7. *Taking Action* Implementation – Focus on Women, Young People and Vulnerable Groups

In Brief

Question: How is *Taking Action*'s specific focus on women, young people and vulnerable groups being interpreted by government decision-makers? Is a significant proportion of funding and activities reaching these priority groups? What are the initial lessons from this?

The UK has made good progress towards the commitments in *Taking Action*. While it is difficult to assess what proportion of funding reaches these priority groups, there is evidence that between 2003/4 and 2005/6 spend on programmes/projects with a focus on young people, OVC and vulnerable groups increased. Spend on those with a focus on women appeared to decrease in the same period.

The UK has demonstrated international leadership on SRH, OVC, harm reduction, comprehensive HIV prevention for youth, and prevention, treatment and care needs of sex workers, IDU and MSM, and has funded global and country partners that lead on these issues. Important support has been provided for innovative, evidence-based programmes for the most vulnerable groups in Asia, Eastern Europe, Latin America and the Caribbean. However, support for HIV interventions for prisoners, a group not mentioned in *Taking Action* but identified subsequently by UNAIDS as at especially high risk, has received limited attention. Support for legislative reform and enforcement of laws that protect vulnerable and affected groups from stigma and discrimination is another area that requires more attention. DFID has pioneered social protection measures, including for vulnerable children, and funded innovative approaches to tackling gender-based violence. Support for international and national PLWHA organisations has increased. There is limited evidence of engagement of PLWHA or vulnerable groups in DFID programme planning or evaluation.

At the international level, DFID funds multilateral agencies and NGOs with a focus on women, young people and vulnerable groups. This evaluation identified some concerns about whether the World Bank and EC give sufficient emphasis to these priority groups, and whether UN agencies can sustain support for critical interventions for vulnerable groups in countries where DFID does not have a bilateral presence. At country level, funding is provided to partner governments, UN agencies and civil society. Since country programming is determined by Directors' Delivery Plans and Country Assistance Plans, it is critical that these address the specific HIV/AIDS-related needs of women, young people and vulnerable groups. There are concerns that PRBS may not be an effective mechanism for reaching priority groups, as a result of poor national prioritisation and political barriers to addressing sensitive or contentious issues. There are also concerns that, as DFID shifts towards greater use of budget support, funding will decline for CSOs that advocate for, or provide services to, women, young people and vulnerable groups. In practice, DFID uses multiple aid instruments to support HIV and AIDS programming, and experience to date suggests that availability of a flexible mix of instruments is essential to ensure that the needs of women, young people and particular vulnerable groups are met.

Introduction

7.1 Women, young people and vulnerable groups are central to *Taking Action* (DFID, 2004a). The following are mentioned as vulnerable: women, young people, children (in particular OVC), MSM, sex workers, IDU, ethnic minorities and migrants. *Taking Action* also refers to PLWHA and poor people. The strategy does not explicitly mention prisoners, one of four sub-populations, together with sex workers, MSM and IDU, identified in 2006 as especially vulnerable to HIV infection and neglected by the international response (UNAIDS, 2006). The International Development Committee[131] also acknowledged that while many groups are vulnerable to HIV infection[132] these four key populations are particularly significant (IDC, 2006a). The strategy also makes little reference to disabled people.

7.2 This suggests that there is no clear understanding of vulnerability related to HIV and AIDS. The term is used to cover increased vulnerability to HIV infection, increased vulnerability as a result of infection and general vulnerability unrelated to HIV. The successor to *Taking Action* would benefit from a clearer analysis of vulnerability that reflects the evolution of epidemics in different contexts, changing patterns of risk behaviour and future challenges, e.g. MSM and IDU in Africa.

7.3 This Chapter is divided into three parts. It provides a brief overview of progress on specific commitments related to women, young people and vulnerable groups (see Chapter 3 and Annex 7, pA92, for more detail). These commitments are largely focused on inputs, which makes it difficult to comment on outcomes or impact of UK action. It explores (p80) trends in UK support to HIV and AIDS activities that benefit these priority groups. It reviews (p88) UK approaches to providing support for these priority groups and ensuring their needs are addressed in the context of country-led approaches, aid instruments such as PRBS, and donor harmonisation.

Progress on Specific Commitments

Priority Action 1: Closing the Funding Gap

7.4 The UK has made good progress on commitments to fund SRH services, girls' access to education, harm reduction programmes and development of OVC plans. The UK is on target to meet its funding commitment to UNFPA. UNFPA received a further £25m in 2003/4 and £10m in 2004/5 to support reproductive health supply security. The UK has committed to increase education funding to £8.5 billion during 2006/7-2015/16. Funding for harm reduction programmes is discussed under Priority Actions 2 (p75) and 4 (p77) and for OVC under Priority Action 3 (p76).

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[131] And accepted by the UK Government (IDC, 2007)

[132] Women, children, young and older people

7.5 The UK has made progress on funding for research benefiting women, providing important support for microbicides research, in addition to funding research in related areas such as maternal health. There is less evidence of funding for specific research to benefit young people or vulnerable groups such as IDU or MSM. For more detail on research, see sections 7.26 and 7.27, p78.

Priority Action 2: Strengthening Political Leadership

7.6 Internationally the UK has taken a strong and consistent lead on SRH and rights, including providing a further £100,000 to UNFPA to review progress on the ICPD agenda and ensuring the ICPD target of universal access to reproductive health by 2015 was reflected in the June 2006 UNGASS High Level Meeting Declaration as well as in the MDG framework. The UK could do more to leverage improved coverage with PMTCT services, through its international leadership on SRH and funding for health systems strengthening.

7.7 The UK provided important leadership for development of the EU Statement on HIV Prevention for an AIDS-Free Generation. The IDC (IDC, 2006a) has urged DFID to continue to play a leadership role, 'given the increasingly moralistic tones of prevention programmes implemented by the US'. This position is not always fully reflected in country programmes (see Box 30, p132).

7.8 The UK has championed the rights of sex workers, MSM and IDU, advocating for their prevention, care and treatment needs to be included in the universal access process and the UNGASS 2006 Declaration. The UK has also championed harm reduction, making the case for evidence-based measures in its Harm Reduction Policy Paper (DFID, 2005k) and developing a strategy to influence UN drugs bodies (HMG, 2006). DFID has increased funding for international organisations that advocate for rights and services for women, PLWHA, IDU and MSM.

7.9 At national level, the UK has advocated for the rights of vulnerable groups and provided support to strengthen government and civil society leadership on behalf of these groups, as examples from country case studies show (see Annex 5, Example 13, pA82). DFID has also provided support to strengthen leadership by women, young people and vulnerable groups themselves. Programmes in countries including Bangladesh, Ghana, Namibia, Uganda and Togo focus on building the capacity of excluded groups to exercise voice and demand their rights (DFID, 2006aa).

7.10 However, international and national political leadership remains relatively weak, reflecting differences in perspectives on gender equality, approaches to HIV prevention for youth and and to reducing vulnerability of MSM, IDU and sex workers. HIV prevention services only reach 36% of sex workers, 9% of MSM and 5% of IDU, and few prisoners have access to HIV services (UNAIDS, 2006).

7.11 In 2006, the GAP team commissioned a review of the extent to which DFID work addresses human rights and HIV/AIDS-related stigma and discrimination (DFID, 2006v). The review concluded that most programmes focus on preventing and reducing stigma, with relatively few challenging institutional

discrimination, and that tackling stigma and discrimination has not received the level of attention required.

7.12 The commitment to promote human rights is central to DFID's Institutional Strategy (IS) with UNHCHR (DFID, 2005l) and DFID is providing £10.8 million to UNHCHR during 2005/8. DFID also supports action at country level (see Priority Action 4, p77 and Annex 5, Example 17, pA85), including on children's rights through funding for UNICEF, which takes a rights-based approach in its advocacy and programming, and for NGOs, e.g. Save the Children and World Vision, who promote children's rights through e.g. children's parliaments. However, a study commissioned by DFID's Exclusion, Rights and Justice team (SDD, 2005) identified few initiatives working with governments on children's rights and concluded that there was potential for more strategic links between DFID country offices and NGOs working on children's rights.

7.13 Also, the FCO plays an important role in promoting the human rights agenda in priority countries, e.g. the British Embassy raises human rights issues with the Chinese Government (Lenton and Ran, 2006). There is scope to increase synergies between DFID's human rights and HIV/AIDS agenda and the FCO's objectives of promoting good governance and respect for human rights (IDC, 2006a), although this can represent a challenge for the FCO (see Annex 5, Example 17, pA85).

7.14 A related commitment was support for legislative reform to combat discrimination (see also Priority Action 4, p77). Available evidence suggests that progress has been limited. Over half of 126 countries that reported to UNAIDS in 2006 had policies that interfere with the accessibility and effectiveness of HIV prevention and care measures. The IDC recommended 'DFID … make specific efforts to encourage the repeal of restrictive policies, at both domestic and international level, that impede effective services' (IDC, 2006a). Even where legislation exists, enforcement is often weak, and DFID could do more in this area, e.g. through funding CSOs that monitor implementation of policies and laws.

Priority Action 3: Improving the International Response

7.15 The UK has endorsed the Strategic Framework for the Protection, Care and Support of Orphans and Children made Vulnerable by HIV and AIDS. Support has been provided via UNICEF to help governments develop National Plans of Action (NPAs) for OVC and to integrate these into AIDS and social sector plans. DFID also gives direct support to governments for NPA development and implementation, e.g. financial and technical support to strengthen national OVC coordination and relevant ministries in Mozambique and mobilising funds for the NPA in Zimbabwe. Annex 5, Example 18 (pA86) shows other DFID support for OVC in Africa.

7.16 A recent progress report (UNICEF et al, 2007) states that at least 20 African countries have completed NPAs. However, on average only 35% of total budgets had been pledged by May 2006 in 14 counties where funding data was available (Webb et al, 2006) (although this may be an under-estimate since some funders, e.g. PEPFAR, are not aligned with NPAs). This highlights the need for

more effective support for, and monitoring of, government implementation of NPAs.

7.17 Other DFID action has included preparation of a joint review of policy on children affected by HIV and AIDS for the Global Partners' Forum, which DFID co-hosted with UNICEF (Green, 2006). DFID is also a donor to the Joint Learning Initiative on Children and HIV/AIDS, which aims to strengthen the evidence base and improve policy and practice concerning affected children.

7.18 *Taking Action* committed the UK to increase access to medicines for women and children. The UK will provide £15 million in 2007, rising to £40 million by 2010, to UNITAID, which will fund ARVs for paediatric treatment. In November 2006, DFID joined the Public-Private Partnership for Paediatric AIDS Treatment, which aims to address barriers to paediatric treatment. Despite growing international commitment, progress in provision of paediatric treatment has been slow. More effort is required to ensure that national AIDS plans consider treatment needs of children and national M&E systems collect data on paediatric treatment coverage.

7.19 In 2005, reported data on the use of ARVs failed to detect any notable gender inequities (UNAIDS and WHO, 2006), although there are concerns about the reliability of this data. There are also concerns about inadequate efforts to address barriers that prevent women from accessing treatment, e.g. stigma and discrimination, limited decision-making power and autonomy, child care responsibilities, lack of money to pay for associated costs, e.g. travel to health facilities, and the potential adverse impact of the introduction of routine ('opt out') HIV testing in health facilities on women's access to treatment (UNAIDS, 2006; Rennie and Behets, 2006; DFID, 2007d). Positive women's organisations have also highlighted neglect of wider treatment and care needs of positive women and of the specific needs of young women as critical issues.

Priority Action 4: Better National Programmes

7.20 *Taking Action* included specific commitments to support comprehensive programmes for women and girls, including access to education, employment and social protection, and efforts to tackle gender-based violence (GBV).

7.21 DFID published its girls' education strategy in 2005 (DFID, 2005m) and advocated for mainstreaming HIV and AIDS and gender equality into the Education Fast Track Initiative (FTI), in its role as co-chair of the UN Girls Education Initiative from 2002-2006. Countries applying for FTI funds must now include gender and HIV education in education sector plans. DFID also supports a range of country initiatives, including providing £26 million for the UNICEF Girls' Education project in Nigeria which, in its first year, increased girls' enrolment by 10-15% in the six pilot states. DFID Zambia supports the Campaign for Female Education International to improve girls' education in rural schools, reinforcing DFID action at national policy level.

7.22 DFID has funded innovative research, advocacy and community interventions to tackle GBV (Edbrooke and Peters, 2006). An evaluation of DFID's gender work (COWI, 2006) concluded that, while progress overall has been uneven, DFID has had some success in promoting gender equality and access in health and

education sectors. In response, DFID commissioned a review of best practice in gender mainstreaming and developed a Gender Equality Action Plan (DFID 2006ab; DFID 2006ac). However, this Plan makes little reference to HIV and AIDS. More generally, there is a perception that much of DFID's work on HIV and AIDS and women relates to SRH and that more attention could be given to addressing underlying gender inequalities and causes of women's vulnerability to HIV as well as to gender programming that considers the roles and needs of men. Country case studies reflect uneven progress. Some country offices have given little attention to gender and HIV, while others have addressed gender and vulnerability in a variety of ways (see Annex 5, Example 21, pA88).

7.23 Specific OVC commitments include the spending target, inclusion of OVC in CAPs, and interventions to keep children in school. Analysis for this evaluation suggests that DFID appears to be on track to meet the OVC spending target, but official figures are not yet available (see section 7.36, p83). Review of a sample of 12 CAPs, developed before and after *Taking Action*, indicates that the focus on OVC has increased, particularly in African country programmes. DFID has promoted social protection measures, mostly in Africa, to support children's access to education and health care (DFID, 2006ae). Efforts are needed to improve M&E and evidence about the most effective interventions to meet the needs of vulnerable children in different contexts (Chapman, 2006; Green, 2006).

7.24 In line with the commitment in *Taking Action*, DFID has provided critical support for activities targeting IDU, MSM and sex workers (see Table 7, p89 and Annex 5, Example 13, pA82). NGOs interviewed for this evaluation stated that DFID funds progressive programmes for vulnerable groups, but had concerns about sustaining such programmes as DFID increasingly focuses on alignment with national priorities and phases out direct engagement in middle-income countries.

7.25 *Taking Action* included a commitment to promote greater involvement of PLWHA in programme planning and delivery. In addition to commitments to international PLWHA organisations, DFID supports NGOs which strengthen national PLWHA organisations (International HIV/AIDS Alliance, 2005), and PLWHA organisations through country offices (DFID, 2006v). However, there is scope to increase support to these groups (DFID, 2006v) and to ensure more consistent PLWHA engagement in DFID programme planning and design, in line with the emphasis on governance set out in the 2006 White Paper, as well as in national AIDS responses.

Priority Action 5: Taking Action in the Long Term

7.26 Specific Priority Action 5 commitments focus on research benefiting women, children and vulnerable groups. A brief summary of progress on these is provided in Table 6 (p79). DFID support for research, e.g. on health systems, maternal health and education, is significant but it is difficult to track how much is HIV/AIDS-related.

7.27 The two RPCs commissioned in 2006, following a thorough consultation and decision-making process (see Chapter 5) focus on social and economic aspects of HIV and AIDS and treatment and care services. The research budget is currently

fully committed but the GAP team and CRD are considering how other areas of research, e.g. on social and behavioural aspects of HIV and AIDS, including gender and sexuality norms, and factors influencing behaviour change, the effectiveness of prevention and treatment adherence, can be addressed. RPCs had to demonstrate user involvement in research as part of their bids, and efforts have been made to increase user engagement in, e.g. in microbicides research.

Table 6. Summary of Examples of Research Supported in Line with Commitments in *Taking Action*

Commitment in *Taking Action*	Examples of DFID Support
Knowledge on how to influence and change **societal and economic impacts** of AIDS, including the challenge of growing numbers of orphans	5-year funding for RPC (HD12) research on social and economic aspects of the epidemic (see section 7.5, p75). Other research consortia (HD3, HD4) are looking at sexual and reproductive health rights, especially for socially excluded groups, and communicable disease and TB-related stigma and discrimination (HD205, HD206).
Global understanding of how the social **roles of men and women**, boys and girls, increase vulnerability to HIV	HIV/AIDS RPC e.g. HD12 (LSTM and partners) receiving £3.75m 2006-2011 to conduct research into vulnerabilities; HD3 Reproductive and Sexual Health and HIV Consortium of the LSHTM is providing technical support to the BBC World Service Trust to assess the impact of media campaigns on stigma and gender relations. (See also section 7.22, p77 for examples of research on GBV).
Innovative treatment regimens that can be safely accessed by marginalised groups	5-year funding for RPC (HD11) (£3.75m 2006-11) to conduct research on HIV and AIDS treatment and care services; and 5-year funding (£2.5m 2002-7) to the Developing Anti-Retroviral Treatment in Africa (DART) trial to look at monitoring practice in the management of ART in adults.
Developing better and more effective **therapies for children**	DFID has provided follow-up financial support to the Children with HIV in Africa: Pharmacokinetics and Adherence of Simple Antiretroviral Regimens' study, to test simplified antiretroviral regimens for children; and is funding (£2.6m 2006-10) the Anti-Retroviral for Watoto (Children) (ARROW) trial, which is similar to the DART trial.
Intensifying the **microbicides** effort and closing the funding gap for microbicide trials	DFID made a commitment in 2005 to give £23.8 million to the Microbicides Development Programme over 3 years, £7.5 million to the Partnership for Microbicides over the same period and £1 million to the Global Campaign for Microbicides.
Continued support for **AIDS vaccine** development	Current commitment to the International AIDS Vaccine Initiative is £20m for 2005/8; previous funding to IAVI to 2005 totalled £19.8m.

Priority Action 6: Translating Strategy into Action

7.28 Access to SRH and rights, the focus of the commitment in Priority Action 6, is discussed earlier in section 7.6 (p75) and in section 10.4 (p128).

Trends in DFID Portfolio

7.29 There are two challenges in analysing trends in UK support[133,134] for (and the proportion of total HIV/AIDS spending on) activities that benefit women, young people and other vulnerable groups. First, the way DFID funds activities (see Figure 5, p24) of this report) and second, the fact that DFID systems do not allow systematic tracking of this information (see sections 4.21-4.24, p37).

7.30 Information included here is mainly based[135] on a working paper for this evaluation (SSS, 2006a), which identified a data set of 1,424 HIV and AIDS projects/programmes from 1987 to 2006, based on clear criteria[136]. Within this, we identified projects/programmes with a focus on women (329), young people (109), OVC (178) and other vulnerable groups (175).

Women

7.31 The number of new projects/programmes with an identifiable focus on women rose during the 1990s but has remained static or declined since 1999/2000 (see Figure 25 p81). Expenditure on projects/programmes with an identifiable focus on women declined from 2003/4 to 2005/6[137] (see Figure 25, p81). DFID's information systems also contain PIMS[138] markers for gender. In total, 333 projects/programmes had gender markers[139]. Only 86 had both an identifiable focus on women and a gender marker. The number with a gender marker has been steadily increasing (see Figure 27, p82).

Caveat

All figures in this Chapter on trends are based on a qualitative analysis of DFID information systems conducted in February 2006 for a working paper produced for this evaluation (SSS, 2006a). These are **not** official DFID figures. To understand, interpret and use these figures, it is essential that the methods used to generate them are fully understood (see Annex 1 of the working paper).

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[133] Limited to the DFID portfolio as specified in the design document for this evaluation (DFID, 2005a)

[134] All financial information in this section was originally collected and analysed in February 2006. At that time, DFID was in transition between methods for calculating AIDS spend. Consequently, analysis was done in a way that was based on DFID's 'old method' of calculating spend (see 1.Table 2, p10). This involved including 100% of all commitments and expenditures of projects/programmes in our data set. Figures relating to 17 projects/programmes identified as PRBS were excluded because of the pending changes in methods for calculating AIDS spending. In addition, as data was collected in February 2006, expenditure figures for 2005/6 are incomplete. **For these reasons, care needs to be taken in interpreting these figures, particularly the absolute values as these may not be comparable to figures currently available under the 'new method'. For this reason, all graphs and charts based on financial figures are marked as follows** .

[135] Some further analysis of this data set has been done for this section.

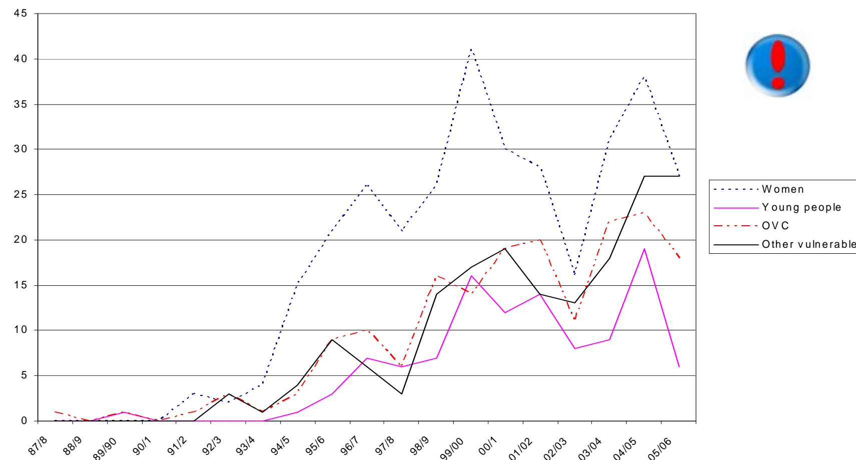
[136] See Annex 1 of SSS 2006a

[137] Figures for 2005/6 were to February only

[138] See footnote 190, section 8.25, p115.

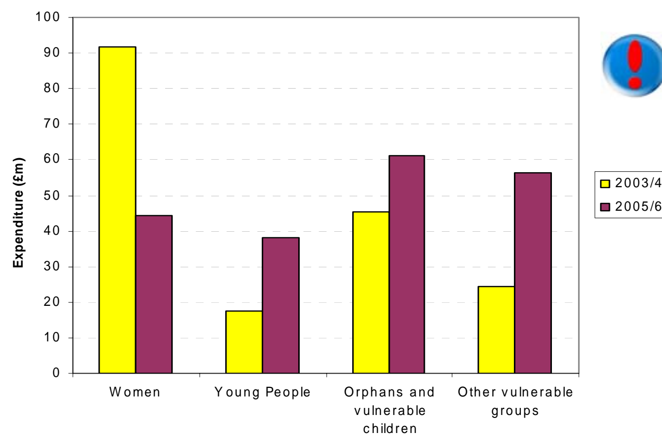
[139] 301 significant (S) and 32 principal (P)

Figure 25. New Projects/Programmes Focusing on Vulnerable Groups: 1987-2006



7.32 Further analysis reveals that most with a focus on women are SRH projects/ programmes[140] (54%) with smaller numbers focused on general health[141] (22%); HIV and AIDS[142] (12%); education[143] (2%) and development[144] (9%). This is broadly the same for projects/programmes that have both a focus on women and a gender marker. However, more of those with a gender marker focus on development (45%) and education (10%).

Figure 26. Comparison of Expenditure on HIV and AIDS-related Projects/ Programmes with a Focus on Vulnerable Groups in 2003/4 and 2005/6



[140] Including support to organisations with a focus on SRH, e.g. UNFPA; contraceptive supply; STI treatment; management of unplanned pregnancy; maternity services; management of cervical cancer; and reproductive health activities in schools

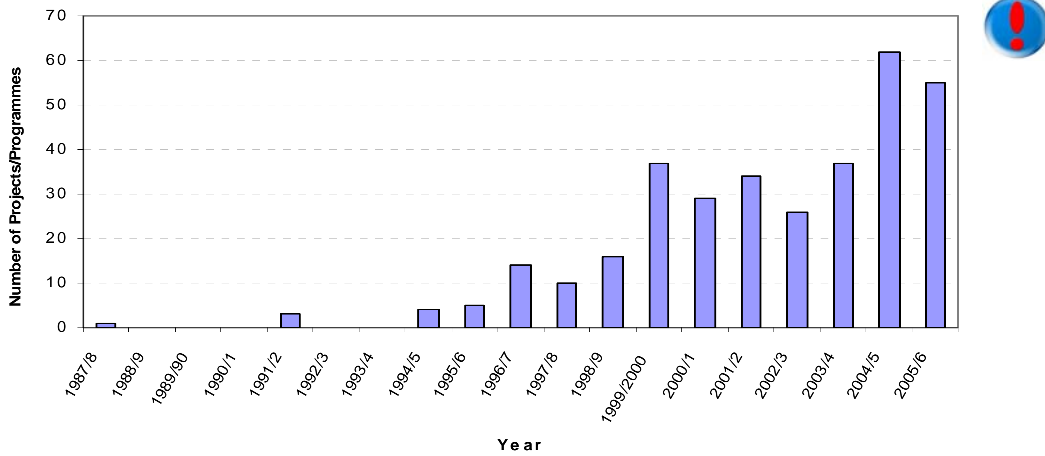
[141] Including maternal and child health programmes; TB programmes and mental health services

[142] Including HIV prevention services in the education sector; sex worker services and condom provision

[143] Including literacy programmes

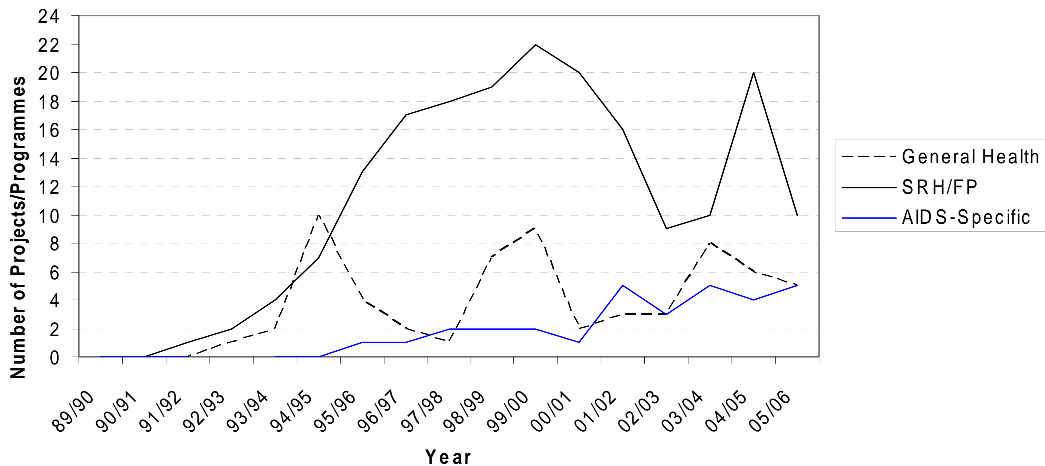
[144] Including PRBS; PPAs; debt relief; building public sector capacity; food security; support to OVC and child rights; combined health/education interventions; water/sanitation programmes; support to UNIFEM

Figure 27. Number of HIV and AIDS-related Projects/Programmes in the Data Set with a Gender PIMS Marker



7.33 SRH projects/programmes appear less likely to be allocated a gender marker than other activities, e.g. education. This may be valid because not all activities focused on women tackle underlying issues that contribute to gender inequities, but does not explain why some SRH projects/programmes are given gender markers and others are not. A more plausible explanation is inconsistency in the way gender markers are allocated by DFID staff. As SRH projects/programmes represent the largest number of those with a focus on women, the trend in these accounts for the overall trend in those with a focus on women (see Figure 28). A recent Reproductive and Child Health team review suggests that it is possible that SRH activities are being absorbed into sector and general budget support and that some of these activities are being captured within AIDS-marked projects/programmes (DFID, 2007c).

Figure 28. Projects/Programmes with Identifiable Focus on Women: Trends



Young People

7.34 The number of new projects/programmes with an identifiable focus on young people has risen[145] (see Figure 25, p81). Spend on projects/programmes with a focus on young people rose from 2003/4 to 2005/6[146] (see Figure 25, p81). A large proportion of these are adolescent SRH projects/programmes[147] (40%), with smaller numbers focused on HIV and AIDS specifically[148] (20%); education (17%) and other[149] (22%).

7.35 Of those with a specific focus on HIV and AIDS, most were prevention projects/programmes, particularly prevention in schools and other parts of the education system. There has been less emphasis on prevention programmes for young people who do not attend school and for especially vulnerable youth, e.g. street children. Other approaches include supplementing IEC with counselling and commodities; fostering youth participation; producing AIDS information and using mass media to reach young people. Examples of approaches supported by DFID's Civil Society Challenge Fund are presented in Annex 5, Example 19 (pA86). Treatment and care of young PLWHA appears to have received limited attention.

Orphans and Vulnerable Children

7.36 DFID has developed a system for tracking spend towards the OVC spending target using a combined system of sector codes[150] and PIMS markers. At the time we reviewed the system, it was not yet fully operational[151]. There are also issues related to application of the method for tracking the OVC spending target. First, a project/programme needs to have a PIMS marker for HIV and AIDS for its expenditure to be counted towards the OVC target. Broad social transfer programmes, which often benefit OVC, may not be given an AIDS marker. Second, the sector code for OVC is relatively new and all relevant projects/programmes have yet to be captured. Third, large programmes with small-scale support for OVC might not be captured by sector codes, which give a broad brush view of spending within a project/programme. An example is provided in Figure 29 (p85).

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[145] Given the overall trend, the apparent 'dip' in 2005/6 is likely to be an artifact due to data for that year being incomplete, i.e. to February only

[146] Figures for 2005/6 were to February only

[147] Including sex education

[148] Including specific HIV prevention services in the education sector and services for sex workers

[149] Including health (7); support to youth-focused organisations (4); youth participation (2) and a variety of other activities including work on juvenile justice; sexual exploitation of young people; abuse of girls; sexual harassment and work with young migrants

[150] Sector codes allow parts of the expenditure of a project/programme to be allocated to particular sectors. There is a sector code for work which has an impact on OVC. Coding a project to this sector does not necessarily mean it is HIV-related. However, the OVC spending target within *Taking Action* is worded as a sub-set of the spending target for HIV/AIDS. As a result, the current methodology for tracking this requires a project/programme to have a PIMS marker for either reproductive health or HIV/AIDS, and a sector code for OVC for expenditure on that project/programme to be counted towards the OVC spending target.

[151] In February 2006, SRSG were able to identify three projects with both an OVC sector code and an HIV/AIDS PIMS marker with a total spend for FY 2005/6 of only £1.58m.

7.37 We identified 178 projects/programmes with a focus on children. The number has risen steadily[152] (see Figure 25, p81). Expenditure has also risen, from £45.2 million in 2003/4 to £61.3 million in 2005/6[153] (see p81). However, these figures should be interpreted with great caution because:

- They are based on PIMS marker allocations to projects as of February 2006. Any subsequent changes to these allocations would affect these calculations[154].
- There was a significant number of education projects/programmes within those with an identifiable focus on children but there does not seem to be a shared view of the extent to which such projects/programmes benefit OVC[155].
- They were based on the method used to calculate AIDS spending in February 2006 (see Table 2, p10). Method changes that could affect this calculation include: reduction in the proportion of S-marked spending counted towards the AIDS target (from 100% to 50%) and allocation of only a proportion of the contribution to UNICEF[156] and of the PPA to SCF as AIDS spending[157].

7.38 Projects/programmes with an identifiable focus on children included health (38%); education (19%); general development (18%); HIV-specific (17%); support to child-focused organisations (7%); and other (2%). Most were in African countries (see Figure 30 p86), in line with the focus on OVC in Africa in *Taking Action*.

[152] Given the overall trend, the apparent 'dip' in 2005/6 is likely to be an artefact due to data for that year being incomplete, i.e. to February only.

[153] To February

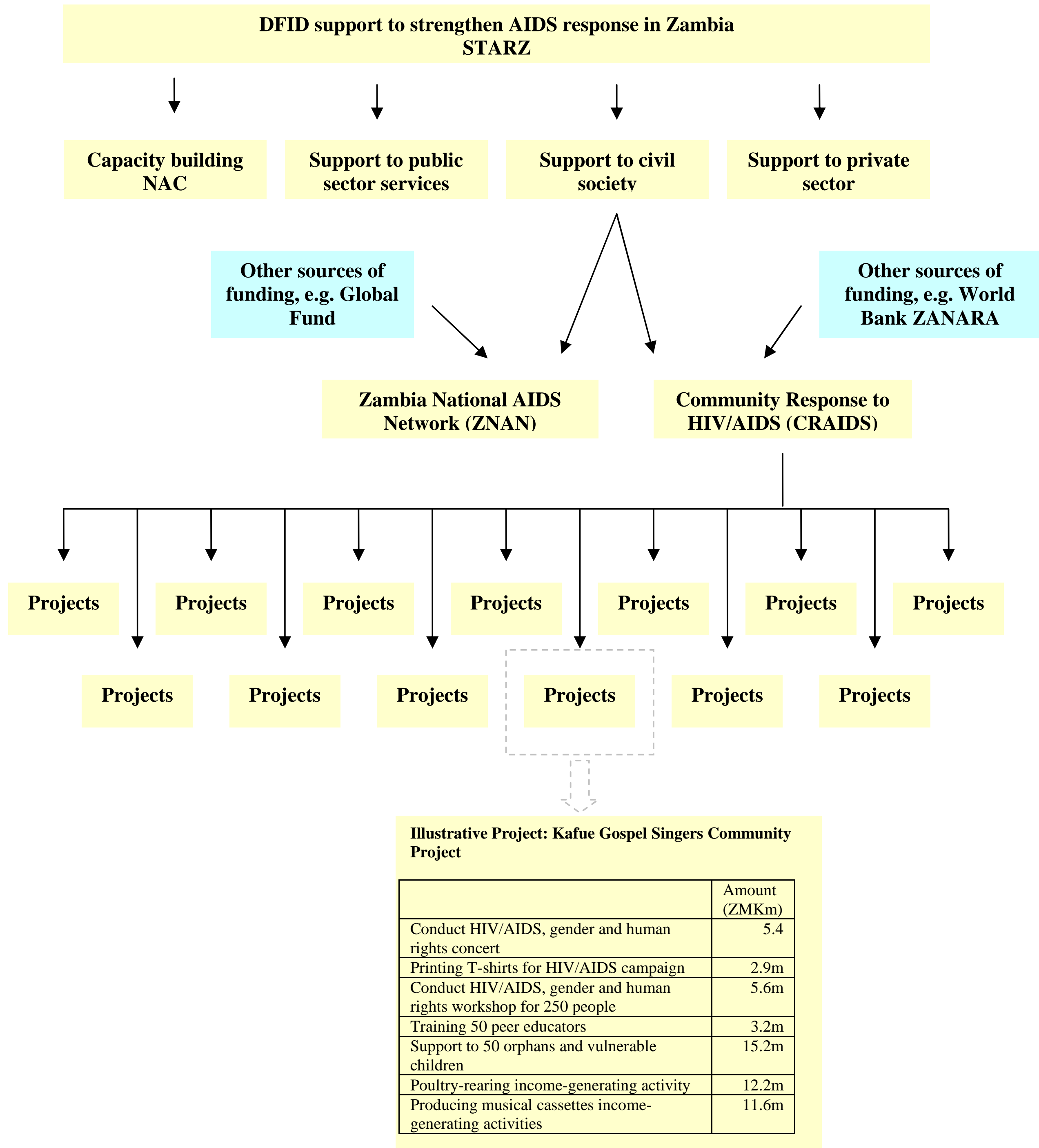
[154] It is understood that a significant data cleaning exercise was undertaken as part of finalising figures for 2004/5 and 2005/6 for UK AIDS spending (see section 3.5, p10). This could have a significant effect on these calculations.

[155] It seems likely that general education programmes could have considerable benefit to OVC, but the benefit is likely to be higher in countries with high HIV prevalence. It seems less clear that HIV prevention programmes in schools have significant benefits for OVC, although there is evidence that female orphans are more vulnerable to HIV.

[156] 13% in 2004/5 and 18% in 2005/6. As the OVC spending target is a sub-set of AIDS spending, only a maximum of this proportion could be counted towards the OVC target. This could be problematic if UNICEF believe that a higher proportion of their expenditure benefits OVC.

[157] This is 3% but does not apply to other means of funding SCF. As the OVC spending target is a sub-set of AIDS spending, only a maximum of this proportion could be counted towards the OVC target. This could be problematic if SCF believe that a higher proportion of their PPA expenditure benefits OVC.

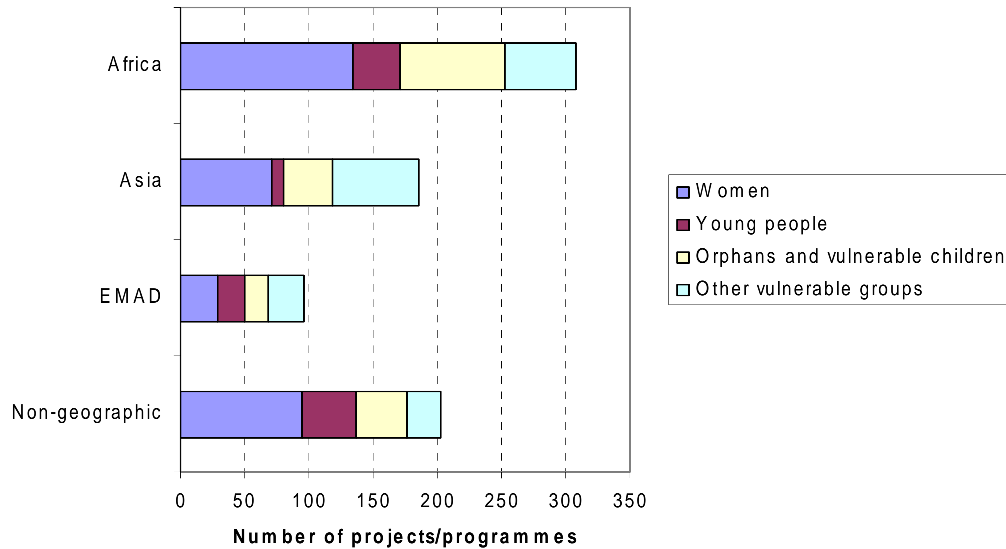
Figure 29. Challenges in Tracking Financial Resources Benefiting Orphans and Vulnerable Children: An Example from Zambia



	Amount (ZMKm)
Conduct HIV/AIDS, gender and human rights concert	5.4
Printing T-shirts for HIV/AIDS campaign	2.9m
Conduct HIV/AIDS, gender and human rights workshop for 250 people	5.6m
Training 50 peer educators	3.2m
Support to 50 orphans and vulnerable children	15.2m
Poultry-rearing income-generating activity	12.2m
Producing musical cassettes income-generating activities	11.6m

7.39 DFID's Africa Division produced a qualitative review of their support for OVC for a meeting with the UK Consortium on AIDS and Development in November 2006 (DFID, 2006z). This explained DFID's approach in Africa and presented a number of country examples, grouping these into different types of support (see Box 18, p87). Other examples of activities benefiting OVC are included in Annex 5, Example 18 (pA86).

Figure 30. Spread of Focus on Particular Vulnerable Groups across Different Regions/DFID Divisions for HIV/AIDS-related Projects/Programmes



Box 18 DFID Support for OVC in Africa

DFID supports activities for OVC in different ways.

- It provides *support to national governments* to develop and implement robust plans, e.g. in Mozambique.
- In many countries, it *works with or through UNICEF* to support national plans, e.g. in Botswana, Ghana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Tanzania, Zambia and Zimbabwe.
- It supports *programmes specific to the needs of OVC*, such as the Programme of Support in Zimbabwe.
- It also supports *components focused on OVC as part of broader programmes on HIV and AIDS*, e.g. support to CBOs providing home-based care in Kenya and to NGOs in Zambia, support through Christian Aid in DRC, financial support to Ghana's National Strategic Framework on HIV and AIDS, funding for the Anglican church and Soul City in South Africa, the rapid funding envelope in Tanzania to fund NGOs, and support to an umbrella programme financing CSOs in Uganda.
- Finally, it supports *activities which benefit vulnerable children as part of broader development programmes* e.g. support to CARE to deliver community-level social protection programmes in Zambia, support to the Productive Safety Nets Programme in Ethiopia and support through UNICEF to the Government of Ghana's social protection strategy. In countries where DFID provides most of its financial aid through poverty reduction budget support, e.g. Tanzania and Uganda, these funds can be used by government to address the needs of OVC.

Other Vulnerable Groups

7.40 The number of new projects/programmes with an identifiable focus on other vulnerable groups has risen since the early 1990s (see Figure 25, p81). Spend on projects/programmes with a focus on other vulnerable groups rose from 2003/4 to 2005/6[158] (see 7.32, p81). Many of these are located in Asia (see Figure 30, p86), where the epidemic is largely concentrated in populations such as IDU and sex workers.

7.41 This grouping includes: the poor (57[159]); mobile populations (49) (including those displaced by conflict or natural disasters, truckers, IDPs, refugees, trafficking victims and pastoralists); vulnerable groups in general (47)[160]; most at risk and neglected populations including IDU (8), MSM (4), sex workers and their clients (8); uniformed services (5); older people (5); disabled people (5); religious or ethnic minorities (5); children, including positive children (4); farm workers (3); miners (1).

[158] Figures for 2005/6 were to February only

[159] These figures refer to the number of projects/programmes that mention a particular vulnerable group in the project purpose in PRISM. As a project/ programme could refer to more than one vulnerable group, figures are expressed as numbers rather than percentages.

[160] This analysis is only as good as the descriptions of project purpose in PRISM. If a project/ programme provides services to a particular vulnerable group but this group is not specifically mentioned in the project purpose, it would not be picked up in this analysis.

7.42 As discussed in section 7.1, p74, IDU, MSM, sex workers and prisoners are significant both as 'drivers of the epidemic' and as groups whose needs and rights are neglected. Examples of UK activities in case study countries are included in Table 7 (p89). Examples from PRISM are in Annex 5, Example 13, pA82.

People Living with HIV and AIDS

7.43 Analysis of the data set found 81 projects/programmes with an identifiable focus on PLWHA. Twenty were comprehensive programmes, e.g. DFID support to the Global Fund and PPA with the International HIV/AIDS Alliance. Others focus on services, e.g. treatment, including ART, palliative care, PMTCT, drug supply (20), social care and support, including nutrition (13), treatment of opportunistic infections, including TB (9); and on impact mitigation, including food security initiatives (10). Country case study examples of PLWHA involvement are in Annex 5, Example 20 (pA87).

Approaches to Support for Priority Groups

7.44 The UK funds action for women, young people and vulnerable groups at international and country level. At international level, the main mechanisms are support for multilateral agencies and international NGOs. At country level, support is provided to governments, through aid instruments including general and sectoral budget support, to multilateral, mainly UN, agencies, and to civil society, directly or through umbrella mechanisms. Funding for research related to these priority groups is discussed in sections 7.26-7.27, p78.

7.45 Decisions about funding are decentralised within DFID, to different divisions dealing with specific regions and with relationships with multilaterals and NGOs, and to country offices. This represents a challenge to developing an overall, coherent approach to support for actions to meet the HIV/AIDS-related needs of women, young people and vulnerable groups, and to tracking overall support for these groups. In addition, there is a lack of clear allocation of responsibility within DFID for HIV/AIDS issues related to women, young people and vulnerable groups. HIV and AIDS is most commonly the responsibility of health advisers, but many issues relating to these priority groups cut across education, social development, governance, livelihoods and other sectors. As discussed in Chapter 8, country offices need to have the staff capacity to address these issues.

7.46 The following examines international and country funding mechanisms – including the issue of balancing country-led approaches with meeting the needs of women, young people and vulnerable groups – and the advantages and challenges of using these approaches to reach priority groups.

Table 7. UK-supported Work with Four Key Populations: Examples from Country Case Studies

	Injecting Drug Users	Men who have Sex with Men	Prisoners	Sex Workers[161]
China	DFID has provided critical support for piloting effective HIV prevention programmes for IDU, including needle exchange and methadone substitution therapy. This has led to some change in approaches to IDU which was previously solely based on arrest, detention, detoxification and 're-education'. Although there are some activities on improving IDU access to HIV treatment, more could be done on this.	MSM have been included in activities supported by the UK and this has led to a shift in official views towards MSM. More could be done to ensure the sexual and reproductive health needs of MSM are met.	Health promotion, including a focus on HIV, has been carried out in some detention centres.	DFID has provided critical support to piloting of effective HIV prevention programmes among sex workers in China, including peer education and provision of condoms. However, more is needed on SRH needs of sex workers and more preventive work with clients. DFID support is credited with a shift in official attitudes to sex workers.
DRC	Not covered in report	Not covered in report	Not covered in report	There is recognition that very poor economic opportunities are driving women into sex work in DRC. DFID has been supporting work with sex workers through PSI..
Ethiopia	Not covered in report	The issue is not being discussed in Ethiopia despite evidence from UNICEF that 21% of victims of sexual violence are boys.	It is noted that MSF are conducting work in some prisons.	MSF are currently working with sex workers. DKT are planning to do so.
India	Challenge Fund grants have been used to support CSO leadership on behalf of IDU. DFID has provided support for legislative reform through UNODC, the Society for Promotion of Youth and Masses and a lawyer collective. This is focused on establishing a	Grants have been used to support CSO leadership on behalf of MSM, including organisations advocating for legislative reform. India's focus on MSM is	Not covered in report	India's national AIDS response had a very strong initial focus on sex workers. This ensured that interventions reached scale in some settings, e.g. it is estimated that services reached 80% of sex workers in Gujarat. DFID is

[161] In some country case studies, the terms sex worker and female sex worker are used synonymously. In none of the country case studies was evidence presented on issues relating to men selling sex. This issue is covered in UNAIDS, 2006a (p107).

	Injecting Drug Users	Men who have Sex with Men	Prisoners	Sex Workers[161]
	legal basis for the provision of harm reduction services. India's focus on IDU is reported to have started later than the focus on sex workers.	reported to have started later than the focus on sex workers.		supporting UNDP's work on trafficking including efforts to reform the immoral trafficking act. However, progress is reported to be slow.
Russia	Injecting drug use is the main behaviour driving the epidemic. There is high incidence and prevalence of HIV among IDU and overlapping vulnerabilities with sex work, with an estimated 48% of sex workers also injecting drugs. Supporting interventions in this area has been a strong focus of DFID's funding. However, this has declined as DFID prepares for office closure in 2007. NGOs are strongly focused on this issue. The Russian Government has been less than willing to focus its national AIDS response on IDU. Access to ART by IDU has been extremely limited due to barriers to access, including stigma and discrimination and non-availability of substitution therapy.	Issues relating to MSM have a lower priority among NGOs than those relating to IDUs or sex workers.	It is reported that there are high rates of injecting drug use in prisons and that HIV prevalence stands at 5% among prisoners.	There are documented high levels of HIV prevalence among sex workers in some Russian cities, e.g. 62% in Togliatti, and overlapping vulnerabilities with injecting drug use, with an estimated 48% of sex workers also injecting drugs. Activities among sex workers are a strong focus of work of Russian NGOs. Although many sex workers are HIV positive and in need of ART, few are receiving this. One barrier is fear of going for HIV testing.
Zambia	Not covered in report	Not covered in report	FCO has been advocating with UNAIDS on prison conditions. The 2006 JAPR stated that there were 14,240 people in Zambian prisons, where HIV prevalence was 27%, conditions include no formal access to condoms.	NGOs are recognised as having a comparative advantage in working with sex workers. The need to provide services to sex workers is recognised in the national response to HIV/AIDS. Despite evidence of increasing condom use, rates of STI remain high.
Zimbabwe	Not covered in report	Not covered in report	Not covered in report	PSI are working with sex workers supplying male and female condoms.

International partnerships

Multilateral Institutions

7.47 In 2004/5, around 39% of all DFID funding was channelled through multilateral agencies. This proportion is set to increase. The EC (60%), World Bank (14%) and UN agencies (13%) are the main recipients. The extent to which some of these organisations respond to HIV and AIDS among vulnerable populations is shown in Table 8 (p91). DFID employs a range of approaches to monitor the effectiveness of multilaterals (see section 3.22, p16). These do not, however, address performance in sectors such as HIV and AIDS, or the effectiveness of HIV/AIDS work related to women, young people and vulnerable groups.

7.48 The UK plans to support HIV and AIDS work in middle-income countries where DFID will no longer have a presence, e.g. Russia, through multilateral agencies, in particular the UN system. Country case studies and experience, e.g. in Central Asia, raise concerns about whether UN agencies can sustain advocacy and evidence-based work on issues such as harm reduction (see Box 19, p92).

Table 8. Extent to which Different Multilaterals Respond to HIV and AIDS among Vulnerable Populations

Organisation	Description of Involvement with Vulnerable Populations
European Commission	The most recent DFID IS with the EC (DFID, 2005i) highlights the EC's 2001-6 Programme for Action (PfA), which proposes collective action and better coordination among donors and multilaterals to support country-led programmes with particular attention to women, orphans and vulnerable children. However, it does not provide detailed information about the EC's specific role in relation to these priority groups.
World Bank	The DFID IS with the World Bank (DFID, 2004h) states that the Bank is a major financier for national AIDS programmes, including targeted support through Multi-Country HIV/AIDS Programmes (MAP). It highlights the Bank's role in ensuring that national HIV/AIDS strategies are reflected in PRSs. The MAP provides support to NGOs, CBOs and the private sector for local HIV/AIDS initiatives, mainly for service delivery projects, but there is no particular emphasis on addressing the needs of women, young people or vulnerable groups. Evaluation of the MAP recommended that the World Bank do more to reach these groups, stating that 'failure to reach people with the highest-risk behaviour has reduced the efficiency and impact of assistance' (World Bank, 2005). For an example of how DFID is encouraging the Bank to do more to reach vulnerable groups in Central Asia, see Box 19 (p92).
UNIFEM	DFID's IS (UNIFEM and DFID, 2005) states that UNIFEM will work through the GCWA to build knowledge of links between women and girl's vulnerabilities to HIV and AIDS.
UNFPA	DFID's IS with UNFPA highlights the agency's role in HIV prevention among adolescents and pregnant women and promoting SRH and HIV/AIDS links.
UNICEF	The Joint Institutional Approach (JIA) with UNICEF, based on the agency's Medium Term Strategic Plan for 2006-9, focuses on supporting UNICEF to deliver its strategic priorities (DFID et al, 2006): rights-based programming for children, women's rights and gender equality, and capacity development for humanitarian response.
The Global Fund	DFID funding through the Global Fund also benefits women, young people and vulnerable groups. This evaluation has not conducted a systematic analysis of Global Fund support but two examples are grants to the Russian Harm Reduction Network and to the Indonesian HIV/AIDS Comprehensive Care programme, which provides services for sex workers through outreach projects.

Box 19 Sustaining Support for Vulnerable Groups in Central Asia

Since 2005, DFID has been using three complementary approaches to support interventions in Central Asia, focusing on Tajikistan, Uzbekistan and Kyrgyzstan:

- Funding a 5-year programme primarily for NGOs to implement harm reduction services for IDU, sex workers and prisoners, the Central Asia Regional Harm Reduction Project (CARHAP), through a £5.4 million fund managed by a contractor (GRM) and involving national implementing partners that include OSI, Soros and World Vision.
- Funding of £1 million over 5 years to the World Bank Regional Trust Find, Central Asia AIDS Fund, which emphasises controlling the epidemic in the region, to which governments and CSOs can apply for regional and national programmes that prioritise harm reduction.
- Funding for UNAIDS for 3 years, including for M&E and national programme and planning support staff, to provide overall support in the region.

The overall objective of DFID support is to encourage governments to adopt and implement evidence-based harm reduction policies and plans, as well as to contain the epidemic. Using three different approaches has enabled DFID to continue support for service delivery by CSOs, which will also provide valuable evidence of the effectiveness of harm reduction interventions and complement World Bank financing. World Bank funds were initially less accessible to smaller NGOs working with vulnerable groups, but demonstration projects in the CARHAP have successfully influenced World Bank financing and a larger amount of funding will now be directed based on evidence and need, e.g. the Bank has agreed to ring fence funds for vulnerable groups. This tripartite funding arrangement means that coherent planning and M&E is supported through UNAIDS. UNAIDS is also expected to take the lead in advocating for harm reduction with national governments. However, in practice, UNAIDS has been unwilling to take a strong stand on this issue with senior government officials. DFID has so far, therefore, needed to continue to advocate for harm reduction measures; funding service delivery has been a critical element of this.

Civil Society

7.49 Most of central DFID funding for CSOs is channelled through the Civil Society Challenge Fund (CSCF) and Partnership Programme Agreements (PPAs). The CSCF, which provided approximately £10 million in 2004/5, funds initiatives to strengthen the capacity of poor people to understand and demand their rights. Currently 11 of around 150 CSCF projects are allocated an HIV/AIDS marker. These include projects to build capacity of vulnerable groups and of PLWHA to advocate for their rights and tackle stigma and discrimination.

7.50 In 2004/5, funding through PPAs totalled £65.3 million (NAO, 2006). DFID currently provides core funding to 26 CSOs through PPAs, of which 18 identify HIV/AIDS-related activities in their success or outcome criteria. Partners particularly active in HIV and AIDS include ActionAid, CAFOD, CARE International, Christian Aid, HelpAge International, International HIV/AIDS Alliance, Oxfam, Panos Institute, Progressio, Save the Children UK, Skillshare International, UNAIS and VSO. Review of PPAs indicates that many have a focus on women, young people and vulnerable groups and address HIV/AIDS-related rights and vulnerability (see Table 9, p93).

7.51 These funding mechanisms are highly competitive. Organisations of vulnerable groups and of PLWHA are often at a disadvantage, because they cannot demonstrate track record and lack core funding to build capacity. PPAs are open to organisations based outside the UK, but these provide relatively large grants for well-established organisations. The CSCF only funds UK-based organisations and North-South partnerships led by UK organisations.

Table 9. DFID PPAs: Women, Young People and Other Vulnerable Groups

PPA Partner	Examples of Focus on Priority Groups	DFID Support
ActionAid	Strengthened capacity of women and girls to claim rights; support for enhanced decision-making role of PLWHA and OVC	PPA 2005-2011 £3.9m/year for first 3 years
HelpAge International	Rights-based approach to support to older carers and older people in families affected by HIV and AIDS	PPA 2005-2011 £1.25m for first 3 years
International HIV/AIDS Alliance	Meaningful involvement of vulnerable groups, women and PLWHA, in policy and action	PPA 2005-2011 £2.75m for first 3 years
Save the Children UK	Vulnerable groups of children in affected communities to receive more effective protection and support	PPA 2005-2011 £6.4m for first 3 years

7.52 DFID funds, and has a good working relationship with, the UK Consortium on AIDS and International Development, which has a strong focus on vulnerable groups. DFID also recently established the Governance and Transparency Fund, which has a budget of £100 million and will provide one-off grants of between £750,000 and £5 million. The Fund aims to build the capacity of southern NGOs to hold governments to account and will consider HIV/AIDS projects.

7.53 The effectiveness of partners funded through the CSCF and PPAs is monitored through CSO reports, e.g. annual PPA reports. PPA reports provide information on progress towards overall success or outcome criteria and may not, therefore, report on specific HIV and AIDS activities relating to women, young people and vulnerable groups unless these are included in these overall objectives. However, DFID is working with PPA partners to develop output indicators. These should include indicators with a focus on women, young people and vulnerable groups.

Country support

7.54 The bulk of DFID's overall funding is in the form of bilateral support. In 2005/6, around 30% of this was channelled through PRBS to 17 countries, 10 in Africa (DFID, 2006af). Bilateral funds also go to multilateral and civil society partners through DFID country offices.

Directors' Delivery, Regional Assistance and Country Assistance Plans

7.55 The focus of DFID support in specific regions and countries is determined by DDPs, RAPs and CAPs (see section 5.3, p41 and Figure 23, p42). This evaluation briefly reviewed the extent to which *Taking Action*'s concern to 'make HIV and AIDS work with women, young people and other vulnerable

groups central to the UK's response' is being interpreted and acted upon by decision makers, by analysing how this is reflected in DDPs and CAPs[162].

7.56 The DDP for Africa (2005-8) includes targets for reducing HIV prevalence in pregnant women aged 16-24, support for OVC and a focus on girls' education. There is no mention of sex workers, MSM, IDU or prisoners. The Asia DDP (2005-8) refers to women, children and unspecified vulnerable groups in relation to support for national AIDS plans, but does not mention OVC. Vulnerable groups mentioned are mobile populations and groups with high risk behaviours in China. The EMAD DDP (2005-8) refers to harm reduction in the Balkans.

7.57 The RAP for Central Asia, the South Caucasus and Moldova (2004-7) highlights the risk of an imminent epidemic, concentrated in vulnerable groups, and commits the UK to mainstream HIV and AIDS in its interventions in the region and provide specific targeted support for national programmes. The RAP for the Western Balkans notes that support is needed to develop and implement HIV and AIDS strategies. Women, young people and ethnic minorities are identified as vulnerable to poverty but this is not linked to HIV. The 2004-7 RAP for Latin America states that the epidemic is largely concentrated in socially marginalised groups (MSM, IDU and sex workers), that women and the poor are most vulnerable to infection and its consequences, and that PLWHA, vulnerable children and youth are affected by exclusion. HIV and AIDS is one of three components of the RAP for the Caribbean (2004-7).

7.58 In total, 16 CAPs (nine from Africa, two from Asia and five from EMAD) were reviewed. Overall, CAP focus reflects regional and national epidemiological priorities. Plans for HIV/AIDS-affected countries combine a focus on HIV and AIDS with measures to address underlying vulnerabilities, including poverty, discrimination and gender inequity, e.g. livelihoods, safety nets and access to basic services. Table 10 summarises the extent to which women, young people, and vulnerable groups are mentioned in Africa CAPs reviewed.

Table 10. DFID CAP Coverage of Issues Relating to Women, Young People and Other Vulnerable Groups

Country	Women	Young people (other than OVC)	Vulnerable groups
DRC (CEP 2003-6)	✓	✓	✓
Ethiopia (CAP 2003)	✓	✓	✓
Ghana (CAP 2003-6)	✓	✓	✓
Kenya (CAP 2004-7)	✓		✓
Malawi (CAP 2003/4-2005/6)	✓		✓
Nigeria (CAP 2004-8)	✓	✓	✓
Rwanda (CAP 2003-6)	✓	✓	
Tanzania (CAP 2003-4)		✓	
Zambia (CAP 2004-7)	✓		✓

[162] The sampling and review was completed in mid-2006 by researchers at London's Institute for Education.

7.59 The CAP for China (2006-11) refers to women and vulnerable groups but not to young people. The CAP for India (2004-8) mentions women, and the CAP review 2004-5 refers to vulnerable groups. Of EMAD CAPs reviewed, the Jamaica CAP (2005-8) addresses these issues most comprehensively, noting the need to tackle stigma linked with homophobia and denial of rights.

7.60 CAPs provide the framework for DFID country programming, so the inclusion or not of support for HIV/AIDS-related actions for women, young people and vulnerable groups is critical. Chapter 5 (p40) discusses CAP decision-making and quality assurance processes and factors that influence country programming decisions, including the role of incentives and of country office staff.

7.61 Progress reports on *Taking Action*, prepared by DFID country offices in Africa and Asia between 2004 and 2006, also highlight the extent to which CAPs influence country office action on women, young people and vulnerable groups. Review of progress reports from 11 African countries (Ethiopia, Kenya, Lesotho, Mozambique, Nigeria, Rwanda, Sierra Leone, Sudan, Tanzania, Uganda and Zambia) shows a strong focus on OVC, which are well reflected in African CAPs, but limited reported activity relating to women, vulnerable groups or PLWHA, which are not. Review of progress reports from 10 Asian countries (Afghanistan, Bangladesh, Burma, Cambodia, China, India, Indonesia, Nepal, Pakistan and Vietnam) shows a strong focus on vulnerable groups such as MSM, IDU and sex workers and increasing emphasis over time on women and OVC, but limited reported activity relating to young people or PLWHA.

Partnerships with Governments

7.62 As country-led approaches increasingly rely on national poverty reduction strategies (PRSs), the extent to which these address the needs of women, young people and other vulnerable groups, in general and specifically regarding HIV and AIDS, is critical. Weaknesses of PRSs in terms of HIV and AIDS are discussed in sections 6.8-6.11 (p58).

7.63 A joint review (World Bank and UNICEF, 2004) of 19 African countries found that the situation of OVC received little attention in PRSPs and National Strategic HIV/AIDS Plans (NSPs). The background paper prepared for the Global Partners Forum (Green, 2006) also noted lack of integration of child poverty and AIDS objectives in PRSPs. A thematic study on voice and accountability (Waterhouse and Neville, 2005), conducted as part of DFID's gender evaluation, found that while women were nominally included in PRSP processes and budget support funding, there was little impact on improving their situation. In Ethiopia, for example, while women and children were included in the PRSP in general and in terms of the impact of AIDS, the national AIDS strategy included little on how to address their specific needs for prevention, care and treatment.

7.64 DFID's experience shows that instruments such as budget support[163] can be effective for funding national responses to HIV and AIDS in countries with

[163] Particularly 'sub-sectoral' budget support through National AIDS Councils or their equivalent

epidemics concentrated among vulnerable populations if an appropriate policy framework is in place. However, poor prioritisation by governments, especially regarding interventions for the most vulnerable groups is a concern (see section 6.29).

Box 20 Country Case Studies: Examples of National Priorities

In **India**, NACP 3 stresses continued emphasis on core high risk groups. Targeted interventions are to be scaled up to reach 50% to 80% of these groups. More emphasis will be given to IDU and MSM then was given in NACP 2.

In **Russia**, the Government does not give priority to groups such as IDU, MSM and sex workers, despite the fact that the epidemic is concentrated in these groups. International agencies largely mean these four key populations when they refer to vulnerable groups, whereas the Russian authorities are more likely to be referring to young people aged 13-18.

In **Zimbabwe**, the national response is strongly focused on women but prevention efforts for young people have been influenced by the abstinence-only agenda.

The Joint Annual Programme Review (JAPR) documents that **Zambia**'s approach to HIV prevention among young people is now strongly focused on promoting abstinence. Other vulnerable groups identified in Zambia's response to HIV and AIDS include sex workers, truck drivers, men in uniform, prisoners, migrant workers and fishermen. The JAPR focuses particularly on men in uniform and prisoners.

7.65 A World Bank evaluation (Mullen, 2005) found that only 7 of 21 NSPs in sub-Saharan African countries referred to high-risk groups in goals and objectives. Aside from prevalence estimates for sex workers, NSPs contained very little data on high-risk groups, with the exception of Mozambique and Zambia NSPs. The evaluation highlighted the impression that more resources were to be devoted to interventions for women and youth in general than for high-risk groups.

7.66 IDC (IDC, 2006a) noted that 'DFID must work with governments to ensure that national AIDS programmes are properly focused and that the rights and needs of marginalised groups are not overlooked'. UNAIDS' 2006 report states that 'many countries fail to direct financial resources to activities that address the prevention needs of the populations at highest risk'. Country case studies provide examples (see Box 20).

7.67 Experience of financing the response to HIV and AIDS through general and sectoral budget support is relatively limited, and is reviewed in sections 6.18-6.23 (p61).

7.68 A review of PRBS, CSCF, PPAs and multilateral channels concluded that all these mechanisms have limitations when it comes to support for actions to address HIV/AIDS-related stigma and discrimination (DFID, 2006af). Funding through PRBS relies on governments to include CSOs and representatives of vulnerable groups and to allocate funds for inclusive access to services. However, governments do not necessarily prioritise these issues or fund CSOs working in these areas. The review concludes that support for CSO initiatives is critical to address stigma and discrimination and the needs of hard-to-reach groups.

7.69 A paper (SDD, 2006) which reviewed the role of different aid instruments in supporting initiatives to tackle social exclusion and promote gender equality notes that PRBS can create opportunities for enhanced policy dialogue with governments on issues such as social exclusion and gender, but that PRBS is not sufficient to ensure these issues are addressed. It concludes that DFID needs to maintain the flexibility to use a range of aid instruments to support civil society advocacy, pilot approaches, and capacity building for ministries responsible for addressing the needs of vulnerable groups.

7.70 A review of aid instruments and SRH and HIV/AIDS outcomes (Taylor, 2007) suggests a mix of aid instruments can be useful in addition to PRBS, especially for more controversial issues and reaching marginalised groups. Inclusion of the needs of marginalised groups in a PRS does not guarantee services will be provided, as governments often prioritise population-based services, and separate earmarked funding may be the only way to ensure services for priority groups.

7.71 Choice of appropriate aid instrument depends on the nature of the epidemic. With generalised epidemics, general and sectoral budget support may be appropriate as long as there is a comprehensive and well-prioritised AIDS plan and budget and mechanisms exist to respond effectively to the needs of women, young people and vulnerable groups. Other aid instruments may be required in countries with poorly prioritised plans or with concentrated epidemics where government services do not reach the most vulnerable groups.

7.72 It is also important to recognise that, in some countries, e.g. Ethiopia, a significant amount of 'off-budget' funding for HIV and AIDS is received from sources such as the Global Fund and PEPFAR. In such contexts, governments devote few of the resources under their control to HIV and AIDS, and it is critical to ensure that these funders are aligned with national priorities and provide adequate resources for vulnerable groups where this is appropriate.

Support for UN Agencies

7.73 UN agencies that focus on women, young people and vulnerable groups also receive allocations from DFID through country offices (see section 3.11, p13; section 3.25, p16; Annex 5, Example 9, pA80; section 4.9, p28 and Figure 11, p29). For example, DFID recently pledged £75m to UNICEF in India over 5 years (2006-2010) and has allocated £1 million regional funding to UNICEF to support OVC work in the Asia-Pacific region. Given the level of support channelled through UN agencies, it is essential that their role is clearly understood by other stakeholders, including civil society.

7.74 Country case studies identified a number of challenges in working through UN agencies at country level, in particular their capacity to address more contentious issues and to advocate for the needs of priority groups. In Russia, UNAIDS reported that prior to working with DFID, it was difficult for them to meet with high-level authorities. In Zimbabwe, UN agencies such as WHO and UNICEF have been active in supporting the national response and providing technical assistance for national policy development. However, they have not always been

as effective in areas of difficult policy dialogue[164] with the Government. This may reflect unwillingness to jeopardise the UN's 'neutral' status[165].

Support for Civil Society

7.75 DFID country offices provide significant funding to civil society. This was estimated to be £154 million in 2004/5 (NAO, 2006). How much of this was for HIV and AIDS and specifically for programmes for women, young people and vulnerable groups is difficult to assess as DFID does not routinely track country office funding for civil society.

7.76 Tracking is also difficult because funds are channelled through a range of mechanisms, including NACs; Challenge Funds and other umbrella funds, e.g. the Rapid Funding Envelope in Tanzania; Strategic Impact Funds; sub-grants of larger DFID-funded programmes, e.g. STARZ in Zambia and HAPAC in Kenya. In Zimbabwe, where DFID cannot currently fund the Government directly, a considerable amount of funding goes indirectly to NGOs e.g. through the Programme of Support for OVC. Zambia illustrates examples of funding for civil society through different mechanisms (see Annex 5, Example 22, pA88).

7.77 Situations where funding for the response to HIV and AIDS might most appropriately be channeled through CSOs are considered in sections 6.40-6.43 (from p70) and in Box 17 (p70). Table 11 outlines some of the advantages and challenges of funding CSOs to address the needs of women, young people and vulnerable groups, drawing on country examples. A review of the civil society umbrella programme in Uganda identified a number of issues that constrain meaningful engagement of CSOs in policy dialogue with government, including lack of skills, poor organisation and coherence within the sector, and limited legitimacy with the constituencies they represent. This suggests that funding needs to be matched with support for civil society capacity building.

Table 11. Advantages and Challenges of Funding CSOs

Advantages	Examples
CSOs can play an important role in fragile and post-conflict states	In **DRC**, DFID is funding a programme, developed jointly by DFID's Security Adviser and HIV/AIDS team and the Embassy Defence Attaché, and implemented by PSI, to prevent HIV spread among and by soldiers and other combatants.
CSOs can reach vulnerable groups not reached by government services	In **Ukraine**, DFID funded projects targeting MSM through support for a Ukrainian NGO to run outreach services, promote awareness of rights and provide legal support. In the **Caribbean**, DFID supports the Pan-Caribbean Partnership Against HIV and AIDS to tackle extreme stigma and discrimination against MSM and other highly vulnerable groups.
CSOs can pilot innovative approaches that governments may not be willing to experiment with, and	DFID recently announced support for a new programme being piloted in resort areas of **Barbados and Jamaica** to address the risks of sex between men working in the tourist industry. In **India**, under NACP2, DFID funding for CSOs through the Challenge Fund provided an opportunity to test innovative interventions and approaches for vulnerable groups, e.g. the introduction of oral substitution therapy for IDU, which is likely to be scaled up under NACP3.

[164] e.g. sustainable ARV supplies and equitable access to treatmen

[165] Although this seems to affect some agencies (e.g. UNDP, WHO) more than others (e.g. UNICEF)

provide evidence for effective interventions	DFID is providing £1.5 million over 5 years to the **Western Balkans** HIV Prevention Among Vulnerable Populations Initiative, which has successfully used demonstration harm reduction projects implemented by CSOs to influence policy. A recent evaluation found that the Initiative had generated evidence and recommendations for policy change and, for example, the Serbian Government had included harm reduction in its national HIV and drug prevention strategy.
Challenges	**Examples**
CSOs may lack 'political space' for action	In **Ethiopia**, development of CSOs outside local government structures is limited; CSOs are involved in the response to HIV and AIDS but capacity limitations and poor relations with the Government of Ethiopia sometimes prevent them from playing a more active role. In **China**, civil society development is limited and in **Russia**, civil society is 'tolerated, but not actively encouraged'. In **Zimbabwe**, it is hard for NGOs to play an advocacy role, particularly if funded by foreign donors, as they are portrayed as pro-opposition by the Zimbabwean Government.
CSOs representing PLWHA are often weak	In **Zimbabwe**, DFID has provided support to PLWHA organisations but this has been hindered by the weakness of these organisations, e.g. the national network ZNNP+ has only recently resumed limited activities.
Civil society overall may not always prioritise in line with the epidemiology of the epidemic	In **Russia**, CSOs have played a key role in defining the country's response to HIV and AIDS and addressing the needs of vulnerable groups. There are more than 200 NGOs actively working on HIV and AIDS. Research conducted by the HIV and AIDS NGO consortium found that most local NGOs target their work toward youth in general. Up to 40% target PLHWA; up to 30% work with IDU and sex workers; MSM receive much less attention.

7.78 Some CSOs interviewed for country case studies see DFID as primarily focused on support to national governments and public sector service delivery. UK NGOs also highlighted difficulties experienced by local partners in engaging with DFID country offices. There are concerns that funding for CSOs will decline as DFID shifts towards PRBS and that donor efforts to improve long-term, predictable funding are only being applied to government. In Zambia, CSOs were particularly concerned about reliability of funding through government mechanisms, e.g. NACs, and those engaged in lobbying and advocacy about possible loss of independence if government becomes their main funder. In India, even though CSOs were engaged in NACP3 design, there are concerns about the extent to which the Government of India will support civil society lobbying on behalf of vulnerable groups. However, it is too early to tell, and DFID India plans to monitor CSO access to funds through joint reviews.

7.79 Experience to date about the effectiveness of funding CSOs through government-led structures is limited. Evidence from NGOs that previously received direct support from DFID country offices indicates that there have been difficulties in accessing funds from government, e.g. Mildmay International has received little support from MOH in Uganda and CAFOD partners in Mozambique have found the process of accessing funds through the NAC to be so bureaucratic that they have sought funding elsewhere. VSO Zambia also reports that community organisations have found it more difficult to access funding as donors have shifted to direct support to government budgets or line ministries. This is an area that will require careful monitoring and more emphasis may need to be given to supporting government structures to improve stewardship of funds, including the efficiency of mechanisms for funding CSOs.

7.80 Experience of umbrella mechanisms indicates that these may not always be efficient channels of support. While the Challenge Fund in India and the RFE in Tanzania have worked well, there have been challenges in Zambia with these

types of funding mechanisms. These include: slow and bureaucratic processes; provision of short-term or one-off funding; and provision of very small amounts of funding, better suited to CBOs than to larger NGOs.

7.81 Another approach used is building the capacity of CSOs. In Russia, the Open Health Institute (OHI) reported that DFID's work with the Open Society Institute (OSI) Harm Reduction Bridging Project (2001-2004), which funded 30 harm reduction projects, is directly responsible for building the technical and administrative capacity of local NGOs as well as OHI, preparing them for successful implementation of GLOBUS, the Global Fund Round 3 grant[166].

7.82 There is a need to consider more strategically when and how best DFID can engage with CSOs, especially in contexts where governments do not give high priority to evidence-based programming for women, young people and the most vulnerable groups or where governments fail to fund civil society appropriately.

Use of a Mix of Approaches

7.83 In practice, DFID uses a mix of instruments and implementation mechanisms to support HIV and AIDS programming and service delivery for women, young people and vulnerable groups. This ensures that DFID has the flexibility to respond appropriately to the epidemic. However, the extent to which strategic choices are made about the selection and balance of aid instruments is unclear.

7.84 As discussed in Chapter 6 (section 6.22, p63), in most countries where DFID funds through PRBS, this is supplemented with use of other aid instruments to fund HIV and AIDS (see Box 14, p62). In Vietnam, DFID provides budget support, funds the DFID-NORAD (Norwegian Agency for Development Corporation) Preventing HIV in Vietnam project and supports targeted programmes e.g. harm reduction for IDU through WHO. In Rwanda, HIV and AIDS is supported through general budget support, sector budget support, SWAps and funding for CSOs. In Uganda, budget support is complemented by funding for large NGOs including The AIDS Support Organisation, AIDS Information Centre and Straight Talk, a civil society umbrella programme, and UN humanitarian work on HIV and AIDS.

7.85 Country case studies also provide examples of use of a mix of approaches to fund programmes for women, young people and vulnerable groups. In Zimbabwe, UK support for OVC, for example, will be through both a focused Programme of Support, co-financed with SIDA, CIDA, EC, Germany and New Zealand, involving 23 intermediary organisations channelling funds to over 100 CBOs and 15 grants for specialist areas of work, e.g. with street children; and through more general social protection measures, targeted on the basis of poverty, which will benefit OVC and their families. Experience in India highlights the value of using multiple funding instruments to reach vulnerable groups (see Box 21, p101).

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[166] The NGO consortium includes the Open Health Institute (Global Fund Principal Recipient), FOCUS-MEDIA Foundation, AIDS Infoshare, AIDS Foundation East-West (AFEW), and Population Services International (PSI).

Box 21 Multiple Funding Instruments Under NACP2 in India

DFID's support to the national HIV/AIDS programme will shift from use of a variety of funding instruments and partners during NACP2 to full alignment with the country programme and almost exclusive use of a country-led aid instrument (sub-sector budget support) in the successor programme NACP3. Using multiple funding channels during NACP2 – earmarked budget support, MOUs and trust funds with various UN organisations, contracted out technical assistance, and a contracted out Challenge Fund for civil society – greatly aided DFID India's capacity to extend support to women, OVC and vulnerable groups receiving relatively less attention in the national programme. Off-budget support for prevention complemented that provided through the budget. In particular, it has been used to focus on prevention among relatively neglected groups such as MSM and IDU, develop and pilot innovate models of provision, e.g. oral substitution therapy for IDU, generate new knowledge, support networking and sharing of information among NGOs, and support advocacy efforts. Several lessons can be drawn from the India experience of moving from NACP2 to NACP3. First, lead time is required to move into full country alignment and adoption of budget support. Second sub-sector budget support (and sector support when HIV/AIDS is a sector in its own right), can allow for good donor engagement and the ability to influence and shape the national programme. Third, strong national leadership, and a willingness to be open and participatory helps this process.

Support for vulnerable children has been provided through several funding channels and partners. DFID support to State AIDS Control Societies (SACS) has included support to street children. Several SACS, including Gujarat SACS and Ahmedabad Municipality, are funding NGOs to raise awareness and reduce risk among street children. The Programme Management Office (PMO) portfolio of work also contains a programme with street children. Plan India has been funded to develop an HIV/AIDS awareness package, using a range of media tools and approaches. UNICEF has received funds from DFID for HIV prevention among young people and children in Gujarat and West Bengal, including vulnerable children not in school.

7.86 In middle-income countries, where DFID offices have closed or will close, future funding will be provided through multilateral institutions such as the Global Fund, UN agencies and World Bank, and through CSOs. While CSOs may be able to continue service delivery for vulnerable groups, it is less clear that they, the Global Fund or UN agencies have the influence or capacity to advocate with governments for the changes required in national policy and plans to sustain comprehensive programming for these groups. The approach taken in Central Asia is a good example of how DFID is using a mix of aid instruments to sustain support for interventions for vulnerable groups in the absence of a bilateral presence, but also illustrates the limitations of UN agencies (see Box 19, p92).

7.87 DFID has also used a strategic mix of approaches to influence government policy and plans and improve prioritisation of HIV and AIDS responses (see Table 4, p66), including those targeting women, young people and vulnerable groups. These include funding for epidemiological surveillance, for pilot projects to generate evidence (see Box 22 p102), and for organisations of PLWHA and vulnerable groups to ensure their needs are reflected in the national response.

Box 22 Influencing Policy in Ethiopia and China

Donors, including DFID, participate in on-going policy dialogue on HIV and AIDS priorities in **Ethiopia** and have secured agreement from the HIV/AIDS Prevention and Control Office (HAPCO) and MOH for an open and participatory mid-term review of the Strategic Plan for Management (SPM), with the aim of encouraging costed annual multisectoral HIV/AIDS implementation plans and more rigorous thinking about controlling the epidemic. The SPM currently has a strong focus on treatment and longer term strengthening of health sector capacity and lacks specific prevention strategies to address vulnerability in specific groups, e.g. urban populations, and the differential between male and female infection rates. The upcoming SPM mid-term review and the development of a second Ethiopia Multisectoral AIDS Project (EMSAP2) will provide opportunities for discussion of these and other issues.

UK funding and technical assistance has contributed to the design of **China**'s HIV and AIDS programme through introducing new ideas and models and demonstrating that preventing the transmission of HIV among vulnerable groups is feasible and politically acceptable. This has been achieved in respect of needle exchange and methadone substitution programmes for IDU and peer education and condom promotion programmes for sex workers.

7.88 Other approaches include policy dialogue and joint donor-government reviews, e.g. in Ethiopia (see Box 22). Evidence on whether PRBS can create opportunities for enhanced policy dialogue appears to be mixed. For example, the Common Approach to Budget Support initiative in Malawi provides a measure of conditionality to donor budget support, and the Mozambique policy matrix sets out a limited number of clear and costed targets against which further PRBS disbursements will be made, providing scope for advisers to negotiate gender and social exclusion based targets (SDD, 2006). This approach could equally be applied to HIV/AIDS targets.

7.89 However, other experience is that PRBS has reduced room for policy dialogue. For example, in Tanzania the fact that no DFID resources have gone directly to the Ministry of Health since 2004 is thought to have contributed to failed discussions on user fees. Other donors still engaged in the health SWAp have not raised concerns of social exclusion in the same way, suggesting a case for DFID presence at the sector level (SDD, 2006). There is also a risk of disempowerment of ministries responsible for women, children, youth and vulnerable groups, many of which are already under-resourced and weak, as dialogue around PRBS focuses on ministries of finance and planning. In Tanzania, for example, the ministry responsible for OVC lacked the capacity to argue with the finance ministry for a scaled-up OVC programme (SDD, 2006). Technical support and capacity building for ministries responsible for women, children, youth and vulnerable groups to enable them to develop coherent, well-costed plans, to secure adequate funding and to implement effective programmes, is critical.

7.90 Experience to date of balancing the focus on donor harmonisation and alignment with reaching women, young people and vulnerable groups is limited. Donor harmonisation can be effective in strengthening policy dialogue with governments on issues related to these priority groups, provided that donors themselves agree. Where donors have different perspectives, e.g. the US Government's approach to HIV prevention in youth, this can be more challenging. Burma and China offer good examples of harmonised approaches and pooled donor funding that address the needs of vulnerable groups:

- In Burma, where vulnerable groups are most affected by the epidemic, DFID is contributing £20 million over 5 years to the Three Diseases Fund, a multi-donor pooled fund. The major proportion of this fund will be used to support HIV/AIDS activities directed to those sub-populations groups most in need of services.
- In China, the new DFID-Global Fund China HIV and AIDS Programme, 2006-2011 adopts a deliberate strategy of support to national priorities, support to the Three Ones, and harmonisation with national and Global Fund management and implementation systems. The project will scale up the interventions for vulnerable groups that were piloted by HAPAC to another five provinces, support grass roots CSOs, introduce treatment for PLWHA, in particular IDU and sex workers. The new project also addresses youth and rights issues.