ANNEX 5: *TAKING ACTION* IMPLEMENTATION: PROGRESS ON PRIORITY ACTIONS: SELECTED EXAMPLES

This Annex provides further examples, mainly drawn from the country case studies, of progress made towards specific commitments identified for this interim evaluation under each of the six priority actions in *Taking Action*. It supplements the main discussion in Chapter 3 and Chapter 7 and more detailed analysis in Annexes 4 and 7.

Example 1 Different Types of Activities Benefiting OVC Supported by DFID

DFID **Zimbabwe**'s OVC Programme, providing £25 million over 5 years, supports the National Plan for Action on Children Affected by AIDS, to be delivered through UNICEF.

The DFID-supported programme to strengthen the AIDS response in **Zambia** (STARZ) provides £20 million through a consortium of management consultants. Although funding is reaching OVC this is not indicated within PRISM by a sector code. The funding arrangement for this programme, with resources provided at a national level to civil society and UN agencies that can be combined with other funding sources (e.g. Global Fund and World Bank) illustrates the difficulties in tracking the amount of funding that reaches OVC.

Ethiopia has 4.8 million orphans, some due to AIDS, but many more children who are vulnerable for other reasons. Consequently, DFID takes an inclusive approach to child vulnerability and is providing £70 million of funding to the Government of Ethiopia Productive Safety Nets Programme (PSNP). Approximately half of the PSNP beneficiaries are children and most are vulnerable in one or more ways, although the proportion who are children orphaned by AIDS is probably less than 1%.

Example 2: Promoting Harmonisation

While donor collaboration and harmonisation are not the norm in **China**, DFID has established effective partnerships with AusAID, Norway, Global Fund and UNAIDS. DFID is also building on its explicit strategy of engaging with the UN to improve performance. The current focus is on supporting the UN to develop a more effective joint plan on HIV and AIDS. DFID also engages with major US foundations such as the Clinton Foundation and the Gates Foundation. Two of DFID's three current HIV/AIDS projects involve harmonised funding and six of the eight largest health and AIDS projects involve harmonisation or explicit collaboration.

The effectiveness of donor and partner efforts in **DRC** is currently compromised by lack of coordination. Addressing this will be essential to accelerate progress towards 'universal access', given the fragility and limited capacity of the government. Efforts at harmonisation are just beginning and DFID support to UNAIDS' coordination role has been critical. Progress is being made towards creating a national programme, as evidenced by the establishment of the National Multisectoral Programme to Fight AIDS (PNMLS), increasing availability and use of VCT, PMTCT and ART services, with increasing numbers of people on treatment. The UK Government, DFID in

particular, has made an important contribution to these positive developments, including building the capacity of the PNMLS. DFID's comparative advantages include being flexible, easy to work with, able to respond to urgent needs and to consider partners' proposals and strategies rather than imposing a predetermined agenda. This flexibility is especially valued, given the current uncertainties in DRC and the fact that other donors are unable to be so responsive. DFID's willingness to commit to multi-year funding is also perceived as playing an important role in strengthening the response to HIV/AIDS. To address the lack of reliable data, DFID is also co-funding a Demographic and Health Survey, which will include an HIV/AIDS prevalence survey, scheduled for late 2006.

The 2005 MOPAN review described significant progress in harmonisation in **Ethiopia** and DFID has made an important contribution. DFID participates with other donors and the Government of Ethiopia (GOE) in the "Harmonisation Architecture Plan" developed in 2004, through which donors coordinate their efforts through regular meetings of the Development Assistance Group (DAG). DAG has sector Technical Working Groups (TWG), including one on HIV/AIDS that is also a donor sub-forum of the National Partnership Forum, which interfaces with the Ministry of Health and the HIV/AIDS Prevention and Control Office. Protection of Basic Services builds on collaborative mechanisms developed under direct budget support, including Joint Budget and Aid Reviews (JBAR), technical involvement in policy dialogue and links with the DAG's sector TWGs. The Three Ones principle is well-accepted by all players and DFID funding for UNAIDS as part of a regional programme to intensify the Three Ones response in five countries included Ethiopia. In 2005, DFID and DCI jointly funded a consultant for health sector harmonisation, which resulted in the signing of a Code of Conduct among 12 donors and the MOH. DFID's country-led approach to programming and support for capacity building and for collaborative mechanisms developed with other donors have strengthened the national programme and national leadership. The National Partnership Forum and donor harmonisation have facilitated implementation of the Three Ones. A major weakness is the lack of costed, evidence-based planning by the Government of Ethiopia, but pressure is being brought to bear by donors to make this a reality.

In **India**, the Three Ones were only partially in place during NACP 2. There was no donor group commitment to coordinate within a national framework, no joint review process in place, and no agreement on a core national monitoring and evaluation system. As a result, there was a heavy load on NACO to report individually to donors. NACP 3 preparation marked the first effort at development of one national HIV/AIDS strategic plan around which all donors could agree to provide coordinated support. Preparation took place over a one year period and the process has been described as exemplary, inclusive and evidence based. The Three Ones are now fully in place. All donors have agreed to coordinate their support, either through pooled funding arrangements (DFID and the World Bank), earmarked budget support (Global Fund) or off budget (Bill and Melinda Gates Foundation and USAID), to provide information to and report against a common monitoring and evaluation system, and to use one national set of standardised indicators. NACO and donors will carry out an annual joint review of the programme. DFID funding for UNAIDS to support their core secretariat role and progress the harmonisation agenda has been critical in a context where harmonisation has not been easy and UN agencies have focused on project implementation rather than on provision of strategic technical advice. The situation has improved somewhat as a result of the GTT recommendations and the Consolidated UN Technical Support Plan for AIDS (2006-2007), which outlines a

clear division of labour for UN technical support. However, multiple DFID MOUs with various UN bodies and funding through several trust funds have not helped the harmonisation agenda. Another important requirement of donor harmonisation is an effective coordination mechanism. During NACP 2, the UN Theme Group on HIV/AIDS led by UNAIDS was expanded to include UN bodies, NACO, other donors and civil society including PLWHA networks. However, this proved to be too broad based for effective coordination. For NACP 3, the Theme Group will return to only comprising UN organisations and a separate forum will be constituted by NACO for coordinating donors contributing to NACP 3. Salient lessons from India include: funding to the UN should be provided in a way that reinforces GTT agreement on the division of labour across UN organizations and support should be provided to the UN to perform a strategic and technical advisory role rather than implementation of grass roots projects.

DFID **Russia** has made a strong commitment to the process of promoting the Three Ones principles to encourage a better national programme and a coordinated multisectoral response. Two national-level forums exist for donors to coordinate HIV and AIDS efforts, but their effectiveness is limited by the absence of one national focal point to coordinate efforts with the federal government. At the national level, DFID Russia is concentrating efforts through UNAIDS by co-funding with SIDA the 'Coordination in Action' project. This project identifies key national partners such as the Ministry of Health and Social Development of the Russian Federation, the Coordinating Council on HIV/AIDS of the Ministry of Health and Social Development of the Russian Federation, national partners ranging from other government ministries, the Federal AIDS Centre, and State Committees, to the Russian Orthodox Church, and NGOs. Working with SIDA was a natural partnership given similar international HIV and AIDS goals. 'Coordination in Action' is very timely, coinciding with recent federal level commitments to a strengthened national response. Additional milestones demonstrating increase commitment to HIV and AIDS include: on April 21, 2006, at a special session of the Presidium of State Council on HIV and AIDS, President Putin announced goals for developing a long-term AIDS strategy, improving coordination through the creation of a high-level multisectoral Coordinating Commission, and a unified M&E system, essentially committing the government at the highest levels to the 'Three Ones' principles; and the 2006 Russian State Budget for AIDS was increased twenty fold to approximately 3 billion Roubles ($58 million) and funding was allocated to the National Priority Project for Health to develop HIV and AIDS protocols and normative documents and other national-scale efforts to improve coordination and ensure universal access to HIV prevention, treatment, care and support.

In **Zimbabwe**, DFID is spearheading donor harmonisation initiatives[274] based on agreed national priorities. This has involved forging excellent relationships with other donors, including those who have different policies and approaches from the UK.

Example 3: DFID Activities to Strengthen National Leadership

In **China**, the UK has supported the strengthening of national leadership on HIV and AIDS. For example, a meeting of the State Council in June 2005 agreed nine key areas of the response to HIV and AIDS. The DFID-supported HAPAC project was

[274] Including Expanded Support Programme for HIV and AIDS and Programme of Support for orphans and vulnerable children

influential in this regard, demonstrating that HIV prevention interventions for vulnerable groups are politically and technically feasible. Other important UK initiatives were the British Ambassador's engagement on the legitimacy of the Global Fund Country Coordinating Mechanism and DFID support for the CHARTS project. Its work with the State Council AIDS Working Committee focuses on leadership training.

In **India**, the UK's support to the national AIDS response referred explicitly to *Taking Action's* commitment to supporting national leadership. Activities funded by the UK included:

- Funding to UNAIDS to support advocacy efforts with the Parliamentary Forum on HIV/AIDS, the National Convention on HIV/AIDS and Legislative Forums in several states.
- Capacity building of NACO and SACS. Government officials and other stakeholders report that DFID-supported State AIDS Control Societies (SACS) are among the better performing SACS. They have implemented the largest number of targeted interventions and reached high coverage levels of risk groups, e.g. the Gujarat SACS has reached 80% of all sex workers in the State. They have also developed innovative approaches and models for reaching high risk groups, some of which will be scaled up under NACP3.
- Challenge fund grants civil society leadership for advocacy for MSM, IDU and PLWHA.
- Funding to UNDP to undertake a study for the National Council for AIDS (NCA) on opportunities for mainstreaming HIV/AIDS into the work of line ministries.

With the Embassy taking the lead, the UK government works to strengthen political leadership in **DRC**. The main challenge when visited was to see through the presidential election on 30 July. In the build up to the election, while the UK has not been pushing the transitional government on HIV/AIDS *per se*, the Embassy has led in drawing attention to human rights abuses by the Congolese army, including rape, which contribute to the spread of HIV.

DFID support for projects such as 'Coordination in Action' and UNFIP strengthened political leadership in **Russia.** Support for harm reduction initiatives for vulnerable groups showed initial gains. However, Russia's change in status to that of an upper-middle income country has affected the relationship between the government and donors. It raises the issue of how to sustain support for goals in *Taking Action* within a government framework that does not share the same priorities. A big challenge is the stigma and discrimination associated with an HIV epidemic concentrated among vulnerable groups, particularly injecting drug users. Like DFID, USAID, currently the largest bilateral donor, will phase out over the next 5 years. Russia's World Bank classification as an upper middle income country makes it ineligible for further HIV/AIDS funding from the Global Fund. As external resources become less available, domestic funding channels become more important to ensure that support for HIV and AIDS is maintained at an effective level to meet prevention, care and treatment needs of those most vulnerable to and affected by the epidemic.

Example 4: Implementing the Workplace Policy

DFID Zimbabwe offers staff, their partners and children up to the age of 21 a comprehensive programme of confidential testing, counselling, care and treatment, over and above the standard medical insurance package, which does not fully cover HIV-related illness. The FCO and British Council are reported to have adopted similar measures. Several issues were raised, including the exclusion of contract staff, such as security guards, and domestic staff employed by UK staff, and cover for staff with more than one partner.

In Ethiopia a joint HMG task team on HIV/AIDS work place policy was formed several years ago, but has met infrequently due to staffing constraints. The country case study noted that HMG has a good HIV and AIDS treatment policy for its staff. The Hayat hospital has a contract to provide a range of medical services including those related to HIV. To ensure confidentiality, each employee is entitled to two vouchers for VCT and long term treatment if necessary. These vouchers are drawn from a basket and bear numbers which simply distinguish whether staff work in the FCO, DFID or British Council. The employee goes direct to the hospital and on presentation of the voucher receives a number from the doctor which is sent to the FCO, DFID or British Council for any costs incurred. Administrative staff are therefore not aware of individuals accessing treatment. Only when extended sick leave is required might management be informed and this can only occur with written consent from the employee.

Example 5: Reviewing the Workplace Policy

Taking Action stated that extension of the workplace policy across Whitehall would be examined. This was discussed at cross-Whitehall group meetings in July and September 2006. In preparation, DFID produced a discussion paper, which provided an overview of departmental policies and international best practice. The group agreed that coherence should focus on ensuring that workplace policies are consistent with international best practice and that all departments would review their policies against ILO guidelines on HIV/AIDS in the workplace.

The accepted framework of good practice relating to workplace policies is provided in ILO's 2001 Code of Practice in the World of Work. The Code outlines key policy objectives as: address prevention, management and mitigation of the impact of HIV and AIDS on the world of work, provide care and support of workers infected and affected by HIV, and eliminate stigma and discrimination on the basis of real or perceived HIV status. The ten core principles laid out in the Code are: recognition of HIV as a workplace issue; non discrimination; gender equality; healthy work environment; social dialogue; screening for purposes of employment or work processes not tolerated; confidentiality; continuation of employment relationship with employees who are infected; prevention; and care and support. The Code of Practice was supplemented in 2003 by a Consensus Statement reflecting lessons learned since 2001 and the UNGASS commitment.

It was also noted that amendments to the Disability Discrimination Act, which will classify HIV as a disability, are due to come into force later in 2006 and that this will affect all government departments.

Example 6: World Bank and Global Fund Comparative Advantage

The Shakow study concluded that the Global Fund's main comparative advantage was in financing prevention and treatment of HIV/AIDS, TB and malaria while the World Bank's lay in systemic health capacity building[275]. The report recommended that the Global Fund should not have a specific category of health systems strengthening in future rounds. It also concluded that both bodies should unite behind the Three Ones principles, promote the unification of country coordinating mechanisms and national AIDS councils[276], use common procurement and monitoring and evaluation systems, and agree a lead donor in each country to coordinate with the national coordinating authority. It recommended that the Fund ensure proposals take into account investments by others in core health delivery programmes and become part of national programmes supported by donors, as reflected in pooled funding, sector-wide approaches or other forms of joint or coordinated funding. It also recommended that the Bank give priority to helping governments build an enabling policy framework including doing more analytical work, such as public expenditure reviews, assisting countries to prepare strategic plans for the health sector and AIDS, and placing more emphasis on applied research and evaluation of what does and does not work.

Example 7: Funding UN Agencies in Country

In Zambia, DFID is funding HIV and AIDS activities of both UNICEF and UNFPA as part of an overall programme aimed at strengthening the AIDS response in Zambia (STARZ). Support to UNICEF has been used to provide technical advice on prevention of mother to child transmission, while support for UNFPA is essentially to procure condoms.

There has been a rapid increase in UK funding through UN agencies in Zimbabwe largely as a result of current constraints over direct funding to government. Advantages of working through UN agencies include ease of procurement, greater political acceptability and organisational capacity. However, there are concerns about UN capacity, ability to engage in policy dialogue, diversion from core roles and poor coordination. Some steps have been taken to developing one UN team and programme on AIDS, but this is currently an aggregation of individual agency plans. Practical obstacles to developing a truly unified team and programme include competition between UN agencies, separate locations and organisational systems, overlap of responsibilities in some areas e.g. PMTCT and young people, and the other responsibilities of the Resident Coordinator e.g. leading UNDP.

Example 8: UN Agencies in Middle-Income Countries

The UN has the potential to play an important role in HIV and AIDS in China, but some observers believe that it is under-performing as a result of poor coordination and a focus on implementing projects rather than on harmonising and supporting a national response. The UK is playing an active role in supporting a new combined UN plan of action on HIV and AIDS, funding UN agencies to provide quality technical assistance

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[275] Although this has, to date, been a limited focus in Zambia. The argument here is that agencies should work in countries in areas which fit with their comparative advantage. It is acknowledged that this may not reflect current practice in a particular country but the study quoted here argues that this is the direction in which these agencies should move.

[276] Although it is recognised that this is potentially problematic where CCMs also cover TB and malaria

and advocacy work, and encouraging the UN to complement bilateral actions. Many of these developments are reflected in the design of a new project, *The DFID-Global Fund China HIV and AIDS Programme, 2006-2011*, which adopts a deliberate strategy of support to national priorities and the "Three Ones" and harmonised management and implementation systems.

In Russia, under DFID's graduation plan, funding is focused on support for UNAIDS to promote effective leadership and coordination. UNAIDS reports that, before working with DFID, it experienced difficulties in meeting with high-level authorities, and UN agencies admit that they have less influence in Russia than in countries where external funding is of greater importance. DFID's decision to focus on the Three Ones may have been strategic in order to make the best use of rapidly scaled-back funding, but the widely held view among NGOs is efforts to strengthen leadership in more controversial areas have diminished and there are concerns about whether earlier successes in areas such as harm reduction will be sustained by the government and UN agencies.

Example 9: Support for UNAIDS

In Russia, DFID funding has been instrumental in increasing UNAIDS' capacity and visibility and enabling it to assume a leading role in coordinating other UN agency efforts. Prior to DFID support, UNAIDS' staff was minimal and other UN agencies said that UNAIDS' presence was limited. DFID funding will end in March 2007 but UN agencies have secured funding from the US Government and the Bill and Melinda Gates Foundation for a second phase. Notably, UNFPA will not be involved as the US will not fund their activities.

DFID has positioned UNAIDS to become an important player in DRC. DFID central funding supports two additional posts to assist the UNAIDS Country Coordinator. The Country Coordinator, who was working alone until their arrival, noted that DFID support has and will enable UNAIDS to play its intended role. The UN Theme Group on AIDS has not functioned, but it is expected that this will change now that UNAIDS has increased capacity.

The India case study noted that some *Taking Action* priorities require longer lead time, for example, efforts to establish the Three (and Fourth) Ones; move towards greater country alignment; use of instruments, such as budget support; and development of strong national strategies. The shift in DFID support to the national HIV/AIDS programme to full alignment and predominant use of sub-sector budget support, together with the World Bank, marks a good beginning with respect to establishing pooled funding mechanisms. Lessons that can be drawn from DFID India experience include: the importance of wider environmental factors, for example, the move to coordinated donor support and pooling of resources for NACP 3 was aided substantially by the similar approach adopted by the Reproductive and Child Health Programme; prioritisation is less of a concern in sub-sector budget support then sector or general budget support, since it relates to prioritisation across the HIV/AIDS programme alone rather then across sectors or within a sector; policy dialogue and negotiations take time; it is important to have started strengthening national capacity and systems before embarking on budget support; strong national leadership and willingness to be open and participatory is vital.

In Ethiopia, DFID, DCI and the Royal Netherlands Embassy are harmonising support for DKT social marketing, pooling contributions for implementation of a single agreed programme of activities, and have also agreed common formats for reporting and monitoring and evaluation.

Example 10: Support for Comprehensive, Integrated National Programmes

In India, most stakeholders consulted felt that NACP 3 gives the correct emphasis to prevention, treatment, care and mitigation, given the status of the epidemic. In this respect, there is consistency between *Taking Action* and NACP 3 in relation to comprehensive service provision and a continuum of care. However, DFID was one among many voices during NACP 3 development making the case for comprehensive programmes.

In DRC, DFID supports prevention, treatment and care interventions as well as influencing and advocacy activities. DFID is praised for having a "global vision" – illustrated by the HIV prevention activities that DFID will integrate with road rehabilitation work, recognising that better roads are often also "better" transmitters of HIV – and for being willing to support partners working in difficult to access or insecure locations – such as MSF-Holland's work in the east of the country.

Example 11: Support for Comprehensive Approaches in the Education Sector

DFID support for comprehensive HIV and AIDS initiatives in schools, particularly in Africa, has been critical. Some programmes, such as Primary School Action for Better Health in Kenya, which are also tackling the related issue of violence against girls and women, have demonstrated considerable success in reducing high risk behaviour among pupils. DFID support to collect evidence on gender based violence in school has helped to change national policy, for example, in Malawi. A recent progress report on DFID's girls' education strategy highlights the importance of girls' education in reducing HIV risk and vulnerability and recognises the need to be more consistent in ensuring that all education sector programmes in all regions address gender norms that increase the risk of HIV infection in girls and boys.

Example 12: Country Examples of DFID Action to Improve Food Security

In Zambia, DFID support is moving from a relief to a social protection model and the links between HIV, AIDS and food security are explored in the CAP (DFID, 2004a). DFID has been tackling the issue of food security through social protection, working with the Ministry of Community Development and Social Services and piloting of the use of cash transfers through international NGOs. Scaling up will need government to play a leading role, but the Ministry has been neglected by donors and has limited capacity. Coordination with other international organisations in the field is not easy because of widely differing approaches and the absence of a clear coordinating mechanism. The advantages of cash transfers include predictability, flexibility and investibility.

In Zimbabwe, DFID has been supporting efforts to promote food security through the Protracted Relief Programme (PRP), which started in 2002. This works directly through 14 NGOs and 4 technical partners, with a wide range of technical support provided to partners through a management agency. The PRP is an integrated programme offering a range of services including seed, fertilisers, gardens, home care,

livestock and so on. Initially, the programme had a rural focus but is now expanding to urban areas. Efforts are being made to coordinate with programmes providing similar services, such as the Urban Initiative, and programmes offering targeted support to particular populations, such as OVC. At the time of the country visit for the evaluation case study, PRP was going through a process of annual review. Issues being considered included whether maximum support should be offered to a few households or minimal support to many and the extent to which providing support might undermine social cohesion. The PRP has been piloting the use of food vouchers as a social protection instrument. Households are given vouchers which they can use to 'purchase' commodities from a particular supermarket. This mechanism allows use of local markets but avoids some of the problems of cash in a hyperinflationary environment. There could be considerable problems with the use of cash transfers in the Zimbabwean environment but UNICEF and others have developed a concept note to rigorously research the use of cash transfers as a social protection measure.

DFID is the largest donor for Ethiopia's national Productive Safety Nets Programme (PSNP), which is leading GOE policy transformation. While the PSNP does not specifically address HIV and AIDS or identify the vulnerable recipients in term of HIV and AIDS, people are eligible if they are chronically ill and OVC are included as members of vulnerable families, and DFID advisers responsible for health and for food security work closely together.

Example 13: Strengthening Programming for Vulnerable Groups

The UK has concentrated efforts on aspects of *Taking Action* where it has judged that most impact can be made on China's approach to HIV and AIDS (and the epidemiological context). As noted above, the focus has been on strengthening policy and demonstrating effective programming for the most vulnerable groups, such as sex workers, IDU and MSM, rather than support for comprehensive prevention and treatment programmes. As of November 2005, 90 interventions providing HIV/AIDS prevention and care services to 54,000 people were being implemented in Sichuan Province and 74 interventions serving almost 60,000 people in Yunnan Province. Small-scale support has been provided for AIDS orphans and vulnerable children, largely for education costs. Human rights is a sensitive issue in China and the UK has focused on engaging with the GOC on rights in the context of HIV and AIDS. This appears to have shifted official views concerning IDU, sex workers and MSM and to have had a positive influence on policy and practice. Although HAPAC was designed before *Taking Action* was written, it is considered to have been a very successful example of collaboration with and support to the national HIV and AIDS programme. DFID is widely lauded for its decisions to work through government implementation systems, especially at county level, and to focus funds on HIV prevention interventions for vulnerable groups. In China, the UK's support for HIV and AIDS has used a relatively small amount of funding to produce a significantly improved national programme that is based on more rational HIV and AIDS policies, involves significantly improved leadership, and is better planned, implemented and, to a lesser degree, monitored and evaluated. Many of the approaches developed by this DFID-funded project (HAPAC) are being replicated by local authorities with the support of the Government or other projects, most notably China CARES and the Global Fund. HAPAC has effectively disseminated its experience in Sichuan and Yunnan through visits from over 40 groups from other provinces and the more than 1,000 counties involved in the China CARES project.

DFID India funds, channelled through a Project Management Office (PMO), were used to support MSM and IDU prevention efforts, as SACs largely focused on sex worker interventions. PMO grants were used to pilot innovative prevention approaches, e.g. provision of a comprehensive harm reduction package to IDU, including oral substitution therapy; support the establishment of harm reduction and MSM networks; and develop an MSM strategy to guide the national programme. The PMO also funded projects to reduce HIV risk in street children, develop models of community care for positive women, and improve access to services for vulnerable youth.

In Russia, from 1998-2002, DFD committed £775,353 to the Sverdlovsk HIV/AIDS Prevention Project. This project, managed by International Family Health, was focused on preventing HIV transmission among IDU in the oblast by establishing a multisectoral harm reduction programme, establishing three needle exchange pilot sites and raising public awareness of HIV transmission routes and effective prevention strategies. The project was evaluated in June 2000 (Burrows, 2000). DFID also committed £4.2 million to support Open Society Institute activities in Russia from 2001-4. These focused on reducing the transmission of HIV among IDU and sex workers in the 43 harm reduction sites. In addition to the direct provision of services, this project aimed to increase capacity to monitor and evaluate harm reduction activities. DFID has also provided funding to the Russian Harm Reduction Network and to the Knowledge for Action on HIV/AIDS in the Russian Federation (2003-7) which focuses on IDU and harm reduction.

In Asia, in 2005, DFID committed £778,250 to a two-year regional harm reduction programme aimed at accelerating the development of effective national responses to HIV transmission through drug use in China, Vietnam, Myanmar, Laos, Cambodia, the Philippines and Mongolia. This programme is operated by WHO and focuses on developing tools and guidelines, strengthening national capacity and developing a regional support mechanism.

In Ukraine, in 2004, DFID committed £40,840 to fund a consultancy focused on lowering the risk of HIV infection among MSM in Kiev and Donetsk. A further £65,000 was committed in 2005. The project was commissioned following a proposal from a local NGO, Substance Abuse and AIDS Prevention Fund, requesting support to gather information on the situation of MSM.

In Pakistan, in 2004, DFID committed £836,000 to fund the work of Naz Foundation for 2 years. Elements of this work include empowering low-income MSM collectives, groups and networks; advocating for the human rights of low-income MSM; cooperating with NGOs working with MSM; conducting research; and securing funding for MSM collectives, groups and networks.

In DRC, in 2005, DFID committed £709,793 to PSI's Behaviour Change Campaign, focused on sex workers and their clients, truckers, soldiers and policemen. The project focused on Kinshasa and was seen as filling a significant, urgent, short-term gap because USAID funding was focused in regions, World Bank funding was delayed and the Global Fund grant had little available for behaviour change. Outcomes include increased uptake of condoms and reported changes in behaviour.

In Bangladesh, in 2004, DFID committed £492,373 over five years to Concern's outreach programme for socially-disadvantaged people. This focused on empowering

sex workers to exercise their basic rights and gain access to services. The principles underlying this project were that sex workers should not be seen as passive recipients of services but active players with a voice to be heard. Concern reports preliminary outcomes include greater acceptance of sex workers and their children and some signs of a reduction in stigma and discrimination.

Example 14: Scaling up Prevention and Treament

In **China**, approaches to HIV prevention implemented as part of the DFID-supported HAPAC project in Yunnan and Sichuan are now being replicated by government in other provinces with the support of central government and other projects. DFID pilots have provided the necessary evidence to influence public policy and to inform scale up.

Challenges to scaling up treatment in **Russia** with funds from the Global Fund include lack of vendors to ensure competitive processes, weaknesses in the health system, and corruption. The International HIV/AIDS Alliance, with support from DFID, has played an important role in reducing the cost of drugs in Russia.

DFID was closely involved in the design of NACP3 in **India** and is a key donor to this national programme. The main emphasis of NACP3 will continue to be HIV prevention, but the programme also plans to provide universal free access to first line ARVs. All public health facilities will ensure that ART is provided to PLWHA referred from targeted interventions, HIV-positive women particularly those who have participated in the PMTCT programme, HIV-positive children, and people living below the poverty line. 250 ART centres will be set up by 2011, providing treatment to 300,000 people.

Example 15: Supporting Efforts to Address the Human Resources for Health Crisis

Zambia's response to the human resources for health crisis is guided by a strategy produced by the Ministry of Health, costed at US$313m over three years. This strategy is serving to focus donor support in this area, which has previously been fragmented. Support provided by the UK, in addition to implementation of the Code of Practice, has included DFID funding for training of more doctors and nurses, and fostering institutional linkages between Brighton and Sussex NHS Trust and the University Teaching Hospital in Lusaka. Critical areas requiring further support include: training of locally-relevant staff groups, e.g. clinical officers, scaling up of retention schemes, e.g. pilot health workers' retention scheme supported by the Dutch government, and support to the broader process of public sector reform. The shift to poverty reduction budget support, by providing more predictable funding, could allow government to spend more on salaries, and also to increase allocations to the education and vocational training sectors.

DFID is supporting the Government of **Ethiopia**'s human resource strategy, which includes innovative models for delivery of health care, including HIV and AIDS services. Measures being taken include training a new cadre of Health Extension Worker. However, further efforts are required to encourage the GOE to address issues affecting retention of health professionals, in particular salary rates, which are constraining progress and impeding efforts to scale up access to HIV and AIDS prevention, treatment and care interventions.

Example 16: Research Areas Mentioned in *Taking Action*

- Further research into microbicides and close funding gap for trials (pp6,23,57,62)
- Support for AIDS vaccine development (p62)
- Development of new technologies for the poor and vulnerable groups (pp6,57,59,62)
- Research on how to reduce risks such as the development of drug resistance (p59)
- Research which benefits women and young people including orphans and vulnerable children
    - Technologies (pp6, 59)
    - Taking action in long term (p62)
- Research which benefits marginalised groups
    - Provision of and access to treatment (p59)
    - Innovative treatment regimens (p62)
- Research into the social, economic and cultural impact of AIDS (pp6,57,59,62)
- Research into the impact of AIDS on livelihoods (p59)
- Research about how best to deliver services to the poor and vulnerable groups (p59)
- Research to reduce stigma and discrimination which affects access to services (p59)
- Scale up research into treatment for children (p23)
    - Develop new and more effective therapies (p62)
    - What therapies are most successful (p59)
- Research into how preventative treatment and care interrelate in relation to:
    - Other health issues (p59)
    - Livelihoods (p59)
- Research into what makes some groups more vulnerable to HIV (p59)
- Research into how the societal roles assigned to men and women, boys and girls, increase vulnerability (pp59,62)
- Research into the challenge of the rising numbers of orphans (p59)
- Develop research that will engage a wide range of users including policy makers, practitioners and the poor (p62)

Example 17: DFID Support for Action on Legislative Reform, Stigma and Discrimination

During NACP2, DFID **India** used its Challenge Fund to support Naz Foundation project work with MSM and UNODC and the Society for Promotion of Youth and Masses to work with the lawyers' collective to advocate for provision of comprehensive harm reduction programmes for IDU, including oral drug substitution. The FCO has also funded a study by the Naz Foundation on social, political and legal constraints to working appropriately on male to male sex and HIV in India and Bangladesh. However, it has been difficult for the FCO to work in this area, because India does not encourage direct involvement in legal matters by another government. DFID, working with UN partners and with CSOs through the Challenge Fund, appears to have been more able to support activities on legislative reform.

In **China**, human rights can be a sensitive issue. Nevertheless, the UK Government continues to engage with the Chinese Government on human rights, including in the

context of HIV and AIDS. This appears to have shifted official views concerning sex workers, IDU and MSM and to have had a positive influence on policy and practice. China enacted legislation in early 2006 prohibiting discrimination but further efforts are needed to challenge stigma and discrimination on the ground.

In **Africa**, a Southern African Development Community (SADC) programme, supported by DFID, includes a training component for journalists on sensitive reporting. The DFID-funded Soul City edutainment programme in South Africa, which raises awareness and understanding about gender equality, HIV and AIDS and positive attitudes towards PLWHA, is being expanded to cover the SADC region. In Asia, a DFID-funded programme in the Mekong Region works with journalists to reduce stigma and discrimination in the reporting of HIV and AIDS. In Latin America, the Champions for Change programme focuses on reducing homophobia and HIV/AIDS-related stigma through high-level commitment and support for stigmatised groups by public figures. A conference in 2004 enabled senior political and faith-based leaders to engage directly with PLWHA and identify ways they could take action.

Example 18: DFID Support for OVC Programming

In **Ethiopia**, many children are vulnerable for reasons other than AIDS. According to the Sixth Report on AIDS in Ethiopia, there are an estimated 4.9 million orphans in the country, of whom almost 750,000 were orphaned by AIDS. For this reason, DFID Ethiopia advocates for and supports poverty reduction strategies that reach all vulnerable children. DFID participates in the HIV/AIDS Donor Forum Vulnerability Working Group and is a major donor to the GOE Productive Safety Nets Programme, which provides resource transfers in the form of cash and food to 5 million people in food-insecure rural households. This programme is currently commissioning work to look at how it impacts on vulnerable children, including those affected by AIDS.

Various steps have been taken to strengthen the national response for OVC in **India**. UNICEF organised a national consultation in 2005 to take forward the Strategic Framework. The meeting set up a task force, of which DFID is a member, led by the Ministry for Women and Child Development (MWCD) and NACO. Progress includes: situation assessment and action planning for affected children in six high prevalence states, integration of care and protection of children strategies in the MWCD 11th 5-year plan, and assessment of institutional care for children including affected children. DFID was one of the champions for inclusion of OVC issues in NACP3, and the Programme Implementation Plan specifies increased coverage of most vulnerable children, strengthened child protection systems and mainstreaming HIV/AIDS into existing programmes for children.

Example 19: Innovative HIV and AIDS Activities for Young People – Civil Society Challenge Fund

In **Togo**, DFID committed £487,077 from 2004-8 to the Little Sister Project supported by PSI Europe and a local NGO, FAMME. This initiative aims to improve the wellbeing of at least 1,000 young sex workers. It seeks to do this by establishing a Little Sister Centre in Lome, which will provide services related to health, social support, education and economic development; a peer education network; an advocacy union for young sex workers and an awareness campaign on issues relating to cross-generational sex.

In **Uganda**, DFID committed £477, 418 from 2006-10 to Project Hope supported by Interact Worldwide and the National Community of Women Living with HIV/AIDS. This initiative aims to improve the quality of life of women and girls living with HIV, and their families, in a number of areas, including health, equity, dignity and respect in the community. Activities include support for positive living and treatment; raising awareness of the needs and rights of PLWHA, and community and civil society monitoring of health and education services.

In the **Philippines**, DFID committed £392,547 from 2004-8 to an HIV prevention project supported by Marie Stopes International. This initiative aims to advocate for sexual and reproductive health rights of adolescents aged 13-19, by building the capacity of Youth Councils in the provinces of Lanao del Norte and Misamis Oriental in Mindanao to engage in local decision-making processes.

Example 20: Increasing the Involvement of PLWHA

PLWHA are increasingly involved in policy dialogue in **Ethiopia** through representation on the CCM and National Partnership Forum (NPF), and in developing policies and guidance, including for ART and VCT. DFID supported the establishment of the NPF with the aim of increasing the involvement of vulnerable groups in the response, and has also provided funding for *Tilla,* an association of HIV positive women in Southern Ethiopia, and the Network of Positive Women in Ethiopia (NAPWE). The establishment of women-only PLWHA associations has enabled more women to be involved, including at leadership and decision-making levels, an opportunity denied them in mixed-sex associations.

In **India**, DFID supported INP+, which has 40,000 members in 140 districts, through the PMO. Activities include advocacy, establishing networks and research. There has been demonstrable progress in the meaningful involvement of PLWHA in India. NACP2 acknowledged this role and moved away from seeing PLWHA only as passive recipients of services. PLWHA were very actively involved in the design and development of NACP3, including the establishment of a working group on the greater involvement of PLWHA.

In **Russia**, DFID has supported a number of regional conferences, including one in May 2006, which included a focus on partnerships with PLWHA.

Zambia has national nutritional guidelines for PLWHA and is piloting the provision of nutrition alongside ART. PLWHA report that NAC has played a critical role for them. There is a national association of PLWHA, NZP+, however its capacity is limited.

In **Zimbabwe**, PSI is recruiting PLWHA as promoters of care, workers on treatment preparedness and anti-stigma campaigners. PLWHA express concerns about limited access to HIV testing in rural areas, over-reliance on laboratory testing in provision of ART and access to adequate nutrition. DFID has supported associations of PLWHA in a number of different ways. The national network of PLWHA, ZNNP+, is very weak. It was previously suspended for financial mismanagement. It is now functioning again with support from CDC. However, its annual budget is currently only around $40,000. NAC is planning a survey on the meaningful involvement of PLWHA.

In **DRC**, two PLWHA associations (RCP+ and Task Force des Femmes PVV) were extensively consulted as part of the country case study for this evaluation. They expressed concern that their associations are not fully respected and a strong aspiration to be involved meaningfully in the national response to HIV and AIDS. They expressed similar concerns about access to essential services including adequate food, ART and schooling for children.

The **China** country case study concluded that DFID China could strengthen the involvement of vulnerable groups, including PLWHA, in programme design and monitoring. Although DFID organised a one-day consultation with PLWHA concerning the new joint DFID-GFATM project, staff acknowledge that it would be have been helpful to repeat this during the design phase.

Example 21: DFID Support for Programming for Women

In **Zimbabwe**, DFID supports a range of programmes to address the needs of women. These include:

- Funding for the International Organisation for Migration (IOM) to prevent and mitigate GBV during and after acute emergencies, such as Operation Murabambatsvina. IOM activities included training staff to deliver humanitarian assistance, e.g. water and shelter, in ways that reduce the likelihood of girls and women being sexually abused; training communities to identify, report and refer cases of GBV; and providing community clinics with STI drugs, emergency contraception and post-exposure prophylaxis. The next phase will focus on addressing the underlying causes of GBV and improving access to legal services.
- Support for the integration of HIV into reproductive health services for women, and to strengthen FP, MCH and PMTCT services. Currently, 56% of patients on ART in Zimbabwe are women. While this percentage is not expected to change, the total number of women on treatment should increase under the Expanded Support Programme (ESP), which DFID funds along with other bilateral donors. The DFID-supported Maternal and Newborn Health Programme (MNP) will expand opportunities for women to manage their fertility, have safe pregnancies, access HIV treatment sooner, and reduce mother to child transmission of HIV. DFID support to the PSI female condom programme provides an opportunity to address HIV prevention while also strengthening women's social support networks.
- Support for the Protracted Relief Programme, which targets female-headed households below the poverty line with livelihood and nutrition support. Specific activities include self-help groups and microfinance schemes.

Example 22: Funding for Civil Society

DFID and other donors fund civil society in **Zambia** to play a number of roles relating to HIV and AIDS. These include: building voice and accountability, although this role is relatively poorly-developed in the HIV and AIDS arena and PLWHA organisations, e.g. NZP+, have limited capacity; and providing services and humanitarian assistance, e.g. activities that are difficult for the Government, such as work with sex workers, and community support programmes for OVC. There is no mechanism for the Zambian Government to fund CSOs, with a few exceptions, such as the support to mission hospitals. Donors including DFID are increasingly funding CSOs through intermediate organisations, including: Churches Health Association of Zambia (CHAZ), which is

one of the principal recipients of Global Fund monies; Zambia National AIDS Network (ZNAN), also a principal recipient of Global Fund monies and channel for 60% of DFID money for civil society through STARZ; Community Response to HIV/AIDS (CRAIDS), established by the World Bank as part of the Zambia National Response to HIV/AIDS (ZANARA) project and channel for 40% of DFID money for civil society through STARZ

In **Uganda**, the Civil Society Umbrella Programme, which DFID funds, has supported:

- ANPPCAN, which funds a weekly radio programme to discuss child rights issues. This is reported to have significantly contributed to the sharing of views, learning, creating public awareness, increased awareness and stimulating action around child rights issues among the population.
- Centre for Domestic Violence Prevention (CEDOVIP), which has been sensitising communities on how to prevent domestic violence in Kawempe Division of Kampala City Council. As a result, a number of stakeholders including community leaders, police, business persons, health workers, men and women, are reported actively involved in advocating for women's rights and prevention of domestic violence in different forums such as church communities and village meetings.
- The ANPPCAN child rights programme in Kasese District, which has increased reporting of cases of child rights abuse and reduced cases of out of court settlements of child abuse and neglect issues. In addition, there are community managed and owned child labour committees in Kasese integrated into the local government plans and budgets formed to monitor trends in child labour.

Grantees participate in sector and programme reviews and value for money audits. For example UNHCO participates in health sector value for money audits and sector reviews, ANPPCAN participated in the process that culminated in tabling draft bills to review laws protecting children against sexual offences, developed a position paper on various issues and presented proposals to the Uganda Law Reform Commission to review the Children Act.