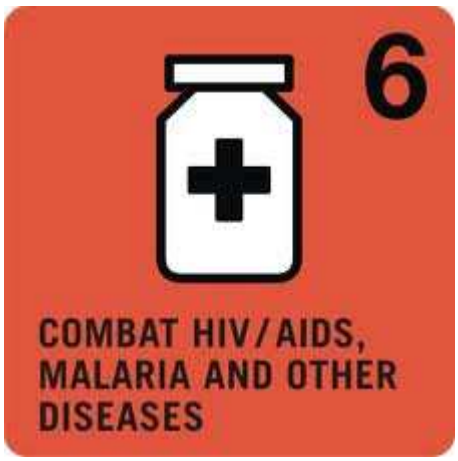
Monitoring system for the implementation of projects and programmes of external cooperation
LOT 3 – Asia and Central Asia

MDG 6: Combating HIV/AIDS, malaria and other diseases



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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARVs/ARTs	Antiretroviral Drugs/Antiretroviral Treatment
CBOs	Community Based Organisations
CTTs	Core Training Teams
EU	European Union
HIV	Human Immunodeficiency Virus
HQ	Head Quarters
IDUs	Injecting Drug Users
IGAs	Income Generating Activities
KAP	Knowledge, Attitude and Practice
MDG	Millennium Development Goals
MdM	Médecins du Monde
MSM	Men who have Sex with Men
MU	Mahidol University
NGO	Non-Governmental Organisation
OSS	One-Stop-Services
OVIs	Objectively Verifiable Indicators
PLHA/PLWHA	People Living with HIV/AIDS
SWs	Sex Workers
TB	Tuberculosis
VCT	Voluntary Counselling and Testing

Teaching street children about HIV/AIDS - Cambodia

Registration for free of charge health check-ups in Health Station – Laos

AIDS wives/widows - Nepal

Introduction

The objective of this study[1] is to analyze if and how projects funded by the EU are contributing to the achievement of the Millennium Development Goals (MDGs) established in 2000 during the Millennium Summit. It will focus in particular on MDG6, which aims at combating HIV/AIDS, malaria and other diseases. In order to do this, we will first look at the progress made so far on the targets defined by the MDG, internationally and more specifically in Asia[2]. The following section will look at the ROM results obtained by a selection of 14 EU funded projects. Since all of these projects aim to achieve one or more of the MDG targets, the next step will be to identify if, and how, they were successful in doing so and what best practices can be singled out. A similar exercise will be done for the three best performing projects; after having highlighted the points they share in common, their particularities will be looked at. Finally, some recommendations will be made to donors regarding some parameters to be kept in mind during the selection process of potential grantees as well as the support they could provide to grant recipients to facilitate their work.

1. Progress on MDG 6

Health is of course a central aspect of the MDGs and is referred to in three of them. MDG 6 aims to halt, and begin to reverse the spread of certain diseases (HIV/AIDs, Malaria and Tuberculosis) by 2015. It is subdivided into three components, two of them focusing on HIV/AIDS and the third one extending to malaria and tuberculosis (TB). The indicators used to measure progress are as follows:

Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bed nets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed short course treatment.

Source: Millennium Development Goals Indicators. The official United Nations Site for the MDG indicators. http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm

[1] ***Disclaimer*** This report is the sole responsibility of the authors. It does not necessarily reflect the views of the European Commission

[2] Note that the projects selected for the present review have all been implemented in Asia.

1.1. HIV/AIDS

1.1.1. Incidence and prevalence

As far as HIV/AIDS is concerned, it appears that globally, the spread of HIV has stabilized and that people are now surviving the disease longer. Worldwide, the number of people newly infected with HIV peaked in 1996 and then declined. *[1]* Unfortunately, whereas the infection rate has diminished in countries such as Asia, Latin America and Sub-Saharan Africa, it appears that new infections have been on the rise in Eastern Europe and Central Asia. *[1]* According to the Millennium Development Goals report produced by the United Nations in 2010, HIV prevalence in these areas has almost doubled since 2001, increasing from 760 000 to 1.4 million. The most heavily affected region in terms of HIV however remains Sub-Saharan Africa which, in 2008, accounted for 72% of all new infection cases. *[1]*

The estimated number of AIDS deaths appears to have peaked in 2004 when it was estimated at 2.1 million; by 2009 it had declined to 1.8 million, mainly thanks to increased access to antiretroviral drugs in poorer countries. *[2]* Access to these drugs also explains why, despite the fact that the number of new infections is decreasing, the number of people living with HIV worldwide continues to grow. In 2008, an estimated 33.4 million people were living with HIV. *[1]*

In Asia, the countries with the highest number of people living with HIV are showing good progress with regard to the MDG 6 targets. In effect, Myanmar, India and Thailand are early achievers and China is still on track. *[5]* Only Viet Nam and Indonesia show no progress (or have regressed) and, according to projections, infection rates in the latter could keep increasing until 2020. *[5]* Unfortunately, disturbing trends are also observed in countries such as Cambodia where changes in legislation increase the stigma against sex workers and men having sex with men. *[5]* This legislation clearly has a direct impact on prevention work making access to these target groups very difficult.

1.1.2. Prevention

The Millennium Development Goal Report highlights that the lack of knowledge on how to protect oneself from HIV remains unacceptably high in developing countries. *[1]* Whereas the target set for 2010 was that 95% of young men and women between the ages of 15 and 24 would have access to the necessary information and services to reduce their vulnerability to HIV, it appears that less than one third of young men and less than one fifth of young women know how to prevent infection. The worst situation is reported in Northern Africa where only 8% of young women have this knowledge. *[1;11]* That said, some countries have come a long way, especially as far as the education of young women is concerned. Namibia is the best example since, between 2000 and 2007, the number of women aged 15-24 who with comprehensive correct knowledge of HIV increased from 31% to 65%. *[1]*. As far as Asia is concerned, Cambodia and Viet Nam show significant improvements too, the former passing from 37% to 50% and the latter from 25% to 44% in the same timeframe. *[1]* Apart from gender, there seems to be a direct correlation between the level of knowledge and two other factors: wealth and urbanization. Poorer rural communities tend to be much less informed than communities living in urban areas. *[1]* The same factors seem to significantly affect the use of condoms. According to the report, 60% of men use a condom if they belong to the “richest” group against only 24% if they belong to the “poorer” group. Similarly, 43% use a condom in rural areas against 60% in urban areas. *[1]*

According to Sethi, in Asia, HIV infections appear first among Injecting Drug Users (IDUs), Sex Workers (SW) and their clients and Men having Sex with Men (MSM). *[5]* It is then spread to wives and children, which explains how 200000 more Asian women are living with HIV in 2008 compared

to 2001. [5] The author also shows how migration - which tends to be very high in Asia – makes men more vulnerable to HIV infection. [5] In Viet Nam for instance, only 2% of non-mobile men buy commercial sex, while the number rises to 32% when they become mobile. [5] This phenomenon has seemingly rightly been acknowledged by the Global Fund; between Funding Rounds 6 and 8, funds allocated to migrant and mobile populations were increased from 1% to 17% respectively. [5]

1.1.3. Treatment

As far as treatment is concerned, the rate of HIV infections increases much faster than the availability of medicines. The 3 by 5 initiative (by which 3 million people in low- and middle-income countries were to receive Anti Retroviral Therapy (ART) by 2005) significantly contributed to an increased uptake of ART. [1] By 2008, the number of people receiving such treatments had increased 10-fold, thereby fulfilling the needs of 42% of the 8.8 million people needing treatment at that time. But much still remains to be done. [1] In recent years, a particular focus has been put on HIV-positive pregnant women and it is estimated that in 2008, 45% of these women living in low- and middle-income countries received treatment, thus increasing the chances of their babies not being infected. [1]

While ART coverage is also increasing in Asia, it remains lower than the global level; in 2008 an estimated 330 000 people died of AIDS in Asia. [5]

1.2. Malaria

According to the World Health Organisation (WHO), 38 countries are on course to meet the MDG target for reducing malaria. [8] That said, in 2008 an estimated 243 million cases of malaria caused 863 000 deaths, mostly of children under five. [8] 89% of deaths caused by malaria occur in Africa while 10% of the malaria cases are fatal in Asia and the Pacific. [1;4] Lower mortality levels in Asia are in part due to a lower incidence of the more severe and lethal cases caused by Plasmodium Falciparum; only 25% of all cases of Falciparum malaria were recorded in Asia and the Pacific. [4] Of all fatal cases reported in Asia and the Pacific, 41% occurred in Myanmar. [4] It is likely however that the incidence of malaria and the deaths deriving from this disease remain significantly underestimated since its symptoms might easily be mistaken with other diseases and surveillance systems are still rather weak in certain regions, thereby leading to under reporting.

The use of bed nets only really scaled up in 2005, and by 2008, the number of children under 5 sleeping under a net had increased from 2% in 2000 to 22%. [1] While the production of long-lasting insecticidal bed nets has risen fivefold between 2004 and 2009, poverty unfortunately still limits the purchase and use of these nets. The situation has improved in countries where nets were distributed free of charge in high risk areas but not all countries in need benefitted from such programs and currently needs continue to significantly outweigh availability almost everywhere. [1;8] Despite a significant increase in funds available for malaria control, the 1.5 billion USD made available in 2009 remains insufficient. It is estimated that in 2010, 6 billion USD would have been needed for the global implementation of malaria-control interventions. [1] Interestingly, it seems that more attention has been given so far to smaller countries and that the decrease in incidence has been seen primarily in countries where the burden of the disease is rather low. In order to reach the MDG target, more attention should have been given to larger countries. [1]

Access to antimalarial medicines (especially artemisinin-based combination therapy) has increased but in 2007-2008 still remained inadequate. [8] In addition, resistance to anti-malarial drugs is becoming more and more common. In the Asia-Pacific region, the South-East Asia region has the highest levels of resistance to drugs and insecticides in the world; the median value resistance to some drugs and drug combinations exceeding 40 per cent in many countries. [4] Artemisinin-based

combination therapy has become the only reliable treatment in some areas of South-East Asia, however, the high cost of this medicine is an important barrier preventing the widespread use of artemisinin-based combination therapy. *[4]*

1.3. TB

Apart from CIS countries and Sub-Saharan Africa, the prevalence of TB has decreased globally and so have the number of deaths related to it. *[1]* However, TB remains second only to HIV in the number of people it kills. *[1]* The target to halve the 1990 prevalence and mortality rates by 2015 only seems to be possible if TB control efforts and funding for them are sustained. *[1]*

Sethi reveals that the largest share of the global burden of TB is to be found in Asia and the Pacific, the total prevalence in China and India combined exceeding 6 million. *[5]* Mortality rates in Afghanistan and Cambodia among tuberculosis patients are among the highest in the region – 92 and 94 per 100,000 people respectively. *[5]* Among the high-burden countries, Viet Nam has exceeded the targets for identifying and treating cases of tuberculosis. The Philippines is another high-burden country that has reached both targets, while Cambodia, China, India, Indonesia and Myanmar are making good progress. *[5]* Only about 10 countries in the Asian-Pacific region, mostly in the North and Central Asian sub-region, have experienced rising prevalence figures for tuberculosis – increases from 36 per cent up to 80 per cent since 1990. *[5]*

In many countries, the increasing incidence of tuberculosis is associated with the spread of HIV/AIDS epidemics. Up to 40% of all people living with HIV/AIDS worldwide contract tuberculosis and it is responsible for a third of all AIDS deaths. Of the estimated 1.7 million deaths due to tuberculosis in 2004, up to a quarter million were of people co-infected with HIV. *[5]*

As with malaria, multidrug-resistant tuberculosis (MDR-TB) is also emerging in parts of Asia, more particularly in China, Kazakhstan, the Russian Federation and Uzbekistan. Despite the development of new drugs, their effectiveness is not guaranteed and treatment is longer, thereby also increasing the cost of drug regimes. *[5]*

Sethi does mention however that the countries with the highest number of PLVH prevalence in Asia are showing good progress in achieving the MDG 6 target for TB. *[5]* In effect, while Myanmar, Thailand and India are currently still on track to achieve the target, China, Indonesia and Viet Nam are considered early achievers for TB incidence; all these countries have already been identified as early achievers as far as TB prevalence is concerned. *[5]*

2. Assessment of EC funded projects

This study is based on a sample of 14 EU funded projects which have been or still are being implemented in Asia and which address one of the aspects of MDG6. All of them were monitored in 2010 and 7 of them had already been monitored once before. In only one case was the monitoring an ex-post (the monitoring took place after the project had been finalized). The thematic breakdown is as follows:

HIV/AIDS	Malaria	TB	Avian Flu
10	3	0	1

Two of the projects extensively address both HIV/AIDS and malaria. Regarding TB, despite it not being addressed as a priority by any of the projects, it is often touched upon when work is done on HIV/AIDS issues.
The projects at stake have been granted to a mix of:

Local		International		UN Organisation/World Bank	Profit oriented organisation
NGOs	Universities	NGOs	Universities		
1	1	9	0	2	1

As can be observed, most organizations implementing the projects under review are international, however it has to be underlined that all international organizations work through local partners and are only minimally staffed with expatriate personnel.

Generally speaking, no particular difference is to be noted between projects implemented by NGOs and UN organizations except in the case of efficiency (see below).

As far as the geographical breakdown is concerned, only one project is regional and covers four countries while the remaining projects take place in a single country:

Bhutan	Bangladesh	Cambodia	India	Indonesia	Laos	Myanmar	Nepal	Sri Lanka	Thailand	Viet Nam
R	R	4	2	2	R	1	1	1	2	R

R = Regional

The information analyzed in this section is based on monitoring reports summarizing the strengths and weaknesses identified during Result Oriented Monitoring (ROM) missions. The data available is therefore not exhaustive and does not provide any insights into the detailed approaches used by the different organizations. The criteria used to assess the performance of the projects are standard and focus on the five DAC criteria: i) Relevance and Quality of Design; ii) Efficiency; iii) Effectiveness; iv) Impact Prospects and v) Potential Sustainability. Every project was awarded grades (A,B,C and D, where A is the highest and D the lowest score) for each of these criteria. On the basis of these assessments (scores) it can be stated that ten projects are considered to be performing well, three particularly well (3 or more As) and one is experiencing problems (3 or more Cs). Overall, the first criteria (Relevance and Quality of Design) tends to receive the best scores with impact scoring second and sustainability last.

Looking at each of these criteria in more detail allows the following assessment.

2.1. Relevance and Quality of Design

As mentioned above, of the five criteria used to assess the performance of projects, relevance/quality of design receives the highest scores:

A: 5	B: 8	C: 1	D: 0

This is mainly due to the scores received on contextual relevance and explains itself by the fact that most of the projects are in line with one or more of the following policies or strategies:

- National Strategic Plan
- The Government's HIV/AIDS policy and/or the National HIV/AIDS strategy
- The Millennium Development Goals. The EU's respective Country Strategy Paper

Relevance is generally also guaranteed by the recognition of the particular needs of rural populations and/or in the case of HIV/AIDS, of vulnerable and marginalized groups such as Injecting Drug Users (IDUs), Sex Workers (SW) or Men having Sex with Men (MSM).

In only one case was relevance rated with a C; despite being in line with national and/or international policies, the project was not considered relevant as it offered awareness raising to AIDS widows who had already been infected with the disease themselves![3]

In contrast, in half of the cases under review, the scores attributed to design are inferior. In other words, although projects are deemed to be relevant, the quality of their designs is not considered adequate. In effect, in the health sector recurrent problems are identified regarding the timeframe of the interventions, the difficulty of identifying valid Objectively Verifiable Indicators (OVIs) and the lack of a phase out/exit strategy.

2.1.1. Timeframe

Out of the 14 projects under scrutiny, only 5 have a five year timeframe; all of the others have less time to make a difference. This is particularly problematic when dealing with communicable diseases and thereby behaviour change. Cultural norms and beliefs are deeply rooted and it is unrealistic to expect to achieve significant change in less than five years. Given the timeframe they dispose of, projects are generally speaking, too ambitious. When dealing with capacity building or health promotion, they often foresee the implementation of an exaggerated amount of training sessions, which will allow them to reach a maximum number of beneficiaries. Trainings are then often replicated as such, without necessarily being adapted to the needs of the various groups being trained and quantity often prevails over quality. Trainings sometimes still take place towards the very end of the project and the fact that they are not necessarily followed by refresher courses, or at the least, follow-up meetings to discuss the information received, can render these one-off interventions superficial and futile. The fact that most projects work in rural and therefore remote areas means that activities take place in locations which are often difficult to access. Projects are therefore not only overambitious in terms of the quantity of activities to be carried out but also regarding the geographical coverage they aim to achieve. Another issue is that start-up time is seldom planned for appropriately. In the first place, qualified medical personnel are not always easy to find and are only rarely willing to work in rural or very remote areas. Secondly, Knowledge

[3] In addition, the project presented weaknesses in terms of its design and was criticized for its cost distribution since most of the money was used to cover the functioning cost of the implementing organisation.

Attitude and Practice (KAP) surveys, which are indispensable to measure change, represent a very time consuming exercise. Projects often estimate that these will be finalized within the first weeks of the action but this is hardly a realistic timeframe. Unfortunately, the initial KAP survey is only seldom followed by a final survey which means that, ultimately, the progress made is only relatively measured. In reality, projects with three year timeframes often need between 6 to 9 months to get going and if one takes into account that a phase out period of 6 months is also required, then in effect, the actual time available for implementation is seriously curtailed.

2.1.2. Objectively Verifiable Indicators (OVIs)

The main criticisms made regarding the OVIs are that they often do not change to be properly measured, that they are output- instead of result-oriented and that they are not based on realistic data. This partly relates back to two issues, the first one being that no unified tools and measurement systems are currently being used in the health sector and secondly, that targets are often not set against proper baseline studies. Governments, donors and organizations implementing health projects often use different indicators and have different ways of measuring them. This becomes particularly problematic in cases where different donors sponsor the same project. It is observed that, in some cases, an impressive amount of indicators is proposed in the logframe but that only few of them are really relevant to the action. A pragmatic approach has yet to be found however. As far as baseline data is concerned, insufficient time is often foreseen for gathering this information, which should contribute to the definition of the strategy to be adopted by the project. As a consequence, OVIs are determined well before the data has been analyzed and are either inadequate or improperly quantified. Unfortunately they are only rarely adjusted accordingly once data is made available. It is not clear whether this is due to a lack of attention from the side of the projects or whether this relates to the fact that modifying indicators and submitting them for approval to the EC is a cumbersome process, which risks delaying the actual implementation of activities in the field. Unfortunately this all means that, ultimately, progress will be difficult to assess and that potentially interesting and useful data will be lost.

2.1.3. Phasing-out strategy

The fact that a proper phasing-out period is often not integrated into the design of the project is also recognized as significantly weakening implementation and jeopardizing the sustainability of health interventions. In the case of health promotion and awareness raising for instance, health messages are passed to groups of beneficiaries who are then expected to become actors of change and to further disseminate this information in their communities. While they might have understood both the messages and the importance of sharing them with others, they often have not been prepared to plan future activities autonomously. So-called “planning for change” activities carried out together with the beneficiaries and stimulating them to come up with feasible and realistic plans to guarantee some sort of continuity of the action beyond the lifetime of the project, could help solve this problem. Similarly, local counterparts need to be progressively prepared to take over the management of health services; such structures cannot simply be handed over at the end of a project without a gradual phase-out period. While stakeholders are normally aware (and this sometimes happens at a very late stage) that a project is coming to an end, they are only rarely gathered together with beneficiaries to discuss possible ways of keeping the services running and maintaining the increased standards brought about by the project. Here again, instead of being stimulated to propose ways forward, they are often only requested to formally commit to take over what has been done and, possibly, to keep it alive. Surprisingly the different stakeholders involved in one single project are often also addressed individually instead of being brought together to brainstorm jointly to find possible solutions.

2.2. Efficiency

The scores obtained for efficiency are as follows following:

A: 3	B: 8	C: 3	D: 0

As mentioned above, efficiency is the only area where a difference has been noted between projects being implemented by NGOs and projects being implemented by UN organizations. In effect, it is worth mentioning that 2 out of the 3 Cs are attributed to UN agencies. These lower grades partly refer to sometimes significant delays in spending and in implementation. Interestingly, they are also the only cases where the appropriateness of some of the procured equipment is questioned.

2.2.1. Cost-efficiency

While some problems have been encountered due to fluctuating exchange rates, the cost-efficiency of the interventions is only put into question once; projects manage to keep administrative costs fairly low thanks to the fact that they usually work through already existing health structures. They therefore bear no - or little - additional costs for human resources and physical infrastructures. This allows them to keep overhead costs at a minimum while sometimes bringing about improvements to already existing infrastructure which will last over time.

2.2.2. Data management

One of the weaknesses noted in the health sector is the lack of strategic analysis and of proper documentation of the successes achieved as well as the challenges encountered. As mentioned above, the data produced thanks to baseline studies is not always used appropriately to re-orient activities. This is particularly problematic when a significant amount of time has passed between the drafting of the proposal and its actual implementation, since the situation in the field might have evolved in the meantime. A good example of this can be found in Cambodia, where one of the projects addressed malaria based on data revealing a high prevalence of the disease as well as a lack of knowledge as to how to prevent it. The baseline study, which was carried out a little more than 2 years after the project had initially been written, showed that malaria was not a priority issue anymore in the geographical area covered by the project. By the time it was carried out, 82% of the respondents knew how to protect themselves and 72% were already using bed nets. At the same time, the survey highlighted serious problems in terms of sanitation, however the activities were not re-oriented to focus more on hygiene promotion. The data was available but beyond a mere description of the numbers, no actual analysis ever took place and the possibility of redirecting activities was not discussed. The same holds true for most progress reports where quantitative data is presented but insights into the more qualitative aspects of projects are hardly ever discussed. Challenges encountered and solutions found are not presented either and best practices, despite the fact that they do exist, are not being shared. This information is crucial since it would help local governments and institutions to identify lessons learned as well as approaches to be replicated.

2.2.3. Dissemination of material

Another flaw identified by monitors is the fact that the material made available to complement HIV/AIDS prevention actions is sometimes inadequate or provided late in the process which is counter-productive. In the case of condoms, organizations with a religious background sometimes find it difficult to provide such items and do not systematically involve other organizations to fill

this gap on their behalf. In numerous other cases, the amount of condoms made available is far from sufficient. Unfortunately, even during awareness raising campaigns their distribution is not systematic. Lubricants are another missing item since they are not yet part of the "standard package" of material to be given out to beneficiaries. Despite their relevance - in particular for target groups such as SWs and MSM - their importance is often overlooked.

In one case it was observed that cooperation amongst organizations could potentially become counterproductive. In effect, one project found itself in a situation whereby it could no longer distribute free condoms during its dissemination sessions because it had an arrangement with Population Services International (PSI) and therefore could only *sell* the contraceptive. Particular attention should be given to avoid this type of situation.

As far as information, education and communication (IEC) material is concerned, it is observed that projects often undermine the impact of such tools. They sometimes fail to adapt them to the literacy level of the target groups, they unnecessarily delay their production or are insufficiently generous in terms of the quantity made available for distribution. While most of the projects have an awareness raising component, it is striking that proper dissemination kits including A4 sized posters, leaflets, condoms and the necessary support to show how to put them on correctly are hardly ever distributed to people meant to carry out outreach activities.

2.2.4. Training

Most projects under review attach a lot of importance to capacity building which they propose at various levels, from highly qualified medical staff to community members. The number of trainings and of trainees is often impressive, however the quality of these interventions is often questionable. In effect, the approach and the content of the trainings tend to be standard instead of being adapted to the audience. In the Asian context, top down lectures still seem to be common and are only rarely replaced by more participatory strategies. The quantity of information shared during a single session is usually significant despite the fact that the audience might not necessarily be able to absorb it all, which holds particularly true in the case of illiterate beneficiaries. Breaking the information down into smaller chunks would not only make it more digestible, it would also offer the opportunity to meet the beneficiaries again and to assess what they remember from previous sessions and, when needed, to go over the information again. This would be particularly useful in contexts where follow-up or refresher courses have not been foreseen.

2.3. Effectiveness

The scores obtained for effectiveness are:

A: 3	B: 9	C: 2	D: 0

2.3.1. Measurement of the quality of the results achieved

Most projects pay little attention to the actual quality of their interventions and focus almost exclusively on their quantitative aspect. Mention is frequently made of the number of participants in dissemination activities, but the extent to which they understand and remember the content of the messages shared is almost never discussed. Trainings which were discussed above can be mentioned here again since they are a good example of this phenomenon. While some projects propose pre- and post-tests to evaluate their training sessions, an actual needs assessment to properly tailor their content is only rarely done. Similarly, while post-tests are carried out immediately at the end of the trainings, they are never repeated at an interval of 3, 6 or even 9 months to establish to what extent beneficiaries still remember their content.

All the projects under scrutiny have an outreach component and they usually apply a combination of different approaches to contact different target groups. Unfortunately, they only rarely make a comparative study of the effectiveness of the different strategies put in place. The correlation between the exposure to the intervention and the uptake of services for instance is only rarely measured. This information would be fundamental to identify best practices and what interventions would be worth expanding or replicating.

2.3.2. Integrated approaches

In terms of effectiveness, one of the main issues when dealing with HIV/AIDS is to strike the right balance between prevention, treatment and access to income generating activities (IGA). It is crucial that demand not be created for services that do not exist or that are not yet in place: projects can end up being deceptive and counterproductive if they push beneficiaries to go for screening but then do not offer a viable option for treatment. In cases where such services exist however, it is observed that the opportunity is often missed to complement awareness raising actions with the provision of concrete support such as access to income generating activities (IGAs). This missing link is regrettable not only because it significantly decreases sustainability but also because it is often mentioned that people are more likely to be discriminated against because of their poverty level rather than their HIV status. In effect, integrated approaches including a livelihoods component have a greater impact since they take beneficiaries one step further on the path of recovery. Once their health has improved and they have regained their capacity to work, IGAs provide security, thereby helping to reduce both poverty and stigma.

A problem which often arises in the projects under review is that, despite constant efforts to improve the referral system to allow for continuity between prevention, screening and treatment, projects are only rarely successful in doing so. This can be explained by the fact that they generally work in contexts where different departments or health structures work independently and hardly ever interact with each other. The situation is worsened when they work under different authorities. Once again, 2-3 years is an unrealistic timeframe to get a referral system going in such conditions and more time needs to be allocated for such initiatives.

2.3.3. Access to target groups

Numerous projects go out of their way to have access to the beneficiaries and, in the case of marginalized groups, sometimes even take risks to do so. The use of peer educators has proven particularly effective in this endeavour and should be opted for whenever possible since it significantly increases the acceptability of the actions. This holds true for sex worker and MSM but also for people living with HIV/AIDS or TB. Apart from being a good communication strategy, it also boosts the self-esteem of the peer educators themselves, helping them gain recognition and respect in their communities. While peers help reduce the discomfort/embarrassment related to sensitive topics such as sexuality for instance, the involvement of religious leaders or respected community elders appears to significantly increase acceptance of the messages being shared, especially amongst older community members. This in turn helps reduce stigma and accelerates the uptake of new behaviour. Despite its success, this strategy is still not commonly used and it would be worthwhile for projects to document their achievements in this respect.

The biggest problem however is met when dealing with mobile populations. To reach this target group remains challenging and additional ground work and research is necessary to identify meaningful strategies to gain better access to them. One of the projects proposes to disseminate information regarding HIV/AIDS in various locations along the routes used by migrants. However, these travellers are unlikely to stop their journey to seek this type of information. Increased networking and collaboration with organizations working in the place of departure and destination of these migrant populations should be considered to fill the existing gap.

As far as youths are concerned, particular attention should be given not to target only young people in the school setting but also those out of school, especially in contexts where school attendance is low and/or drop-out rates are high.

2.4. Impact:

The scores recorded for impact are:

A: 4	B: 9	C: 1	D: 0

As can be observed, only once was impact graded a C and this was the case of a project which had also been awarded a C for both its relevance and effectiveness (or lack thereof). In this case, HIV prevention was supposed to lead to increased disclosure of the target group's HIV/AIDS status but the corresponding VCT and ART services were lacking, thereby significantly reducing the impact of the intervention.

2.4.1. Poverty reduction

Criticism is repeatedly levelled at the lack of support to PLVHA. Projects were recognized as having greater impact when they managed to change the socio-economic situation of the beneficiaries. The two main strategies identified for increased impact through poverty reduction, are birth control and access to IGAs. Initiatives dealing with sexual reproductive health have proven to be very successful even in contexts where sexuality is taboo. In effect, female beneficiaries are thankful for the information they receive; they feel more in control of their lives and are now in a position to make informed choices. Interestingly, their partners, once properly informed, do not seem to oppose resistance to the uptake of a birth spacing. The two main arguments used for the promotion of these methods are poverty reduction and increased health for the mother. In the case of IGAs, it is argued that increased income is also likely to diminish migration which, in turn could mean a decrease of extra-conjugal partners and potentially of exposure to HIV.

2.4.2. Service provision

As far as service provision is concerned, the mix of drop-in and mobile clinics guarantees proper coverage and therefore significantly increases impact. Mobile clinics have been particularly successful in bringing services closer to remote and underserved communities. Unfortunately, despite the fact that it could reinforce activities already being done through the public sector, the private sector is only rarely involved in such activities. This is particularly regretful in settings where the public sector is not yet ready to cater to the needs of local communities by itself and where the private sector is therefore needed to fill the gap. Training on sexually reproductive health, HIV/AIDS, malaria and TB for instance could be extended to pharmacists. It would also be relevant to include them in steering committees overseeing the evolution of the project. In addition, they could be involved in the creation and dissemination of IEC material. A connection could be created between end-users, health services and private services and it is likely that it would raise the awareness of pharmacists or other health professionals on the importance to refer patients.

It is surprising that only one project makes a conscious effort to work on positive prevention. In effect, once treatment is proposed, it would make a lot of sense to combine it with the specific prevention needs of HIV positive people in order to further delay disease progression.[4]

[4] Positive prevention also seeks to increase the psycho-social wellbeing of HIV positive people and encourages solidarity amongst people living with HIV/AIDS.[9]

2.4.3. Threats to ongoing impact

A practical problem is found in contexts where the legislation in terms of IDUs and sex workers is particularly repressive as is the case in Myanmar and Cambodia for instance, where carrying needles or even simply condoms may lead to arrest, thereby putting both staff members of implementing organizations and beneficiaries at risk. Needle exchange programmes are recognized as being particularly useful to prevent the propagation of HIV/AIDs among drug users, and it would be a shame to undermine the potential of such activities. It is therefore crucial that such actions be accompanied by thorough advocacy work at all levels; organisations which had a component dealing with policy support were recognized as making a significant contribution to increased impact. Representation of the projects in various working groups and a constant presence in coordination mechanisms were also identified as being crucial to influence the policy discourse. Locally, work must be done with law enforcement agencies to prevent extortion and other abuses as well as with religious and other leaders to increase awareness on the positive effects of outreach activities. At the same time, regional and national authorities also need to be involved. Last but not least, it would be desirable that donor agencies be more proactive in terms of lobbying to support the work done in the field.

2.5. Sustainability:

The scores recorded for sustainability are:

A: 1	B: 8	C: 5	D: 0

2.5.1. Financial sustainability

Financial sustainability is clearly the main problem since it often falls beyond the capacity of local governments - in this case of the Ministry of (Public) Health – to guarantee that the necessary funds will be made available to sustain the changes brought about by projects. As a consequence, they usually ask the implementing organizations to scale up their activities. That said, some strategies help diminish this sense of dependency on external resources and it is a relief to see that they are usually being put in place. For the health sector, using existing physical structures such as health points, health centres or hospitals for instance means that no extra rent or maintenance costs will have to be covered after the project ends. The same holds true when working with existing teams of professionals since, besides having the advantage of building their capacity and increasing ownership, it also means that in the future no additional salaries will have to be disbursed by the local health authorities. In that sense, the involvement of volunteers has proven to be problematic since they are likely to drop out of the activities if, in the long run, no incentives are given to them.

Financial sustainability is also a concern for end-users however, and this aspect is insufficiently addressed. In effect, it is frequently overlooked by interventions offering improved health services, that even if the services remain free/available beyond the lifetime of a project, beneficiaries often do not have the economic means to pay for transportation to access these services. It is therefore important that time be taken to support the beneficiaries in elaborating a strategy to counter this problem. Saving funds are one option. Projects could also facilitate the purchase of a transportation means which would then be maintained thanks to pooled community resources. In one case, Village Development Committees were successful in sourcing funds to support PLHAs; similar initiatives should be encouraged early on in the project in order for them to be well established before the end of the activities. It is observed that cost-recovery schemes are seldom used or introduced however, combined with the creation of health centre management communities, they have proven to be a good option to make community members more responsible. The money set

aside can contribute to the costs of purchasing medicine, improve infrastructures or supporting the poor for instance.

To link screening and treatment with research involving medical schools and/or universities in the projects is proving to be a relevant approach to increase both financial and technical sustainability. In effect, beyond the fact that research is crucial for better management of the diseases in question, it is likely that additional funds can be found either for research or for educational purposes. The final product becomes more "marketable" and results can serve as evidence to support policy changes.

2.5.2. Policy support

Sustainability in terms of policy support seems to vary greatly according to the size and influence of the contracting authority as well as of the location of the project. If activities are run in remote locations and there is no main office in the capital, it is likely that little influence will be exerted on key stakeholders. As is the case for impact, insufficient response from the local authorities or limited policy support are seen as a major threat to the longer term sustainability of the activities. This is particularly true for actions benefitting highly vulnerable groups such as sex workers, MMS and injecting drug users and involving harm reduction strategies such as needle exchange and/or methadone programs.

2.5.3. Institutional sustainability

While most organizations take particular care in building the capacity of their local partners or of local institutions, some still do not pay sufficient attention to this aspect. Interestingly enough, it is more likely that big organizations such as UN agencies - rather than NGOs – acknowledge the importance of properly developing the financial and managerial responsibilities and capacities of local authorities or local partner organizations.

2.5.4. Knowledge sharing

Thanks to an important number of trainings and dissemination activities, health projects are often very successful in guaranteeing "intellectual" sustainability in the sense that increased knowledge and skills will remain with the beneficiaries. Sustainability however also means that the effort to keep sharing that knowledge will continue independently of who will transmit it, be it medical personnel or community members. Unfortunately however, it is observed that groups who acquired this new knowledge have only seldom been prepared to carrying on outreach activities without external support. While technical knowledge is transferred, the necessary planning and management skills to run the activities by themselves have not been given, which increases the chances for the activities to quickly be dropped. Similarly, most of the reporting (and proposal writing) is seemingly being done abroad at HQ level and local staff members are therefore only rarely supported in improving their reporting skills.

2.5.5. Exit strategy

Overall, great improvements could be made if proper exit strategies were an integral part of the project design. Unfortunately time is rarely foreseen for a gradual phasing out of the managing authority and a similarly gradual taking over by local partners or authorities. It is still too frequent that projects end abruptly and that no proper plan has been developed to guarantee continuity. Where an exit strategy is thought of, it unfortunately often fails to involve the stakeholders. To inform them of the fact that from now on they will be the ones responsible for certain activities or structures will not help them get ready for the task. A joint brainstorming exercise helping them

come up with realistic ideas on how they could manage the situation without external support might be more relevant than a simple handing over of responsibilities or task distribution. Donors should be more proactive in encouraging applicants to include a phasing out period in their strategies during the programming phase and to explain how they foresee this.

2.6. Progress over time

As mentioned above, seven of the projects under review had already been monitored once and it is interesting to note that improvement only occurred in three cases while the four remaining projects received lower scores during the second ROM visit. It has to be underlined however that no major variations took place in terms of scores.

Unfortunately, no major lessons can be learned from the evolution of these projects. Monitoring is subjective and different criteria are evaluated differently depending on the moment at which they are looked at. Impact and sustainability for instance will be difficult to measure early in the project but will gain much more importance at a later stage. One project received a better grade on both effectiveness and impact during the second ROM mission mainly because, due to a late start, little was to be seen during the first visit. Most of the time, grades were slightly increased in cases where recommendations made during the previous visit were followed and this usually concerned the revision of OVIs. Grades tended to be revised negatively when external factors such as changes in policy presented a threat to the ongoing impact and sustainability of the actions. Other factors such as under-spending close to the end of the project or managerial difficulties also led to lower grades. Other than this, no relevant trend is worth mentioning.

3. Best practices

So far, most of the attention has been put on common shortcomings of projects addressing the sixth MDG, however there is no doubt that EU funds are contributing to reaching the MDG targets. As far as HIV/AIDS is concerned, the projects under review mainly address **target 6.A** – having halted by 2015 and begun to reverse the spread of HIV/AIDS. They do this either directly by addressing HIV/AIDS as a priority action or working on sexual reproductive health. In both cases, most of the time focus is put on prevention work, the aim being to increase beneficiaries' knowledge regarding the characteristics of the disease and how it can be prevented and, at the same time, to promoting the use of condoms. By doing so, they successfully contribute to targets 6.2 and 6.3 and, by default, to target 6.1 which aims at reducing HIV prevalence. Interestingly, only one of the projects under review tackles target 6.4. i.e. the school attendance ratio for orphans; in the remaining projects, no activity is foreseen to address orphaned children.

Regarding target 6.B - the achievement by 2010 of universal access to treatment for HIV/AIDS for all those who need it - of the ten projects examined and working on HIV/AIDS related issues, surprisingly only five actually combine prevention activities with the provision of treatment.

All projects have had positive to very positive impacts and the following are some of the strategies which contributed to success:

1. A combination of the following components:
    a. increased knowledge through capacity building or awareness raising;
    b. increased access to improved services and
    c. provision of home-based services
    d. work at the policy level

It was also observed that impact is further strengthened when projects are embedded in a scientific setting or an academic environment.

2. Another crucial point is the involvement of stakeholders from different but relevant ministries; this can happen thanks to the creation of "Core Training Teams" (CTTs) for instance. These teams are composed of representatives from the Ministry of Health, the Ministry of Education and the Department of Women's Affairs and religious leaders who receive training on a variety of topics such as HIV/AIDS, sexual reproductive health and malaria and are then asked to train community members. While their status gives more weight to the messages they deliver, it is also felt that this exercise brings communities and authorities closer together. Participants in such groups feel an increased sense of responsibility towards the topics they discuss and towards the communities they address. Their increased concern and commitment should ultimately have a positive impact on service availability. Another project foresaw capacity building for the personnel of rural health centers on topics related to HIV/AIDS, malaria and childhood illnesses. While the organisation facilitated the logistical organisation of the trainings, it involved key stakeholders from the ministry of Health to carry out the training and then involved the newly trained staff in passing on the newly acquired information by facilitating workshops at the community level.

3. The involvement of the affected groups in project activities is essential to gain access to vulnerable groups. Peer education is often used and has proven to be particularly suited to reach vulnerable and marginalized groups such as sex workers, IDUs and MSM. Similarly, it is acknowledged that PLWHA are best suited for raising awareness of the dangers of HIV/AIDS. The involvement of religious leaders certainly contributes to increasing the acceptance of - and adaptation to - changing social norms and to the creation of supportive community networks, which are crucial when dealing with people living with HIV/AIDS. Training of trainers are a cost-efficient way for the information to trickle down from one group of beneficiaries to another.

4. The use of steering committees composed of representatives from key governmental agencies as well as national/international universities and research institutes and community representatives. Such committees have proven useful to influence the policy discourse especially in cases where the legal framework played against the interests of highly vulnerable groups.

5. The inclusion of a livelihood or income generating component will help reduce stigma and guarantee that the beneficiaries will be able to keep accessing services. IGAs are a key element in the chain linking access to treatment – improved health – increased capacity to work – reduced poverty – reduced stigma – increased access to education.

6. The creation of "One-Stop Services" (OSS) i.e. services where prevention and care strategies are integrated in the same location. In the case of HIV/AIDS, this means that voluntary counselling and testing (VCT), condom promotion and distribution, treatment of sexually transmitted infections or other opportunistic infections (OIs) and ARV are all taking place in the same health structure. In the case of malaria, this involves rapid diagnosis and immediate treatment of malaria and guarantees that cases are not lost after screening or left without treatment. One-Stop Services also offer child immunization and the opportunity to build awareness.

7. The provision of transportation to guarantee regular attendance in cases where treatment has to be followed.

8. The involvement of both the public and the private sector. In particular the involvement of pharmacies is recognized as being very useful.

9. The involvement of children both in and out of school. While numerous projects foresee prevention/education programs targeting children in school, a high percentage of boys and girls in

the region and at risk are out of school and it is crucial that strategies are put in place to reach out to them as well.

10. The use and sharing of additional management tools allowing progress to be tracked and to measure the rate of achievement against expected targets at any given time, leads to higher performance. Such an approach is particularly relevant in the health sector where most projects work with or through local implementing partners who tend to have a low capacity for data collection. In addition to the fact that such tools allow a unified approach, their use is also part of the capacity building process.

As for **target 6.C** - having halted by 2015 and begun to reverse the incidence of malaria and other major diseases – only two projects tackle the issue of malaria and both positively affect the evolution of targets 6.6, 6.7, 6.8. Approaches worth mentioning are:

1. Bringing different departments from the provincial to the local level to work together in a collaborative manner in order to significantly improve the surveillance system.

2. Awareness raising in schools involving practical activities instead of limiting it to a top down lecture-type approach. Children are taken out of the classroom on a regular basis to examine the evolution of breeding sites and use microscopes to test the water.

3. In addition to bed net distribution, spraying is also done at the community level, especially in the school and sites where religious services are carried out.

None of the projects examined for the current analysis works specifically on TB and this target will therefore not be examined here.

4. Success stories

Three projects are worth mentioning here. The first one is implemented by Medecins du Monde (MdM), addresses HIV/AIDS and, during the second ROM Mission, received "A" s for all five criteria i.e. overall score of 4. The second one is implemented by the Mahidol University (MU) and addresses malaria; its average score was 3.6. The last project is implemented by Concern, addresses HIV/AIDS and has an average score of 3.4.

4.1. Common success factors

While each of these projects has some particularities making it different from the others, all three of them share a few common points which clearly distinguish good projects from others. First of all, all three are praised for their long experience in the technical field they address as well as in the geographical area they work in. Local stakeholders acknowledge and appreciate this competence. Secondly, they all address highly vulnerable target groups and are very relevant in that they respond to clearly felt needs. MdM and Concern focus, amongst others, on IDUs, SWs, MSM, slum communities and PLWHAs while MU addresses the needs of illegal migrants. Thirdly, they all work on the basis of good quality logframes. Another common point is their capacity to contribute to capacity building in a way that stimulates and produces highly qualified local staff, supporting them in becoming leading authorities on the subject matter. Interestingly they are also all praised for their internal monitoring systems and for their capacity to collect good baseline data as well as to generate excellent evidence to expand activities and feed into the policy discourse. Thanks to their proven successes and despite the fact that their interventions would otherwise not be particularly financially sustainable, they manage to have access to additional funds allowing them to sustain their efforts in the future. Treatment is provided in all three cases and adherence rates are

impressive. The two projects undertaking dissemination activities involve people who have previously received assistance themselves, and the third one hires members from the communities it takes care of, to guarantee that communication is good. All three projects deliver more than expected and demonstrate good capacity to adapt to changing circumstances by refining their activities. They have a very good impact and significantly contribute to the achievement of MDG6. Constant coordination with other actors working in the sector is another common factor. MdM and Concern combine risk reduction with treatment and extend their assistance to improve the quality of life of PLWHAs. They empower vulnerable groups, giving them a voice and have a holistic approach taking into consideration sustainable social development.

4.2.Particularities

4.2.1. Medecins du Monde

In the project under review, ***Medecins du Monde*** manages to combine HIV awareness, education and prevention with harm reduction, home care, medical mobile teams and ART in prison. It proposes access to high quality HIV/AIDS and STI care as well as the treatment of OIs. The socio-psychological needs of the beneficiaries are also taken care of thanks to the creation of support groups and recreational activities. The project is embedded in already existing structures relying on the national health system for detoxification services while filling a gap in service provision by providing ART for PLWHA. Despite the fact that its approach to harm reduction goes against the standard approaches of the government, it gained the support of all stakeholders in that it was able to demonstrate success and therefore managed to positively influence institutions to transform their response to harm reduction. The impact achieved is in line with and extends beyond the MDG targets; besides the increased use of condoms and the reduction of HIV transmission rates, the project also allowed for an increase in the use of clean needles and the reduction ofantisocial and risky behavior associated with illegal drug use. One of the original aspects of the project is the fact that it managed to involve IDUs in the national drug users' networks, thereby giving them a voice they previously didn't have. Besides being an empowering experience, this also means that an informed voice is present in governance structures related to drug use. Finally, thanks to contacts with a variety of national and international organizations, MdM is making a difference atthe policy level, and this despite the fact that harm reduction still isn't culturally accepted or understood.

4.2.2. The Mahidol University

The ***Mahidol University*** project targets illegal migrant populations living outside of the refugee camps, a sort of "invisible" population not entitled to the health services available in the camps and not covered by local health services outside of the camps either. What makes it particular is that, despite the fact that:

- The action is not supported by any national or sector policy;
- The action is not embedded in local structures;
- The continuation of benefits requires continuous external funding;

the project manages to be sustainable. The key to this success is that the intervention is seen as indispensable and there is an actual felt need for it, both from the side of the institutions who tolerate the fact that assistance is being provided to illegal migrants, and from the side of the beneficiaries themselves. The results achieved are impressive so donors are willing to keep financing the initiative while at the same time, good relations with the Provincial Public Health Office compensate for a lack of supporting policy. The recognition of the value of MU's work by the local authorities has translated into a joint proposal between MU and the provincial health department to address the TB situation along the border, further proving the validity and

appreciation of the current intervention. This is also an indication that the achievements of MU may contribute to changing the views and attitudes of the local authorities towards a fragile population, which continues to face health challenges. Another particularity of the project is that it is the only one (of the 14 examined) that addresses the issue of transportation. It does so by sending a bus and a boat to collect female patients coming for weekly pre-natal care visits from distant villages and thereby manages to guarantee regular attendance and to reduce drop-outs. MU efficiently combines research and service delivery. The analysis of the data assists in decision-making and contributes to reactive, adaptive and innovative management. In terms of impact, both the number of malaria episodes in pregnant women per annum as well as the absolute number of malaria cases detected have significantly decreased. Within two years, the incidence rate of malaria for women came down to an average of 0.33 episodes against a target of 1.2 and a baseline of 2.2. The number of cases detected fell by 39% compared to the baseline and is below the Y2 target of 15,000. The ratio of Plasmodium Falciparum to Plasmodium Vivax infections is also falling: 0.2 PF for 1 .0 PV while the baseline was at 0.8 PF/1.0 PV and the Y2 target was 0.3 PF /1.0 PV.

4.2.3 Concern

Concern is one of the few organizations implementing a project with a 60 month timeframe. It opted for an integrated approach aiming at reducing risk and vulnerability to HIV infection while at the same time ensuring that the quality of life of those who live with HIV or are affected by it, is improved. The project aims to achieve this by facilitating the enrolment of PLHIV in a social security scheme granting them a small amount of money on a monthly basis and proposing small grants to PLHIV families in order to set up small livelihood generating activities. The creation of self-help groups complements this socio-economic approach. Concern has a TA package which supports both the CBOs it aims to strengthen as well as the local health system and is praised for being cost-effective. The organisation has been very successful in its initiative to change the attitudes of health care providers and more specifically of low paid staff such as ward boys and sweepers who now serve the beneficiaries without fear of being infected by HIV/AIDS. It is also praised for implementing different and relevant actions for different target groups. The project has a high impact in that it manages to contribute to reduce risk and vulnerability to HIV as well as reducing poverty through the empowerment of youths from rural, tribal and slum communities. The indicators selected are valid and a good system is in place to assess progress at different stages of the project. The timeframe of the project will allow data to be compared over time and to measure the extent to which behaviour change is occurring. Finally, it is felt that this project significantly increases the understanding of the stakeholders regarding the needs of the target groups.

5. Additional Recommendations

- Considering the importance of getting off to a good start, donors should work more proactively with the projects they select to support them in the production of meaningful logframes. Training sessions could be offered two or three times per year at a national level. Participants could be divided into groups according to their thematic background (health, environment, governance…). Health indicators could be discussed and common decisions taken regarding unified data collection. This would also represent a possibility for organizations to network and share experiences. Participating organisations should then be encouraged to share the newly acquired knowledge with their partner organizations. Ideally, by the end of the training each should have a proper logframe in hand.
- Donors should encourage implementing organizations to modify their intervention strategies during the inception period and beyond, when necessary. In effect, the conditions on the ground may have changed since the formulation of the project and this needs to be accounted for if the intervention is to remain relevant. Organisations are often fearful of modifying activities or approaches once their projects have been approved for financing, and are tempted to stick to the proposal to avoid potential problems with the donor. This is clearly counterproductive and shows that insufficient discussion is taking place between funding agencies and the organisations they support. Implementers often comment on the fact that they would appreciate if the donor would visit their project more often and advise them on ways forward. In the case of the EC, it is felt that the administrative procedure to modify logframes is too cumbersome and that delays in the procedure might hold back the implementation of project activities. The EC should consider how to facilitate this process.
- Monitoring and Evaluation (M&E) within organisations should be given more emphasis by donors and they should encourage organisations to develop and use M&E systems in all cases. Organisations should also be encouraged to see M&E as a learning tool to identify critically what works and what doesn't and to share this information. Considering that M&E is time-consuming and mobilizes significant resources (when done properly), donors should also allow organisations to have a proper budget line for these activities.
- Donors and key stakeholders should agree on a set of indicators to be used to inform on the progress made in the health sectors. The use of unified indicators would allow for the comparison of results, ease analysis and would provide an evidence-base to support the policy making process.
- Donors should encourage projects to be more realistic. Behaviour change is a time consuming process and two to three year projects are not long enough to achieve this goal. The same holds true for putting in place a functioning referral system. Five year timeframes should be favoured over 2-3 year projects.
- The project design should include reasonable phase-in and phase-out periods (minimum six months each). During phase-in, time should be foreseen for baseline data collection and the fine-tuning of OVIs while a progressive withdrawal by the implementing agency should take place during the phase-out. For prevention work, planning for change strategies could be reflected upon with the beneficiaries/stakeholders and management could be progressively taken over by local partners. It would be relevant to systematically ask projects to carry out a final baseline study to show if and what progress has been made.
- To be consistent with a result oriented approach, the EU reporting format should be modified since it currently focuses on activities. It should also include a section on challenges met and lessons learned.
- A policy component needs to complement activities done with marginalized groups in order to increase sustainability.
- Most countries under review cannot fully respond to the health needs of their populations who ultimately have to revert to the private sector. This sector should be involved as a stakeholder or beneficiary (recipient of trainings for instance) in health projects to create synergies.
- The involvement of medical schools and/or universities should be privileged in health projects.

Annexe 1: List of projects included in the study

Country	CRIS Reference	EX-post Ongoing	Title	Budget Million EUR	MR Number	Previous MR YEAR
CAMBODIA	133-823	Ongoing	Integrated approach to health promotion in highly vulnerable communities within Siem Reap Province	0,7	MR-131440.01	
CAMBODIA	100-443	Ex-post	Rural Cambodian Youth Sexual Reproductive Health (RCYSRH)	1,5	MR-020716.02	2007
CAMBODIA	105-225	Ongoing	Increasing Community Action on HIV/AIDS Prevention integrated with Care and Impact Mitigation Efforts	2,6	MR-111180.02	2008
MYANMAR	105-168	Ongoing	STI/HIV & AIDS prevention, care and support among sex workers and drug users in Yangon and Kachin States.	3,9	MR-114081.02	2008
INDONESIA	105-033	Ongoing	Theme II/Prevention, control and treatment of HIV/AIDS among intravenous drug users in West Java	3,0	MR-020665.03	2009
INDIA	159-184	Ongoing	Supporting the scale-up of HIV services for male-who-have-sex-with-males (MSM)	1,0	MR-133701.01	
INDIA	159-188	Ongoing	Strengthening Local Response to HIV and AIDS in Orissa	1,0	MR-133760.01	
SRI LANKA	127-274	Ongoing	Increasing sexual and reproductive health equity of displaced and uprooted people and their host communities in the North and Eastern regions of Sri Lanka	2,1	MR-122344.02	2009
NEPAL	133-554	Ongoing	Safe Passage: Making the mobility safe by reducing the vulnerability and impact of HIV and AIDS	0,7	MR-135602.01	
CAMBODIA	169-633	Ongoing	Addressing the Reproductive Health, HIV and Primary Health Care Needs of Cambodian Women and Influencing Related National	0,9	MR-136121.01	
INDONESIA	145-079	Ongoing	Implementing the National Strategic Plan for Avian Influenza (INSP-AI)	13,5	MR-120767.02	2009
THAILAND	164-106	Ongoing	Providing diagnosis, treatment and prevention measures against malaria and other infectious diseases in the uprooted Burmese population of Tak Province, Thailand	1,6	MR-127260.02	2009
THAILAND	166-070	Ongoing	Health Care Project for Uprooted People in Sop Moi District, Northern Thailand	0,7	MR-137943.01	
REGIONAL	121-000	Ongoing	Avian Influenza and Human Influenza Pandemic Preparedness in Asia	27,0	MR-138163.01	

Baby born in Baliki - Philippines

Village pharmacy – Cambodia

Free Clinic day – Mindanao - Philippines

Bibliography:

[1] The Millennium Development Goals Report 2010, United Nations, 2010.

[2] Millennium Development Goal 6 – Combat HIV/AIDS, malaria and other diseases, WHO, 20 February 2009 (http://www.who.int/hiv/topics/mdg/info/en/index.html)

[3] Future Policy Choices for the Health Sector in Asia, Walford & all, March 2006.

[4] Achieving the Health Millennium Development Goals in Asia and the Pacific. Policies and Actions within Health Systems and Beyond, Asia-Pacific MDG Study Series, UN ESCAP, 2007.

[5] Towards MDG 6: Progress and Challenges for HIV and AIDS, Geeta Sethi, November 2010.

[6] Millennium Development Goals Indicators. The official United Nations Site for the MDG indicators. http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm

[7] SE Asian Region Focuses on MDG6 - HIV/AIDS, Malaria and Tuberculosis, Aditi Bishnoi, Womens Feature Service, September 2010 (http://newsblaze.com/story/20100921111715iwfs.nb/topstory.html)

[8] Fact Sheet Millennium Development Goals: progress towards the health-related Millennium Development Goals, WHO Fact Sheet, May 2010

[9] Positive Prevention & The Sexual & Reproductive Rights of HIV Positive People. (http://www.icw.org/node/161)

[10] Achieving the Millennium Development Goals for Health: So far, progress is mixed – can we reach our targets?, Disease Control Priorities Project, February 2007.

[11] United Nations Special Session on HIV/AIDS, June 2001. (http://www.un.org/ga/aids/conference.html)