost-effectiveness of test and treat strategies, there is a lack of analysis on how the introduction of these strategies will impact the broader health system in resource-limited countries. In order to help inform national policy and decision making, DFID will support analysis through CHAI to better identify the short-term affordability and longer-term sustainability of test and treat strategies, the opportunity costs of introducing these strategies into national health programmes, and the equity and human resource implications.

## **Looking to the Future**

DFID will work within the post-2015 process to ensure global commitments to finishing the job on existing MDGs, including MDG 6, as well as learning lessons from the HIV response into the new framework. DFID will use the insights, lessons, and recommendations from this review to ensure its investments are responding to the rapidly evolving context to achieve efficiency, effectiveness and equity. DFID will not have a separate HIV strategy beyond 2015, but will rather use the post-2015 framework as a platform for integrating HIV within other sectors, recognising and building on the unique successes and learning from the HIV response to date, and the implications for health and development more broadly. DFID will assess progress on elements of its HIV portfolio within existing planned processes such as the evaluation of the RMNH framework for results.



# Annex A: Key results of Bilateral HIV Programmes

Country	Portfolio Highlights <sup>41</sup>	Project Title	Headline results	Project score <sup>42</sup>
<b>AFRICA</b>				
DRC	<p>£4.6 million to Christian Aid to improve the quality of lives rendered vulnerable and poor by HIV/AIDS in 11 provinces.</p> <p><i>2013 - 2018: £182m (incl. £3m from SIDA) to increase access to essential health care. A focus on RMNH includes ARV provision to reduce MTCT and prevent HIV among women who have experienced sexual and gender-based violence.</i></p>	Christian Aid HIV Project 2006 – 2011	The living conditions of 18,327 beneficiaries improved within 5 years and almost all continued to receive assistance. Behaviour change and increased awareness of HIV was achieved within faith based organisations with the involvement of 110 religious communities and 11 provincial networks of those communities.	A
Ethiopia	£18m to scale up access to RH commodities. Private sector support through social marketing aims to increase the demand and supply of RH commodities for family planning and HIV prevention; a cost effective way of reducing maternal mortality and HIV infection, complimenting DFID health sector support.	Access to Reproductive Health Commodities 2011 –2015	In 2011/12, DKT provided almost 80 million condoms which were estimated to have prevented almost 12,000 HIV infections. The proportion attributable to DFID was not documented in the annual review	A+
Kenya	<p>2008-2012: £20m to reduce the spread of HIV, improve the quality of life of those affected and mitigate the socio-economic impact of the epidemic in Kenya</p> <p><i>.In addition, DFID supports HIV-related outcomes from broader health programmes, including supporting social marketing of condoms for HIV prevention, SRHR and family planning</i></p>	Kenya Harmonised HIV and AIDS Programme 2007 - 2012	Since 2010 DFID has contributed to: delivering 120 million condoms; halving the percentage of men reporting multiple partners (11.9% to about 5%); increasing the number of people tested and counselled for HIV to 6.3m (exceeding the 2.8m target). DFID supported development of various policies on HIV such as PMTCT, the development of a circumcision policy and the roll-out of the Voluntary Medical Male Circumcision.	A
Malawi	<p>2008-2009: £19m to support the National AIDS Programme.</p> <p><i>£21m over 5 years to support national HIV prevention initiatives, including innovative work to involve men</i></p>	Support to Malawi's National AIDS Response 2008 –2012	In 2011/12, DFID contributed to providing 1.2 million free and 900,000 socially marketed condoms; HIV testing and counselling for 108,000 people and 32,778 pregnant women; ARVs to 3,933 pregnant women and 7 clinics for male circumcision. The estimated annual	A

<sup>41</sup> Italics denote new programmes for which results are not yet available

<sup>42</sup> Taken from latest annual review or project completion report from DFID's corporate monitoring system. For evaluations summaries, see Annex D.

	<i>and boys. Expected outcomes: provision of 23 million condoms, HIV testing and counselling for 1 million people, and 17,000 pregnant women.</i>		number of new HIV infections fell from 57,000 to 46,000. Life expectancy rose from 39 (2005) to 50 (2011).	
Mozambique	2009 – 2013: £1.4m to support the National AIDS Council to improve the coordination of the national response according to the priorities set out in the national strategic plan	Support to the National AIDS Council: HIV Common Fund 2009 –2013	In 2011, the national programme distributed 71 million condoms; provided testing and counselling for almost 3 million people (a 79% increase from 2009), provided ART to more than 241,000 adults, 23,000 children and 81,000 pregnant women. Up to 5% of these results were attributable to DFID funding.	B
Nigeria	2008-2014: £100m to enhance Nigeria's response to HIV/AIDS. The programme aims to reduce the spread of HIV and mitigate the impact of AIDS in Nigeria through improved access of those most vulnerable to infection to effective services and information for prevention, treatment, care and support.	Enhancing Nigeria's Response to HIV/AIDS (ENR) 2008 – 2014	In 2012, the distribution of 213 million male and female condoms averted an estimated 1 million DALYS and prevented 33,485 HIV infections. 5 states supported by DFID have anti-stigma laws and a further 7 generated state level evidence, including Modes of Transmission study, State HIV/AIDS and Reproductive Health Survey and State AIDS Spending Assessment.	A
South Africa	£25m over 5 years to support a revitalised response to AIDS and health including: improving quality of services, promoting equal access, strengthening management and planning, improving M&E and improving donor coordination. The programme includes support to the Treatment Action Campaign.	Strengthening South Africa's Revitalised Response to AIDS and Health (SARRAH) 2009 –2014	Support enabled development of the PMTCT Accelerated Plan contributing to reducing MTCT to <5%. Support to the National AIDS Council resulted in improved use of gender-disaggregated reporting. Support to the Treatment Action Campaign has been used to establish important policy reforms and draw attention to systemic problems in drug supply and management including contribution to the debate on Intellectual Property laws, advocacy for Fixed Drug Combination tablets and TB in prisons.	A+
Southern Africa (regional)	£28m over 4 years to implement the Southern Africa Regional Behaviour Change Communication Programme in 11 countries, aiming to reduce HIV and TB infection and related morbidity, especially among women children and other vulnerable groups in Southern Africa, by facilitating social and behaviour change.  <i>DFID is currently supporting a regional HIV prevention programme, particularly for adolescents, prisoners and members of key affected populations. It has a strong focus on generating new evidence on what works for these groups.</i>	Southern Africa Regional Behaviour Change Communication Programme 2007 - 2011	26.5 million youth and adults reached through Soul City OneLove campaign; 2.2 million people reached through SAfAIDS Community Based Volunteers; 1 million viewers per episode reached through Community Media Actions' TV programme. An independent evaluation showed that BCC activities influence the precursors to behaviour change (norms, attitudes, knowledge and interpersonal communication), but this is stronger than evidence supporting the effects of programme exposure on HIV risk behaviours. Radio and print media showed strongest evidence for achieving change, TV showed weakest evidence.	A  (Evaluation published)
Uganda	£16.3m over 4 years to improve the HIV prevention response, including: implementation and monitoring of a national HIV prevention strategy and action plan; increased access to HIV testing and counselling; improved coordination; improved policy and practice	Uganda HIV Prevention Program 2010 - 2014	Delays in the programme due to political factors have been a constraint to progress. Preliminary data suggests that new infections are likely to have risen to 150,000 during 2011 from 120,000 2009 baseline. Lack	B

	through effective dissemination and uptake of HIV-related research, evidence and lessons learned from experience.		of progress is now being actively addressed by DFID.	
Zambia	<p>2009-2013: £2.5m to the national HIV/AIDS programme; supporting the NAC and Zambian Network of AIDS Organisations to strengthen civil society capacity to deliver prevention, treatment, care and support services; piloting cash transfers to support adherence and outcomes for patients starting ARVs</p> <p><i>2012 – 2016 £4,5m to enhance HIV prevention by providing couples with integrated services including family planning and HIV testing and counselling. This is expected to avert 11,600 HIV infections and prevent 100,000 unintended pregnancies.</i></p>	HIV and AIDS Programme Oct 2009- Jun 2013	Strengthened national response in respect to gender; attitudes towards people living with HIV have improved, with behaviour and attitude surveys showing less stigma and discrimination; and there is also a growing, albeit limited, recognition that the issues of MSM and FSW cannot be ignored on public health grounds; adherence to ARV treatment was very high among clients enrolled in the cash transfer (more than 95% as opposed to an average of 70% among patients who did not get any nutritional support).	B
Zimbabwe	DFID provided support to social marketing of condoms and the Expanded Support Programme (ESP) until 2012. From 2012, DFID is providing £57m over 3 years for a comprehensive SRH and HIV programme. This includes provision of male circumcision; HIV prevention services for sex workers; cervical cancer screening, family planning and initiatives to address violence against women. DFID is also supporting an MNCH programme which includes procurement of ARVs for both adults and children and integrated comprehensive paediatric care and treatment.	Population Services International (PSI) - HIV Prevention 2006 –2012	>246 million male condoms and 9.9 million female condoms distributed; 1.37 million people received HIV testing and counselling; 11,700 men were circumcised. An evaluation showed the social marketing programme had averted 88,000 HIV infections, and calculated cost effectiveness of \$22 per DALY for male condoms and £214 per DALY for female condoms.	A
		Expanded Support Programme (ESP) 2004 –2012	ESP contributed 34% of total funding HIV/AIDS programming funding (2007-2009). HIV prevalence dropped from 17.7% (2006) to 13.6% (2010). The review found that ESP contributed to: scaling up ARV; improving access for communities; a marked reduction in distances travelled to get medication (through outreach programmes and decentralisation of ART) and a reduction in HIV-related deaths. ESP supported broader health services: retention and training of health staff, blood services, quality control of medicines, laboratory support and transport. 80,000 people received ART through the national ART programme by 2011. <500 health workers trained in ART/opportunistic infection management. ESP engaged national authorities and supported policy and public services without entangling in political debate.	A  (Evaluation published)
		Sexual and Reproductive Health and HIV Prevention in	Voluntary male medical circumcision is being scaled up, cervical screening is being rolled out and family planning is being integrated with other services demonstrating good progress towards a one-stop shop in public/private partnership social franchising model.	B

		Zimbabwe 2012-2015	The annual review measured only a partial year of implementation due to start-up and contracting delays.	
<b>ASIA</b>				
Burma	2006-2012: £34m (2006- 2012) to the 3DF.  <i>2010 – 2016: up to £80m to a 3MDG Fund focused on addressing essential maternal and child health needs. This includes: a focus on HIV prevention and care for IDU and prisoners; supporting HIV testing and counselling for people newly-diagnosed with TB with a focus on improving the availability and quality of HIV care and treatment in remote areas of Burma.</i>	Three Diseases Fund for HIV, TB and Malaria 2010 – 2012	More than 61 million condoms and 13 million needles were distributed. The final evaluation (2012) found that “3DF reflected an impressive donor response in both scale and timing, and was the single largest contributor to all three disease areas in Myanmar during the period 2007-11. Overall, 3DF contributed between about one to two thirds of the total national targets for the three diseases”	A++  (Evaluation published)
Cambodia	2207-2013: £4.4m to support behaviour change interventions and social marketing of condoms.	Social Marketing and Behaviour Change Intervention 2007 –2013	Measured improvements were seen in increased condom penetration and sales, protective behaviours, and appropriate health-seeking behaviours. In 2011, the number of condoms sold was 25.4 million. In both 2010 and 2011, more than 1 million condoms with lubricants were provided to MSM.	A
Central Asia	£7.8m over 9 years to the Central Asia Regional HIV/AIDS, supporting interventions in Kyrgyzstan, Tajikistan and Uzbekistan	Central Asia Regional HIV/AIDS Project (CARHAP) 2004 –2013	Together with GFATM supported programmes, CARHAP was the only programme supporting the increase in needle exchange services in the region. 8 million needles and syringes were distributed and >5 million condoms (though not all results were captured due to limited data from Uzbekistan). CARHAP was successful in building sustainable systems & capacity, including demonstrating the important role of harm reduction services. These systems are still used by other funders.	A
India	2007 – 2012: £102 million to support the National AIDS Control Programme (NACP) III. Services were particularly focused on key affected populations	National AIDS Control Programme III, 2007 – 2012	Over 9,000 counselling and testing centres set up; 42.2 million people tested; people receiving ART increased from 42,000 adults and 1800 children (2006) to 500,000 adults and 26,000 children. Services were focused on key affected populations - 5,350 IDU received substitution therapy in 52 centres.	A+  (Evaluation published)
Nepal	£16.6 million over 6 years to support the national response to HIV with a particular focus on key affected populations	Support for HIV/AIDS Response 2006 – 2012	Over 9 million condoms and 120,000 HIV tests provided among key populations. 1.3 million needles and syringes provided to almost 14,000 people who inject drugs. The independent evaluation suggested the response contributed significantly to the containment of HIV prevalence in Nepal over this period.	A
Vietnam	2002-2012: £24.2 million to support the national response to HIV, focused on services for key populations. A further £6.2m (2012-2014) with the World Bank, to support HIV prevention.	Preventing HIV/AIDS 2002-2014	Distribution of >18.5 million needles to 55,000 IDU (2002-2012). <25 million condoms sold through social marketing and 8 clinics in providing substitution therapy to 1,720 people by mid- 2012.	A

# Annex B: Key Results of PPA funded civil society working on HIV

In addition to the PPAs outlined in the table below, DFID's PPAs with Marie Stopes International (MSI) and IPPF, while not reporting specifically on HIV, have a broad SRH focus which encompasses HIV. Similarly, Save the Children does not report specifically on HIV but does include a relevant indicator on maternal new born and child health (MNCH).

Organisation	PPA Funding (Annual)	Outcome of DFID investment	Headline year 2 results	Assessment of progress <sup>43</sup>
Specific HIV focus				
International HIV/AIDs Alliance	£3,891,623	Communities take effective action to stop the spread of HIV, meet the challenges of AIDS and build healthier communities.	<ul style="list-style-type: none"> <li>• 4,678,741 people reached directly through HIV/AIDS prevention, care, support and treatment services (including integrated TB, SRH and MCH services) of Alliance's supported Linking Organisations.</li> <li>• 13 Linking Organisations have become principal/prime recipients of Global Fund, USG or other Multilateral grants over USD 1 million.</li> <li>• 26 countries have been targeted by the Alliance with community initiatives that are influencing policy at the national level.</li> </ul>	A+
Report to DFID on at least 1 HIV focused indicator				
Catholic Agency for Overseas Development (CAFOD)	£4,177,643	CAFOD supports, influences and mobilises the Catholic church to empower people in poor and marginalised communities to have greater access to and control over the resources and decisions affecting their lives.	32% of women and men sampled living with, and affected by, HIV provide evidence of improved quality of life. (Results from 21 partners in 12 countries – 2,348 beneficiaries sampled. Quality of life is considered for four domains: health, psychosocial, human rights and livelihoods.)	A
Christian Aid	£5,995,867	To achieve major measurable and sustainable improvements in health status and livelihoods for the most	<ul style="list-style-type: none"> <li>• 21% of people (men, women, children and young people, people with HIV) supported by partners report increased adoption of safe preventative practices and/or uptake of health services. - an</li> </ul>	A+

<sup>43</sup> Overall annual review score: **A++** (Outputs substantially exceeded expectation); **A+** (Outputs moderately exceeded expectation); **A** (Outputs met expectation); **B** (Outputs moderately did not meet expectation); **C** (Outputs substantially did not meet expectation)

		marginalised communities in countries of extreme vulnerability to climate change and poverty related health issues.	<p>estimated 953,522 individuals.</p> <ul style="list-style-type: none"> <li>• 11% of people report a reduction in stigma and discrimination associated with HIV has improved their health outcomes.</li> </ul> <p>(FDGs and surveys with random sample groups from target population – baseline, mid-point and end of programme)</p>	
Progressio	£2,025,015	Sustainable benefits through piloting appropriate approaches in sustainable farming, natural resource management and improved levels of knowledge, attitude, practice and behaviour for PLHIV, especially women.	<ul style="list-style-type: none"> <li>• Level of knowledge and attitude of people living with HIV: value of 66.5 out of 100. (Baseline in 2011 51.38)</li> <li>• Level of practice and behaviour of people living with HIV: value of 57.59 out of 100. (Baseline in 2011 48.44)</li> </ul>	A
Restless Development	£2,755,439	<p>A critical mass of young people in target countries benefit from programmes and services including in SRH practices, in particular the prevention of HIV.</p> <p>Strategic partners in the public sector (government, bi- and multi-lateral) and private sector produce a multiplier effect for the work of the Consortium.</p>	<ul style="list-style-type: none"> <li>• 42% (117,600) of young people using condoms at last high risk sex. (Baseline in 2011 32%: range of 9%-45% across target countries)</li> <li>• 304,857 young people accessed SRH programmes and/or services in target countries.</li> <li>• 86 national and local government institutions and departments formally consulted with young people in their strategies, operational plans and budgets, including on SRH, in particular the prevention of HIV.</li> <li>• 12 targeted bi- and multi-lateral agencies successfully engaged and made provision for youth in their global strategies, country assistance plans, operations and budgets, including SRH, in particular the prevention of HIV.</li> <li>• £3,011,585 was the financial value of partnerships with private sector organisations providing financial and technical support for young people including SRH, in particular the prevention of HIV.</li> </ul>	A
HelpAge	£2,670,269	Governments and other actors changing policy and practice to address the needs of older people	Six governments increased access to ARVs/caring and support for older people and HIV+ family members.	A+

# Annex C: Summary of VfM Approaches for Prevention Programmes in Malawi, Zambia and Zimbabwe

Country Programme	Programme Summary	Cost-Effectiveness Analysis	DFID Value Added
<b>Malawi: HIV Prevention Programme (Business Case, January 2013)</b>	£21 million over five years (including 2013-17) through the Malawi Government HIV Prevention Programme, with earmarked funding for priority interventions in the National Strategic Plan (NSP) (PMTCT, and condoms), technical assistance and operational research	Malawi NSP is based on a modes of transmission study, with attention to the UNAIDS investment framework. A cost-effectiveness analysis was conducted, based on regional effectiveness assumptions for HIV prevention interventions converted to Disability Adjusted Life Years (DALYs). The weaknesses of these assumptions and lack of evidence for effectiveness are recognised, particularly for behaviour change interventions. A reliance on quantitative cost-effectiveness results alone was therefore deemed insufficient for making sound programming decisions, institutional and political factors were taken into consideration. Procurement and contracting gives attention to minimising costs.	Funding was based on a gap analysis for funding, National AIDS Council capacity and research. The DFID contribution comprises 2.6% of the total NSP funding (5.6% of PMTCT, 7.8% of HIV Testing and Counselling (HTC) and 17.2% of condom budget)
<b>Zambia: Intensifying HIV Prevention (Business Case December 2012)</b>	Up to £4.5 million between 2013 and 2016 to scale up couples voluntary HIV counselling and testing (CVCT) with family planning counselling and provision of long-acting contraception methods in Zambia	The choice of interventions to support was based on past programme performance, and practitioners' consensus on the most effective, drawing attention to the lack of good evaluations, cost-effectiveness studies or monitoring of prevention services. Thus, the final choice of option was based on references to effectiveness (based on modelled benefits), and to the political and institutional dimensions rather than primarily to cost. Modelled outcomes suggested that the approach is cost-effective.	Although scale-up of treatment falls short of the new infection rate, the DFID priority was to fund prevention, perceived as a strategic gap, in conjunction with the other donors' efforts.
<b>Zimbabwe: Sexual and reproductive health and HIV prevention in Zimbabwe (Business Case March 2012)</b>	£57 million in 2012-15 to improve health outcomes for the poorest and most vulnerable populations in Zimbabwe, focusing on women and adolescent girls in particular. The programme will focus on family planning commodities, male circumcision, HTC, gender-based violence, post-exposure prophylaxis and cervical cancer screening	Programme outcomes will be across HIV, SRH and VAWG, including treatment options and prevention. The evidence strength for effectiveness is "medium" with regard to behaviour change interventions. Evidence is stronger for treatment as prevention and male circumcision from large-scale trials, but none have been rigorously evaluated in a programme context. The results provide strong a-priori justification for DFID support of these interventions. Benefits for each option were calculated from model results, in terms of DALYs and HIV infections averted. The choice of option was not based on a consideration of long-run programme impacts and improvement of overall RH provision.	The funding decision was primarily driven by a gap analysis (between needs and funding by DFID and other donors), and by a perception of the importance of prevention – rather than by quantitative analysis.

# Annex D: DFID HIV-related Independent Evaluations: Summary of Findings

Independent Evaluations <sup>44</sup>	Key HIV-Related Findings
<b>The Three Diseases Fund (3DF), Burma</b>	3DF delivered an impressive response, proving it possible to deliver aid in Burma, significantly contributing to the Global Fund return. Over 59,000 people from vulnerable groups were tested for HIV, IDU involvement in self-help groups increased four-fold. 22,001 people received ART in 2011 (up from 10,418 people in 2007).
<b>DFID Health Programme, Burma<sup>13</sup></b>	HIV/AIDs and TB interventions were cost effective, achieving up to two thirds of national programme targets. Good geographic distribution was achieved; those most in need were reached. The evaluation found that interventions reduced some social stigma of HIV/AIDs.
<b>Community Responses on HIV/AIDS, multi-country evaluation</b>	Community responses help mobilize substantial local resources. Community group participation and frequent discussion of HIV can increase knowledge and change behaviours. Use of HIV services increased following community responses though stigma remains a significant barrier to service access, and often preventing the most at risk from accessing services. Community group membership can affect health outcomes including reducing HIV and STI incidence. Results vary by gender and the stage of the HIV epidemic may impact effect size.
<b>Targeted Interventions on HIV transmission, India</b>	High intensity targeted intervention (TI) projects, comprising safe behaviour promotion (increased condom use and decreased needle sharing) and treatment of STIs, showed an increase in condom distribution and use, and a significant decline in HIV and syphilis prevalence among FSWs and young antenatal women. Significant changes were not seen following low intensity TI projects.
<b>Expanded Support Programme (ESP), Zimbabwe</b>	The ESP had a significant impact; increasing access to prevention, treatment and care services. Resource decentralisation led to more equitable access, though those in rural areas remain disadvantaged. Little documentation exists of reaching vulnerable groups. Development of human capacity resulted in dedicated, competent care givers. Future emphasis must balance the HIV focus with broader health systems development.

<sup>44</sup> DFID Annual Evaluation Report, 2013: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/237332/annual-evaluation-report-july-2013a.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/237332/annual-evaluation-report-july-2013a.pdf);

<sup>13</sup> ICAI publications: <http://icai.independent.gov.uk/>;

<b>DFID Support to the Health Sector in Zimbabwe<sup>13</sup></b>	DFID support has had a substantial positive impact for PLHIV. Delivery has been well co-ordinated and aligned with agreed priorities. Value for money has been good. DFID significantly increased the availability of free ARVs and contributed to halving the HIV/AIDS prevalence since the 1990s. HIV/AIDS programmes have drawn on and influenced global best practice.
<b>Youth Reproductive Health Programme, Sierra Leone</b>	Positive behaviour change was seen in patterns of sexual behaviour especially when compared with control groups. Condom use among young people increased from 22% to 86.9% (control 63.9%). Key government agencies were successfully engaged in developing youth-friendly services, monitoring and evaluation systems and directly engaging young people.
<b>Southern Africa Behaviour Change Communication Programme</b>	Evidence that BCC activities influence the precursors to behaviour change (norms, attitudes, knowledge and interpersonal communication) is stronger than that evidence supporting the effects of programme exposure on HIV risk behaviours. Radio and print media showed strongest evidence for achieving change.



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Published by the Department for International Development, November 2013