ANNEX 3: SUMMARIES OF COUNTRY CASE STUDIES

China

The UK has provided support to pioneer work with those groups most vulnerable to HIV in China

UK funds in China have been used to demonstrate to the Chinese Government how to mount an effective programme of HIV prevention among injecting drug users and sex workers by introducing new models, such as needle exchange and methadone substitution programmes for injecting drug users and condom promotion for sex workers. This support has been welcomed by the Chinese authorities and has shown that targeted programmes of this nature are effective, feasible and politically acceptable. Through this approach, the UK has made a unique and major contribution to the national HIV and AIDS response in China.

China illustrates a distinctive 'country-led approach'

China is a very large lower-middle-income country with a long history and strong central government. All these factors contribute to a distinctive aid environment. There is little scope for aid instruments such as general or sectoral budget support because official development assistance comprises such a small part of Chinese GNP (<0.07%). The Chinese Government exerts strong control over the provision of external aid, preferring bilateral projects from individual donors rather than pooled mechanisms. In this regard, the development agenda, in general, and the national AIDS response, in particular is country-led, although there is limited scope for actors other than government, e.g. civil society to play a role.

Learning Points: China

1. Given the current global political environment for responses to HIV and AIDS, the UK has a major comparative advantage in championing harm reduction approaches among groups most at risk of HIV infection, such as injecting drug users, sex workers, men who have sex with men and prisoners. These approaches are particularly critical now because they are known to be effective and some of the world's most rapidly spreading epidemics are concentrated among these groups, including in middle income countries. Ways need to be found to ensure this comparative advantage is not undermined, e.g. when a DFID office closes.

2. The amounts of money needed are modest. The key ingredients required are technical expertise and courageous political leadership.

3. Experience from China shows that country-led approaches are possible using a range of aid instruments. For example, in countries that have little dependency on aid, general and sectoral budget support are likely to be less relevant than projects, technical assistance and policy dialogue.

4. However, an effective country-led approach needs participation of other players in addition to government. UK support to build capacity of civil society is particularly important in this regard, as would be increased support for the meaningful involvement of people living with HIV and members of other vulnerable groups.

5. Good quality technical expertise can be important in stimulating political leadership in contentious areas, such as provision of harm reduction services for injecting drug users and sex workers

The UK has influenced political leadership on HIV and AIDS in China through technical assistance rather than through providing funds

Although significant, levels of funding provided by the UK to China's response to HIV and AIDS are modest in comparison to overall funding levels (£4.2 million, 6% in 2005). However, these funds have been critical in providing international technical assistance in areas which have proved difficult for some other donors, in particular, prevention programmes focused on the most vulnerable groups. This support has exerted a positive influence on political leadership on HIV and AIDS at several levels in China – national, provincial and county – and is credited by some with shifting official views concerning injecting drug users, sex workers and men who have sex with men.

Other issues

- UK decision making on HIV and AIDS in China is not well-understood by partners but DFID's consultative, collaborative and flexible attitude is much-appreciated.
- DFID China office and the British Embassy work closely together although not on issues relating to HIV and AIDS. There are no links to other UK government departments on HIV and AIDS in China.
- The DFID China office is scheduled to close in 2011. This raises issues of how UK support to the HIV and AIDS response in China will be provided until that point and beyond. There are concerns that the strong progress made could be undermined by loss of technical capacity and rapidly rising staff workloads.
- DFID China office seeks to work in partnership with others where possible, including co-financing AIDS projects. DFID's contracting and procurement systems could usefully be reviewed to ensure that they do not unnecessarily inhibit more harmonised working, e.g. with the Global Fund on a new joint project.
- The new joint project with the Global Fund includes a focus on treatment. This is welcome as, based on UNAIDS figures, only 18-25% of PLWHA needing antiretroviral treatment in China are receiving it. Reasons for low levels of treatment include:
  - High cost of drugs and diagnostics; low cost, fixed-dose combinations not yet available – UK assistance on addressing this has been requested
  - Low levels of testing based on fear of discrimination and lack of belief that treatment will be forthcoming
  - No HIV activist movement to advocate for treatment
- UN agencies could potentially play an important role in HIV and AIDS in China, but they may be under-performing as a result of poor coordination and a focus on implementing projects. The UK is playing an active role in addressing these issues.

Democratic Republic of Congo (DRC)

Responding to HIV and AIDS in post-conflict settings

DRC is a 'weak-weak' fragile state. This is mainly due to longstanding conflict, but there have also been problems of government mis-management, non-accountability and personal use of public resources. The UK is supporting efforts to improve governance, contain conflict, provide humanitarian assistance and launch development initiatives. Although HIV prevalence rates are currently modest, there are concerns that conditions in the post-conflict recovery phase may encourage HIV transmission.

The response to HIV in such a setting faces major challenges, particularly in trying to scale up to universal access to prevention, care and treatment services. This requires not only support to develop a functioning health system, but also needs to encompass other issues such as livelihoods and food security, and to be integrated into other development sectors, e.g. road rehabilitation, resettlement and disarming of militias. DFID has supported a number of AIDS-specific activities, such as condom social marketing and has championed greater coordination of efforts including supporting the establishment of the National Multisectoral Programme to Fight against AIDS (PNMLS) and an expanded role for UNAIDS. DFID support is particularly valued as flexible, rapid and available over a multi-year time frame.

Learning Points: DRC

1. A fragile state is one in which its government can or will not provide basic state functions. Many post-conflict states, like DRC, fall into this category. Support to HIV and AIDS responses in fragile states should be provided in ways which address the underlying fragility, i.e. the failure to provide basic state functions. This involves building capacity to provide sustainable basic services and aligning with national priorities and plans, where they exist. This is beginning to happen in the response to HIV and AIDS in DRC, e.g. through establishment of PNMLS. However, there are significant challenges because capacity is very limited and the overall political situation remains uncertain, with ongoing wrangles over recent presidential elections.

2. Women are particularly vulnerable to HIV for a number of reasons. One of the most important is gender-based violence, which may be used in conflict settings as a weapon of war. Recent work by the UN's InterAgency Standing Committee documents that gender-based violence is under-reported but particularly likely to occur in emergency settings because of breakdown of social systems and institutions, and women and children being separated from their families and communities. Survivors of such violence experience many other problems in addition to risk of HIV, including unwanted pregnancy and other sexually transmitted infections.

3. People living with HIV and AIDS do not wish to only be passive recipients of services. Rather they aspire to be involved meaningfully in all aspect of HIV/AIDS programming, including planning, implementation and progress review. Organisations led and managed by PLWHA have a unique role to play in this regard.

Violence against women as a weapon of war has increased their vulnerability to HIV

Women are particularly vulnerable to HIV infection in DRC. Factors are complex but include poverty and limited livelihood options giving some women few alternatives to selling sex. Women interviewed for this study aspired to improved reproductive health services including family planning. Perhaps the most disturbing factor has been the systematic use of rape and other forms of violence against women as weapons of war by the different sides in the conflict. This issue, rather than

HIV itself, was justifiably the focus of UK policy dialogue in the run-up to the July 2006 presidential election.

People with HIV and AIDS aspire to more meaningful involvement in responses

It is unclear the extent to which people with HIV and AIDS have formed their own organisations in DRC and the extent to which these are involved in the national response. However, limited consultation with PLWHA revealed that they want to be actors and not just beneficiaries and that their aspirations are not being met in this regard. For example, one person commented, '*There should be emphasis on the contribution of PLWHA organisations which should become actors as well as beneficiaries in all the projects and programmes in the fight against HIV/AIDS.*'

Other issues

- Availability of data regarding the AIDS situation and response in DRC is very limited. DFID is currently supporting a demographic health survey which will gather relevant data, not only for HIV and AIDS but also for other areas of health.

- DFID's office in DRC was established fairly recently in 2003; there are two staff who have responsibilities for HIV and AIDS but they have other responsibilities also and heavy workloads.

- FCO and DFID have an extremely close working relationship. At the time of the country case study visit for this evaluation, they had a strong shared focus on the July presidential elections.

- A joint initiative supported by DFID, FCO and the Ministry of Defence focused on HIV prevention among soldiers and other combatants is a good example of joint UK Government action.

- DFID is committed to ensuring that at least 50% of those receiving ARVs in DRC are women. However, it is unclear if accurate and reliable data systems exist to track this information.

Ethiopia

General budget support suspended

From 2003, DFID and other donors provided general budget support to Ethiopia. This was suspended in late 2005 because of concerns over governance, human rights and political detentions following contested elections. The donors that previously provided budget support now fund a programme of protection of basic services (PBS). This shift has had a significant effect on apparent UK spending on AIDS in Ethiopia because of the way this is calculated (see learning point 2). Recent DFID Ethiopia calculations indicate that spend on HIV and AIDS appeared to rise from around £3 million in 2005/6 to over £30 million in 2006/7. However the content of the programme changed relatively little.

Because of the large amounts of direct funding to HIV and AIDS from the Global Fund, US Government and World Bank, DFID has focused its support on technical assistance to increase absorptive capacity, donor harmonisation and policy dialogue. While this has led to lower DFID visibility in the response, DFID continues to have influence, e.g. over the decision to review the HIV/AIDS strategic plan for management and examine issues, such as whether treatment is being prioritised instead of prevention and whether some vulnerable groups are being overlooked.

DFID support to orphans and vulnerable children (OVC) is based on need not disease

About 10% of children in Ethiopia are orphans but relatively few have been orphaned by AIDS. More children, who are not orphans, are vulnerable for other reasons. To date, the response to OVC has been fragmented. An OVC task force is addressing this by developing a national action plan to supplement the National Plan of Action for Ethiopian children. DFID is supporting efforts which view vulnerability holistically,

Learning Points: Ethiopia

1. Although general budget support is intended to provide countries with long-term, predictable financing, this is still subject to suspension if the political environment is considered inadequate by the international community. This was considered to be the case in Ethiopia following disputed elections in late 2005.

2. Currently, DFID counts 5% of all funding through general budget support as spending on HIV and AIDS. Other spending is counted as 0%, 50% or 100% depending on whether it has a marker for HIV/AIDS or reproductive health, and the nature of that marker. This means that if the same activities are funded through different instruments, there could be an apparent change in funding to HIV and AIDS without any real change having taken place.

3. *Taking Action's* spending target on orphans and vulnerable children sees this as a sub-set of overall AIDS spending. This is problematic, in general, because international practice is to programme support on the basis of need, not the cause of that need. It is particularly problematic in countries like Ethiopia where AIDS is just one of many causes of child vulnerability.

4. Social protection measures which provide cash and other transfers, targeted on the basis of food insecurity and poverty, can be provided to scale and could be financed through general or sectoral budget support. These mechanisms are effective in providing support to those affected by HIV and AIDS, including PLWHA and OVC. Providing support on the basis of need rather than on the basis of disease is more appropriate in most settings, particularly where levels of stigma and discrimination are high.

e.g. the Productive Safety Nets Programme (PSNP). However, PSNP funding does not currently count to the UK's OVC spending target, even though it was featured in *Taking Action* as a way of supporting OVC.

New approaches to social protection have been introduced on a large scale

Although there are differing views as to the underlying causes of food insecurity in Ethiopia, between 6-13 million people face significant food shortages each year. DFID has been working with the Government of Ethiopia to shift support away from humanitarian assistance, such as food aid, towards more long-term social protection measures using cash and other transfers. This approach is epitomised by the PSNP, for which DFID is the largest donor (£70 million). To date, this programme has provided support to an estimated 8 million people. This includes those affected by HIV and AIDS, although support has reached them based on targeting for poverty and food insecurity, rather than specifically for HIV and AIDS.

Other issues

- DFID has spearheaded successful efforts to harmonise donor activities in Ethiopia, e.g. through funding the National Partnership Forum and chairing the Health, Population and Nutrition Donors Technical Working Group.
- Critical shortages of human resources threaten the health system by undermining both management and service delivery capacity; Government of Ethiopia is seeking to implement a strategy to address these using a model based on creating health extension workers and task delegation.
- DFID has provided support to civil society projects working with vulnerable groups, including women and young people.
- People living with HIV and AIDS are represented in consultative fora, such as the Country Coordinating Mechanism and the National Partnership Forum; the development of support groups specifically for women living with HIV and AIDS has increased their participation.
- Relationships between civil society and government in Ethiopia are sometimes tense. DFID has supported civil society in Ethiopia through direct grants and involvement in the National Partnership Forum. The FCO also has a small grants programme and the British Council has been supporting leadership training.
- DFID's changing role has required staff to emphasise certain skills, e.g. policy dialogue and influencing than others e.g. programme management.
- There is limited evidence of a systematic, cross-UK Government approach to HIV and AIDS in Ethiopia. The cooperation that exists seems largely on the basis of personal interest rather than evidence of a functioning system.

India

The UK has supported pioneering work with groups most vulnerable to HIV

UK funds have supported the introduction and scaling-up of prevention activities among those groups most vulnerable to HIV in India, such as sex workers, injecting drug users and men who have sex with men. Activities supported have included piloting innovative models of service provision, such as oral substitution therapy for injecting drug users; generating new knowledge; sharing of information among NGOs working on similar themes; and advocacy. Civil society organisations have played a leading role in these activities both as service providers and by seeking to improve access to government services. To date, UK support has been channeled to eight states, but the Government of India is planning to roll out elements of this programme nationally.

From pilot projects to budget support

The UK has a long history of supporting India's response to HIV and AIDS. Initially, this was done through pilot projects to build an evidence base and political commitment. Currently, support to the National AIDS Control Organisation (NACO) is earmarked for prevention among most vulnerable groups in eight states. During this current phase (NACP 2), support has also been provided through a Programme Management Office to UN agencies; technical assistance to NACO; a challenge fund for civil society; and funds for social marketing, research and learning. From 2007 (NACP 3), UK will provide unearmarked sub-sectoral budget support through NACO. This relies on work done to build national systems; to implement the Three Ones; and to prepare a new strategic plan for HIV and AIDS.

Learning Points: India

1. Some of the most-rapidly spreading HIV epidemics in the world are among injecting drug users in Asia. The UK is well-placed to support effective responses to these because it is not constrained by restrictive policy frameworks.

2. Civil society organisations have a central role, both in providing services to vulnerable groups and in facilitating access to government services. Sub-sectoral budget support through a National AIDS Council (or equivalent) offers a way of providing financial support to such organisations in a structured and sustainable way. This requires the government to have capacity to commission, maintain quality and provide stewardship.

3. A country needs time to be able to use unearmarked financial support to finance HIV prevention among vulnerable groups. Experience from India of progression from projects to earmarked, sub-sectoral budget support to unearmarked, sub-sectoral budget support provides a model to do this.

4. Providing budget support to AIDS as a sector or sub-sector, i.e. through a National AIDS Council (or equivalent) allows donors to influence and shape the national programme. For this, there needs to be participation of all stakeholders both during design and implementation.

5. Although others, e.g. the Global Fund and US Government, provide the bulk of direct financing for scaling-up ART, targeted UK support can facilitate this scaling-up, e.g. by training private providers and promoting greater involvement of PLWHA. It also demonstrates synergies between UK bilateral and multilateral funds. This approach makes it difficult for the UK to answer questions such as how many people it has 'put' on treatment. Such questions could be answered by stating how many people are receiving ART in PSA countries and describing UK support provided.

The UK has supported expansion of antiretroviral therapy in India

India launched a national programme of ART in mid-2004, funded largely by the Global Fund. Bilateral funds from DFID India have been used to fund targeted activities including the Indian Network of Positive People (INP+) to advocate for their needs and the Population Council to research paediatric treatment. In addition, DFID multilateral support to WHO's Three by Five programme was used by the Government of India to strengthen its capacity to provide ART.

Other issues

- DFID India staff have the skills required to implement *Taking Action*. However, limited numbers of staff was one of the factors that contributed to the decision not to have a dedicated funding channel for civil society in the next phase of HIV/AIDS funding under NACP 3.
- Under NACP 2, DFID had memoranda of understanding with several UN agencies. Apart from UNAIDS, this was for service delivery at grassroots level. This did not positively support efforts to harmonise UN activities on AIDS in India. Future UK support for UN work on HIV and AIDS in India is to be provided in a unified manner through UNAIDS.
- DFID has spearheaded support for the Three Ones in India, particularly through support to strengthen UNAIDS capacity and the design of NACP 3. This has progressed the harmonisation agenda. This is clearly seen in that NACP 3 is based on one national strategic plan for HIV and AIDS, to which all donors have agreed.
- Based on *Taking Action*, DFID India expanded support to OVC during NACP 2. As the number of children orphaned by AIDS is low, this focused on vulnerability of particular children and young people to HIV infection, such as street children and out-of-school youth. The approach of the strategic plan for NACP 3 focuses on building child protection schemes, integrating HIV and AIDS into existing schemes and programmes for children and scaling up access to paediatric treatment.
- DFID has worked to ensure that issues relating to women and young people are addressed in India's response to HIV and AIDS. This has been done through financial support to the Programme Management Office and the UN, and through DFID's active participation in a working group for the development of the national strategy focused on gender, adolescents, youth and children.
- Responses to TB, reproductive health and HIV/AIDS are currently separate programmes in India. Little progress was made on integrating HIV/AIDS and reproductive health services under NACP 2 and it is currently unclear how this will be addressed under NACP 3.
- Part of DFID's support to NACP 2 has been through a research and learning fund with a particular focus on qualitative research among key target groups such as injecting drug users and men who have sex with men.

Russia

UK support to work with groups most vulnerable to HIV has declined

The HIV epidemic in Russia is primarily concentrated in particular vulnerable groups. More than 80% of all registered PLWHA are IDU; HIV prevalence is over 60% among IDU and sex workers in some cities and 5% among prisoners. Yet, Russia has not focused its response sufficiently among these groups. This is because they enjoy little public sympathy as a result of stigma and discrimination, which arises because their activities are illegal and socially unacceptable. The UK provided strong support to NGOs and government to work among these groups, including supporting controversial services, e.g. harm reduction among IDU. UK support to Open Society Institute and local NGOs enabled them to be part of a successful NGO Global Fund bid. However, as available funding declined in preparation for closure of the DFID office in March 2007, the UK reduced support in this area.

UK has prioritised its limited funding on improving coordination of the response

Coordination of the national response to HIV and AIDS in Russia has faced problems. The UN Theme Group does not include NGOs or government (although the Expanded UN Theme Group includes all stakeholders) The Country Coordinating Mechanism's only role seemed to be the application to the Global Fund's 4th round. However, in October 2006, the Government Commission on HIV/AIDS was created. Members of this new body, which has real administrative power, include representatives of the government, State Duma, civil society and business. The UK previously supported efforts to improve coordination on AIDS among UN agencies but, faced with declining resources, DFID focused efforts on support to UNAIDS' coordination role. This support, with SIDA, has raised UNAIDS' profile in Russia, and will be continued by the US Government and Gates Foundation.

Learning Points: Russia

1. Given the current global political environment for responses to HIV and AIDS, the UK has a major comparative advantage in championing harm reduction approaches among groups most vulnerable to HIV infection, such as injecting drug users, sex workers, men who have sex with men and prisoners. These approaches are particularly critical now because they are known to be effective and some of the world's most rapidly spreading epidemics are concentrated among these groups, including in middle-income countries. Ways need to be found to ensure that achievements to date are sustained, e.g. when a DFID office closes.

2. Although Russia was experiencing problems with coordinating its national response to HIV and AIDS, and DFID/SIDA support has raised the profile of UNAIDS in the country, it is unclear that this was the most appropriate use of UK's limited funds, particularly as other funders seem willing to support this area and the opportunity costs of declining support to harm reduction activities were considerable.

3. Given DFID's overall focus on the poorest countries, clarity is needed as to whether the UK will continue to support responses to HIV and AIDS in middle-income countries with rapidly-spreading epidemics. If yes, clarity is needed as to how such support will be provided, both during and after DFID 'exit'.

4. Given the controversial and highly technical nature of these interventions, it seems unlikely that the FCO or multilateral agencies would be able to directly support such interventions in DFID's absence. The most appropriate mechanism would seem to be to support one or more NGOs or private providers to conduct this role through some kind of strategic funding arrangement, like a PPA.

Planned closure of the DFID office in March 2007 has significantly affected the UK's ability to implement *Taking Action* in Russia

Following the decision to close the DFID office in Russia in March 2007, financial resources available to the country declined dramatically from £19.7 million in 2003/4 to only £4 million in 2006/7. This was accompanied by a reduction in staff levels and less focus on the country from DFID centrally. Although a 'graduation plan' was developed, this was done over a rapid timeframe and may not have considered all elements of a comprehensive exit strategy, particularly how critical UK leadership relating to interventions with the most vulnerable groups could be maintained once the DFID office closed.

Other issues

- Russia currently enjoys considerable external financing for HIV and AIDS. However, as an upper-middle income country, this is unlikely to continue. For example, Russia is no longer eligible to apply for Global Fund finances for HIV and AIDS.

- The Russian Government has increased political focus on HIV and AIDS, perhaps linked to their presidency of the G8. It is unclear if that leadership will continue once the presidency ends and whether it always takes the response in the right direction, particularly relating to the most vulnerable groups.

- There has been a very significant increase in the Russian state budget for AIDS, which rose to £58 million in 2006.

- There are a number of significant barriers to the provision of ART in Russia. Perhaps the most significant is the absence of drug substitution therapy which is needed as an adjunct to ART for active IDU. Other factors include the verticalisation of the health system, monopoly and location of AIDS centres, skills and attitudes of health staff, and problems with ARV procurement.

- DFID is seen as a flexible and collaborative donor.

- The Foreign and Commonwealth Office has had little engagement with issues of HIV and AIDS in Russia.

Zambia

UK experience of poverty reduction budget support (PRBS) in Zambia is just beginning

DFID and other donors are beginning to fund Zambia through PRBS. Funding health in this way requires systems to allocate resources between and within sectors. Recent developments affecting this transition include Ministry of Health restructuring, abolition of user fees and massive, off-budget funding to health. Funds for the AIDS response have not yet been channeled through PRBS. Reasons include urgency, the absence of any 'AIDS sectoral' ministry, the newness and developing capacity of the National AIDS Council, the need to find ways of channelling funds to civil society organisations and non-health ministries and the existence of gaps in external, earmarked HIV funding.

New approaches to social protection are being piloted in Zambia

DFID and other donors, e.g. GTZ, have been supporting INGOs to pilot social protection measures in Zambia. These approaches have proved effective. In particular, cash transfers have been shown to stimulate local markets and to be predictable, flexible and investible. These pilots use government systems and are based on a national strategy developed with DFID support. Scaling-up will need more direct involvement of a government partner. The Ministry of Community Development and Social Services may be able to do this but is currently weak. Links between social protection, food security and AIDS are increasingly recognised. Social protection approaches provide a good opportunity to support orphans and other vulnerable children and could potentially complement more specific interventions.

Learning Points: Zambia

1. There are significant issues of transition when changing from one aid instrument to another, particularly PRBS. In general, these include establishing mechanisms for line ministries to bid for resources and to allocate them within their sector. This is particularly complex for HIV and AIDS because it is unclear whether the responsible 'line ministry' is the National AIDS Council or the Ministry of Health. It may be difficult to establish mechanisms to fund civil society organisations and other ministries through PRBS, particularly in line with the urgent timeframes that exist for HIV and AIDS.

2. Social protection measures which provide cash and other transfers, targeted on the basis of food insecurity and poverty, can be provided at pilot level through NGOs. These mechanisms are effective in providing support to those affected by HIV and AIDS, including PLWHA and OVC.

3. *Taking Action* places strong emphasis on bridging the funding gap for HIV and AIDS. However, in countries like Zambia, perhaps the most significant barrier to scaling-up HIV services is the shortage of human resources. Supporting countries to develop, finance and implement comprehensive strategies for human resources in health would fit well with DFID's business model and comparative advantage.

4. Approaches which address gender issues can be integrated into national AIDS responses and reviewed through focused or more general evaluations. Abstinence-focused prevention activities may increase age of sexual debut but risk reducing condom use at high-risk sex if they are allowed to undermine condom distribution and use. Using a joint annual programme review to assess services for prisoners is a good way of raising the profile of this vulnerable group.

Zambia faces a major crisis of human resources for health

Zambia is one of 57 countries facing a particularly severe shortage of human resources in the health sector. Many health workers have left the country because of factors including poor salaries and conditions of service. AIDS has also been a significant cause of loss of health staff. Staff shortages are affecting the ability to provide healthcare services. The Ministry of Health has developed a costed (US$313 million) three year strategy to address this issue. If supported by donors this could provide a focus for a more coordinated response.

Other issues

- Limited capacity affects Zambia's ability to absorb external finances for the AIDS response. There are particular problems because of limited procurement capacity and difficulties is using external finances for the AIDS response for strengthening systems and core capacity.
- Some UN agencies are too focused on implementing small, national-level projects.
- UK in-country support to UN agencies is increasing, procuring their services is relatively easy if done directly but more problematic if done through larger programmes managed by management agencies.
- Zambia, in common with other countries, has been submitting reports on progress in implementing *Taking Action*. These reports could form the basis for coordinated reporting across DFID.
- Central policies and spending targets challenge DFID's commitment to country-led approaches, particularly if these increase and become more binding.
- The latest Joint Annual Programme Review (JAPR) focuses on gender, including describing a 2005 evaluation of a capacity building programme.
- Zambia's focus on sexual abstinence among young people has resulted in delayed sexual debut but reduced condom usage at last sex with a non-regular partner.
- Zambia's response to HIV and AIDS identifies a number of particularly vulnerable groups. The JAPR highlights vulnerabilities of men in uniform and prisoners.
- People living with HIV and AIDS are involved in the national response but their organisations are weak.
- Zambia is strengthening HIV M&E capacity. It is unclear how this impacts on broader health management information systems.
- Relationships between DFID and the FCO are excellent. DFID has led on HIV and AIDS but the High Commissioner and others have been active in policy dialogue.

Zimbabwe

Responding to HIV and AIDS in fragile states

Internationally, Zimbabwe is considered a strong but unresponsive state. Since 2002, international efforts to respond to HIV and AIDS in Zimbabwe have been as a form of humanitarian aid delivered as directly to the population as possible. However, the creation of parallel systems could undermine existing service provision. OECD guidelines on engagement with fragile states emphasise alignment with national priorities and plans and ensuring that assistance does not undermine existing service delivery systems. DFID's current CAP embraces this approach. The HIV and AIDS component of the CAP is positioned within the national HIV and AIDS framework. DFID has just initiated support to two major new programmes: the Expanded Support Programme (ESP) for HIV and AIDS services and the Programme of Support for OVC, both of which feature pooled donor support, common working arrangements, alignment around national plans and joint donor-government monitoring.

Human resources for health

Zimbabwe is one of 57 countries facing a particularly severe shortage of human resources for health. Many health workers have left the country because of the difficult macro-economic situation, poor salaries and conditions of service. AIDS has contributed to the loss of health staff. Staff shortages affect provision of healthcare services. For example, significant scale-up of ART requires additional human resources. Some positive responses have been made by the Zimbabwean Government, including the creation of new categories of health worker, such as the primary care nurse. The new Health Services Board is planning to develop a comprehensive strategy for human resources for health in Zimbabwe.

Learning Points: Zimbabwe

1. A fragile state is one in which its government cannot or will not provide basic state functions. Support to HIV and AIDS responses in these states needs to recognise different causes of fragility. Although support should be provided in ways which address the failure to provide basic state functions, the focus may be on building service delivery capacity in 'weak' states while focusing on issues of democracy and accountability in 'unwilling' states. This should involve aligning with national priorities and plans and using national monitoring and evaluation systems. Duplication and parallel provision of services should be avoided. This does not mean that government should provide all services. Civil society organisations have a key role to play, not only in holding government to account, but also in providing certain kinds of services, e.g. those that are difficult for government to deliver.

2. *Taking Action* places strong emphasis on bridging the funding gap for HIV and AIDS. However, in countries like Zimbabwe perhaps the most significant barrier to scaling-up HIV services is the shortage of required human resources. Supporting countries to develop, finance and implement comprehensive strategies for human resources in health would fit well with DFID's business model and comparative advantage.

3. Increasing in-country support for UN agencies has risks including absorptive capacity, diversion from core roles and problems of coordination between agencies. One option for reform might be to increase central funding of agencies but there are fears that this might increase central bureaucracies with less money reaching countries. Another option would be to finance a combined UN in-country response. This is already happening to some extent, although the current plan is largely an aggregation of agency plans. Developing a truly joint plan could encounter considerable practical problems.

The role of multilaterals such as UN agencies

Along with other donors, DFID has channelled more funds through UN agencies in Zimbabwe in recent years. This is because of constraints on funding government directly and because of ease of procurement, greater political acceptability and levels of organisational capacity when compared to other possible providers, such as NGOs. However, there are significant challenges to this approach, including fears of exhausting capacity, limited ability for policy dialogue, excessive focus on working with government of some agencies, bureaucracy, diversion from core roles and problems of coordination.

Other issues

- Work with OVC proved a good area for DFID support in Zimbabwe because it is prioritised in *Taking Action* and Zimbabwe's National Plan of Action; it was an opportunity to affect an off-track MDG and it is not a contentious political issue.
- Food security is a contentious political issue in Zimbabwe. DFID is shifting away from food aid to broader social protection approaches.
- DFID has supported programmes which address gender and vulnerability, e.g. IOM's programme to address gender-based violence in emergency settings.
- HIV prevention efforts in Zimbabwe among young people appear to be a lower priority than they once were. Approaches appear to have been strongly influenced by particular agendas, such as promoting abstinence before marriage.
- DFID has provided some support to PLWHA and their organisations but this has been hindered by the weakness of these organisations.
- DFID is valued as a donor because of its flexibility, and willingness to support contentious issues.
- Recently, DFID Zimbabwe has experienced high turnover of health and HIV/AIDS advisers. Local staff have provided consistency and institutional memory in this context.
- The 'doing more with less' agenda requires staff to take on new roles needing new skills. However, training opportunities have been limited.
- Coordination between different parts of DFID Zimbabwe could have been stronger. It is hoped that the new impact area teams will improve this.
- There are concerns that DFID information systems, in general, and PRISM, in particular do not always provide the information needed and appear to primarily serve central information needs.
- DFID Zimbabwe offers its staff a programme of confidential HIV testing, counselling, care and treatment, over and above standard medical aid packages.