



THE WESTERN BALKANS REGIONAL PROGRAMME TO FIGHT HIV/AIDS

MID-TERM EVALUATION REPORT

*Implemented by Project HOPE Switzerland
With Financial support from
the Swedish International Development and Cooperation Agency (Sida)*

Prepared by: Lee-Nah Hsu

30th June 2005

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¹ A draft mid-term evaluation report was made available on 15th April 2005. This final report takes into account comments received from Sida and PH.

EXECUTIVE SUMMARY

The Western Balkans Regional Programme to fight HIV/AIDS was initiated with the support from Sida following an extensive field assessment.² The Programme was formally launched in January 2004 for a period of three years ending in 2006. The Programme design provides a unique opportunity to forge collaborative efforts between governments and non-governmental organizations (NGOs) and partnerships between the clinical, community care and support networks. The Programme covers Albania, the two entities of Bosnia and Herzegovina (BiH), Croatia, the United Nations administered Province of Kosovo, Republic of Macedonia, Serbia and Montenegro.

HIV/AIDS is not merely a health issue, but a social, economic and development challenge. Without addressing the booming HIV epidemics, particularly among the socially marginalized groups, efforts to promote democratic governance in countries of this region are not likely to succeed. Although Croatia, Macedonia and Serbia now receive GFATM grants, the other countries and Kosovo do not. Even with GFATM support for these three countries, the gaps currently being filled by the Programme are also addressing the gaps that are not filled by the GFATM. This is owing to the sufficient flexibility that has been built-in, during Programme implementation, to allow adjustment and avoid duplication of efforts.

In addition to this Programme, Sida is also supporting UNICEF in the region for HIV prevention among youth. However, UNICEF's mandate restricts its population coverage up to 18 years of age. Thus, UNICEF's programme, both current and the Phase II Sida support, does not provide the type of clinical and NGO care and support network linkages, as does this Programme.

Regional Perspective

The Western Balkans region has been through conflicts resulting in a large number of internally and externally displaced populations. In addition, there are increasing numbers of economic migrants, trafficking of drugs and people, lack of social protection and legal habitat of Roma populations. All these factors contribute to an HIV epidemiologic profile somewhat different from the rest of the world. Particularly, there is a wider age range of at-risk groups, namely from 15 upwards to 75. Several recently diagnosed AIDS cases in these countries and territories are in the age range of 45 to 75. This Programme not only complements that of UNICEF's and supplements it with combined clinical and community linkages, the Programme also fills a real gap that is not addressed by the mandate of UNICEF. The Programme staff also made special efforts to coordinate with UNICEF thus ensuring neither overlap nor duplication of activities between UNICEF and the Programme.

The current administrative division of countries in this region is, to some extent, artificial. Consequently, there are social linkages that influence behaviours, movement of people and drugs, and do not recognize borders or boundaries. These factors further enhance the intra-regional spread of the HIV epidemics. In addition, the small size of populations

² Henceforth, the Western Balkans Regional Programme to Fight HIV/AIDS will be referred to as the "Programme".

within each administrative division makes it necessary to pool resources or to bank-together in order to have a stronger voice (e.g. negotiating drug pricing). Consequently, to respond to HIV/AIDS in the Western Balkans region, one must address both national and regional dimensions to be effective. Sida should be commended for its vision and foresight in its decision to support regional HIV/AIDS responses.

Programme management

Although Fondation Project HOPE Switzerland was the official signatory to this Programme, Project HOPE USA has been managing this Programme for 2004 with limited input from the Switzerland office. There were disagreements in the management of the Programme between these two entities. The situation is now resolving. The management responsibility has been transferred to Project HOPE Switzerland beginning in January 2005.³ This external mid-term evaluation comes at the time of the management transfer between the two entities.

This evaluation covers the review of implementation based on the agreement signed between Sida and PH, the costs vs. results achieved to-date, the management and the implications of the change in management for the future of the Programme.

Coordination to avoid duplication

Overall, it is impressive to hear from the diverse partners of the PH team who have unanimously praised the PH team's professionalism in communication and keep them well-informed about the Programme. The partners to the Programme include: national Ministries of Health, particularly the infectious diseases branch; the national AIDS coordination office; the Principle Recipient of the GFATM in countries where GFATM funds have been granted; Sida country offices; the United Nations Theme Group on AIDS in each country; UNICEF country offices because of Sida's funding support; non-Sida supported UN agencies with HIV/AIDS project offices; and national and international NGOs. The evaluator was also able to interview a UNICEF office representative for every country covered by this Programme. Every UNICEF country office consulted has affirmed the close communication to avoid duplication of activities.

The United Nations Theme Groups in each country are also pleased with having PH on board as a partner in the country. The UN Theme Group and UN partners, particularly in Serbia and Montenegro, consider PH their key partner. The UN Theme Group chair in BiH commented that they wish the other NGOs (international and local) would have similar professionalism and transparent communications as that of the PH team. The government counterpart in the Ministry of Health Infectious Diseases Services and the national AIDS coordinator in each country considered the input, technical support and collaboration of the PH team as invaluable and filling a critical gap.

Several of the NGOs supported by the Trust Fund (TF) are initiating new frontiers: establishing VCCT services; forming PWHAs networks; forming IDU and MSM networks

³ Upon negotiating the transfer of management authority from Project HOPE USA to Fondation Project HOPE Switzerland, the Switzerland office initiated registration procedures to become a Switzerland NGO. Its registered new name is Fondation PH, Partnerships in Health, which will hereafter be abbreviated as PH.

and services; and introducing preventative HIV education to Roma communities. Such activities have not previously been done. Countries in this region, in many ways, lag behind most other countries in the world in terms of their responses to and understanding of HIV/AIDS. This is understandable as these countries are newly emerging from conflicts and the advances in HIV/AIDS responses have only just emerged in recent years. Good governance of HIV/AIDS responses (participation, transparency, efficiency, rule of law – in protection of human rights, etc.) and the creation of a regional network of both government experts and NGOs are two aspects being promoted by this Programme. The examples set by the Programme and the capabilities being built through the Programme could facilitate these countries in building a foundation towards achieving the Millennium Development Goals in the longer term.

Progress in implementation

The Programme has taken approximately five months to start, which is normal in establishing a new programme at a regional level. The Trust Fund component, however, exceeded expected implementation and exhausted all but 2% of the Fund. This is not only a reflection of the enthusiasm in implementation but also the gaps which the Fund is filling in the region. There is a critical need to mobilize additional Trust Fund support in order to maintain the momentum initiated by the Programme and continue filling the gaps identified by the Programme. The specific initiatives that require continued support pertain to: the new PWHAs networks in countries where there were few; the VCCT centres in places where there is a validated gap and demand; the Roma populations where the need is tremendous but the gaps are wide; and the Albanian side with large migrant populations.

The clinical training component of the Programme has been progressing slower than planned. However, the implementation has been of high quality and received positive feedback. The training activities provided through the Programme was timely as most of these countries are beginning to provide Anti-Retroviral Therapy (ART). However, in view of the small number of cases in most countries, with the exception of Serbia and Croatia, much of the clinical learning provided to date is not being utilized by those trained. The upcoming training of trainers (TOT) skills course will respond, to some extent, the additional training gaps identified. The primary health care providers (doctors and nurses) training, using a TOT approach, is aimed at filling a real gap presently unfilled. The major clinical service gaps in this region are: to engage and mobilize the support from the primary health care sector for early detection of HIV cases and supportive follow-up of AIDS patients; and to de-stigmatize and reduce discrimination in health care providers and the communities.

The Programme is filling a real need in this region and for each of the countries. The shift of management from Project HOPE USA to PH allows for closer supervision, responsive technical oversight and improved financial efficiency and accountability.

This evaluation provides recommendations on: strengthening the technical support and management of the NGO TF recipients to ensure quality and cost-effectiveness of activities and accountability of implementation; supporting the implementation of TOTs;

and Programme team management to ensure continued quality delivery of the Programme. Team management is particularly important in years two and three because this is the time where the NGOs need more technical input and capacity building. At this mid-point of the Programme, it is timely to shift Programme operation by placing an emphasis on a strategic vision for technical oversight, thus ensuring sustainable achievement of the objectives in quantity and in quality.

Of particular significance is the establishment of a Programme website (www.balkans-fight-hiv.org). This is being developed in consultation with country partners, is of high quality and functional as of April 2005. There is a fact sheet about the Programme and information on Programme activities. Plans are underway for continued enhancement of this website and capacity building of Programme staff for the website management.

With input from this mid-term evaluation, it would be timely for the Programme to develop its Programme-wide 2005/06 work plan. The work plan is to reflect the TF NGOs work plan, the clinical and trainer skills training, the preparations for the annual regional conference, the technical capacity building support and Programme monitoring. The annual work plan is a tool to facilitate a shared vision and clear milestones for the Programme team and their partners.

A summary matrix of what was planned vs. implemented, based on the Programme document, is in table 2. Annex I provides suggestions for management of NGO TF. In view of the greater demand than what is available from the TF to achieve the result intended, including scaling-up certain activities, there is a critical resource gap to be filled starting mid-2005 for selected NGOs.

I. BACKGROUND

Project HOPE (PH), with the support from the Swedish International Development Agency (Sida), conducted a seven-country and territory assessment in the Balkans from November 2002 to January 2003. The Western Balkans Regional HIV/AIDS Programme was designed based on the findings of this assessment. The Programme has received Sida funding with a total amount of 3,529,359 euro for a period of three years. The contract was signed in December 2003. The recruitment of Programme staff and initiation of activities began in January 2004. The Programme is for three years ending on the 30th of October 2006.

There are two components to the Programme:

1. *Prevention* – this component plans to strengthen the technical and managerial capacity of local non-governmental organizations (NGOs).
2. *Care and support* – this component plans to strengthen the capacities of infectious diseases specialists and the primary health care providers, both in terms of diagnosis and treatment, work place protection and in assuring the rights of people living with HIV/AIDS (PWA).

In addition, there is a NGO trust fund which will assist in building prevention, care and support networks.

The Programme covers Albania, the two entities of Bosnia and Herzegovina (BiH) and Republic of Srpska, Croatia, the United Nations administered Province of Kosovo, Republic of Macedonia, Serbia and Montenegro. The implementation structure consists of country programme coordinators (CPC), a NGO Trust Fund Manager (TFM), a clinical training coordinator and an IT specialist. They report to a region project manager.⁴ The administration is managed by the country directors based in Macedonia and BiH. These two directors are assisted by a finance officer and administrative assistant. The Programme will receive technical and administrative support from Project HOPE USA Regional Director for Europe, the Project HOPE Switzerland Director and from the Director of HIV/AIDS Programme of Project HOPE USA.

The Programme officially launched in January 2004. However, prior to the launching, Project HOPE USA went through a strategic change. The change resulted in the adoption of a corporate model which centralizes all management and technical functions at Project HOPE USA. As a result of this corporate centralization, conflicts arose between Project HOPE USA and Project HOPE Switzerland on the management of programmes funded through Project HOPE Switzerland. The conflict ended in the split between these two entities. Subsequently, the Board of Project HOPE Switzerland informed its donors of the split and decided to change its name and continue to implement its programmes. The split will become official around the 30th of June 2005.

⁴ The functional titles were based on the Project Document. Originally, this position was called Regional Programme Director. However, the title was change to “project manager”, thus this title will be used.

Between November 2004 and January 2005, there was little technical oversight from USA and the European Director. The Programme staff did not report to the Switzerland office because an agreed upon statement from Project HOPE USA was not issued to the field offices.⁵ The agreement later released by Project HOPE USA specified that the Programme be managed by Project HOPE Switzerland. This represents the change of management authority and technical oversight from Project HOPE USA to Project HOPE Switzerland.⁶

This mid-term evaluation reviews the progress of the Programme from January 2004 to February 2005. This evaluation takes into account the recent agreement by Project HOPE USA on the Programme management and technical oversight authorities and makes recommendations for Programme implementation in 2005-2006.

II. THE TERMS OF REFERENCE & METHODS OF MID-TERM EVALUATION

The following Terms of Reference and evaluation methods have been developed in consultation with and approved by Sida, Stockholm.

Methods

This evaluation started with a briefing with Sida, Stockholm on the 18th of March 2005, attended by the Director of Project HOPE Switzerland and the evaluator. The evaluation methods include desk review of records made available by PH, key informant interviews conducted by the evaluator with UN agencies, including UN Theme Group Chair, UNAIDS, UNDP, UNFPA, UNICEF; Sida country offices; health officials such as infectious diseases specialists dealing with AIDS treatment, National AIDS Coordinators and clinical trainers; and NGO training organization officials such as capacity building trainers, NGO representatives and beneficiaries who receive support from the Trust Fund.⁷ Site visits included NGO facilities, Roma communities, VCCT sites, IDU needle and syringe exchange and drop-in sites, ambulatory and in-patient facilities for PWHAs and laboratories where applicable.

The specific **Terms of Reference** are listed below:

A. Desk review to identify strengths and gaps to be filled in order to facilitate the achievement of the Programme objectives

1. Review annual work plan, especially 2005 work plan, 2004 half-year and Year One Progress Report, personnel and job descriptions, samples of monthly progress reports from the participating countries, travel reports

⁵ Project HOPE USA's Regional Director for Europe informed the evaluator that she had been progressively inactive since October 2004 due to the difficult situation she had been caught in during the peak of the conflicts.

⁶ Although the Project Document signed by Project HOPE and Sida indicated that Project HOPE Switzerland is the implementing agency for the Programme, the actual implementation arrangement had not been supported by Project HOPE USA until the issuance of such an agreed statement.

⁷ The evaluator made a special effort to ensure that every UNICEF country office HIV focal point and its sub-regional HIV project officer were consulted during this evaluation. This is in view of Sida's support of UNICEF on a regional HIV project and a second phase support from Sida for 2005-2007 to UNICEF.

and related financial and expense reports by Programme staff and profiles of consultants.

2. Review available publicity materials generated by the Programme, the NGO Trust Fund records, including proposals submitted and funded, communications and tracking records and the clinical records, including training materials produced.

B. On site assessment

1. In-country/territory visits to interview Programme staff, government counter-part representatives, staff of organizations the Programme is collaborating with and NGOs who received the Trust Fund.
2. Site visits to assess the facilities, both clinical and NGO, where services are being provided with Programme support, including review of record systems and operations pertaining to the Trust Fund activities.

This evaluation report includes findings on the costs vs. results of Programme activities in relation to its fund allocation and expenditures; any deviation of objectives, activities and outputs from original Programme Document, the alternative approaches adopted if any and rationale provided by the Programme staff for modifications; as well as recommendations for the results-oriented future direction of the Programme.

III. FINDINGS

The findings highlight comparisons between what was proposed/planned for the Programme and what has been implemented to-date. It consists of the following components:

1. Regional perspective
2. Planned vs. implemented activities from January 2004 to February 2005
3. Programme structure and management oversight

A. Regional perspective

The HIV/AIDS situation in the Western Balkans region has been rapidly changing since the Programme's inception. Sida has agreed with PH to allow flexibility in the Programme's implementation. The flexibility of the Programme has been one of its strengths. By being flexible, the Programme team avoids duplication with other activities in the countries and region, while maximizing opportunities to achieve Programme objectives.

HIV/AIDS is not merely a health issue, but a social, economic and development challenge. Without addressing the booming HIV epidemic, particularly among the socially marginalized groups, efforts to promote democratic governance in countries of this region are not likely to succeed. Although Croatia, Macedonia and Serbia now receive the benefit of GFATM support, the other countries and Kosovo do not. Even with GFATM support for the three countries, the gaps currently being filled by the

Programme in the three recipient countries are not being met by the GFATM. This is because, on one hand, the needs are too large to be fulfilled and, on the other hand, sufficient flexibility was built-in, during Programme implementation, to allow for adjustments in order to avoid duplication of efforts.

Is there a need for a regional programme on HIV/AIDS? The answer is yes, particularly so in the Western Balkans region. Although there is a necessity for national level programme, to ensure national goals in containing HIV/AIDS can be achieved, it is critical to ensure the existence and networks for regional responses for HIV for the reasons described below.

The current administrative division of countries in this region is, to some extent, artificial. Consequently, there are social linkages that influence behaviours, movement of people and drugs, and do not recognize borders or boundaries. These factors further enhance the intra-regional spread of the HIV epidemics. In addition, the small size of populations within each administrative division makes it necessary to pool resources or to band-together in order to have a stronger voice (e.g. negotiating drug pricing). Consequently, to respond to HIV/AIDS in the Western Balkans region, one must address both national and regional dimensions to be effective. Sida should be commended for its vision and foresight in its decision to support regional HIV/AIDS responses.

There are similarities and differences in AIDS prevalence among the countries covered by the Programme. The inter-connectedness of people in these countries, the increasing mobility of people between countries (both formal and informal), the small number of officially identified AIDS cases, make it necessary to address HIV epidemics both at country and at regional levels. Furthermore, HIV is not known to respect administrative and political borders. The regional networks of IDUs, MSMs, CSWs, migrant workers, including seafarers, and the Roma populations do not stop at administrative borders. In view of the historic and recent conflicts, many families can still be found on both sides of administrative/political borders.

The known HIV prevalence for some countries is low, but in some other countries within the same region, the prevalence is high. This situation is particularly relevant for regional actions. On the one hand, it allows for preventive efforts. On the other, it would require collaboration to reach economies of scale (e.g. negotiating for drug pricing or pooling technical knowledge and resources). One of the key contributions of this Programme has been its ability to utilize regional resources, coupled with international expertise to strengthen capacity. Regional examples, in many instances, are relevant and can inspire start-up NGOs or self-help groups.

As has been demonstrated in other regions, the low prevalence countries in this region are particularly vulnerable. The fact that there are higher prevalence countries neighbouring these lower prevalence countries is a potential time-bomb waiting to explode. It would not be the case if all the countries in the region enjoy similar low prevalence rates with little interaction among their populations and few economic and social connections.

Without a strengthened regional network of responses, even if a particular country has a strong national response, it would not be able to contain its HIV epidemics. There is a large movement of population between and within the countries of this region. As experiences in Africa, Asia and Central Asian Republics have amply demonstrated, there is a need for a regional network of HIV responses to complement national efforts. This recognition has resulted in recent initiatives by several key bilateral donors to begin supporting regional HIV programmes. Sida should be recognized for its foresight in initiating this regional HIV programme in the Western Balkans at this critical stage of the epidemic. Now is the window of opportunity where a combined prevention, care and support approach regionally, coupled with strengthened national responses, might dampen progression of the epidemics.

The Programme took approximately five months to start. This is normal compared to other HIV/AIDS regional programmes. Most new programmes take a minimum of six months to establish. The challenge is bigger when one is dealing with a sensitive issue of HIV/AIDS in a region that has not previously confronted it. In addition, this regional programme involves several countries, different sectors and partners. Some of these countries were previously hostile to each other. Furthermore, to ensure complementary activities and avoiding duplication, this Programme made special efforts, more than any other known programmes, to consult key players in each country covered.

In 2005, regional synergies anticipated by the Programme are beginning to take shape. This is a positive development. In a regional programme, one has to first establish the country bases in order to start a regional network. In some pseudo regional programmes, it was actually a collection of discrete country-by-country activities without true regional linkages. This has not been the case for this Programme. It is important to note that the regional trainings facilitate building professional networks of HIV practitioners. It also provides an opportunity to share lessons learned thus reducing the frustration of starting things from ground zero.

The cross-sharing of experiences is particularly relevant for those NGOs who start new initiatives such as VCCT, PWHA networks, MSM groups and IDU support services and for clinicians who start to provide ARTs. For example, where there was an unexpected shortage of medicine, clinicians began to network among themselves through the Programme training activities. As a result, one concerned clinician was able to contact his counter-part in a neighbouring country to obtain needed treatment drugs to cover the gap while waiting for the in-country procurement bidding results.

Another example is the PWHA network building through the Programme. In BiH, a new PWHA network is being set-up. An established Croatian PWHA network not only provided their experience, but also helped to link the new network to the international network and information. Similar examples relate to outreach and support to IDUs. These are some tangible results of the Programme's regional work.

There is also potential for the Programme staff to facilitate the sharing of tools, preventive materials and information. Among the seventeen NGOs receiving the TF, several are developing similar type of services. Many are developing assessment

instruments and information materials. There is a potential for exchange and sharing of such materials and information within the clinical and with the NGO sectors. There is also the potential for sharing between the clinicians and NGOs. The Programme is in a good position to pool and review such resources. These regional and country level sharing opportunities are being facilitated by this Programme. The sharing applies beyond the direct beneficiaries of the Programme and includes sharing with partners. For example, UNDP in Serbia has developed a guide for dentists. This material could be used as one of the resource materials for the TOT for primary care providers when including dentists.

B. Planned vs. implemented activities

This section refers to the period of January 2004 – February 2005. The Programme did not have a 2004 annual work plan. The 2005 work plan is currently available only on selected activities and does not cover the whole Programme. It will be developed based on the recommendations of this mid-term review. The evaluator reviewed the September 2004 mid-year and February 2005 Year One Progress Reports. There are monthly progress reports submitted by each country office. The country monthly reports are then combined into a Programme monthly progress report. However, no reports are available regarding the travel of the Programme staff. Although some mention was made in the monthly progress report, it would be beneficial to have a record of each visit/event for knowledge base and accountability of staff movements. The Programme keeps financial reports both in the country offices and in the Macedonia regional office. NGO financial reports are reviewed monthly by the finance officer.

Part of the monthly progress reports are based on inputs by NGOs. Among the NGOs funded, there are variations in the quality of record keeping and reporting. Some NGOs keep good activity records. Others keep sketchy records. Yet others who began to receive TF since January 2005 are in the process of setting up their activity records. A few NGOs have work plans. Most NGOs receive TF for 12 months or less. Where NGO work plans were unavailable, the evaluator used the planned activities provided in the NGO proposal as the basis of review.

Table 2, compiled using information from the Project Document, provides a summary of the findings of planned vs. implemented activities for the prevention and care and support components of the Programme. Implementation by each NGO and suggestions are summarized in Annex I.

Clinical training portion of the care and support component

The implementation of this component has been delayed. However, the activities implemented to-date have followed the logical steps designed for this Programme thus ensuring its quality delivery. First needs assessments were conducted on the clinicians, laboratories, as well as on ARV treatment access. Based on the findings of these assessments, one regional course for infectious disease specialists on ARV treatment was conducted in October 2004 with regional and international faculty. A follow-up practicum began in both Zagreb and Belgrade where there are sufficient volume of cases. The practicum allows the selected clinicians to gain hands-on experience under the

supervision of experienced senior trainers. To ensure quality training and hands-on access to patients, each session could accommodate only one or two clinicians. The practical training began immediately after the theoretical course and is still on-going. All trainees found the practicum extremely relevant to their work. This is particularly true for those from countries with a small number of active clinical cases at present. This follow-up practicum enhances the clinician's application of the knowledge gained from the theoretical training in October.

Most of the countries already began developing their clinical protocol with the support of WHO. The Programme thus dropped this activity to avoid duplicative efforts. Other training activities were taken on by the Programme, although not initially planned. For example, the Programme provided training to clinicians on second generation surveillance when WHO, in collaboration with the School of Public Health in Croatia, offered this course in 2004. At the request of the BiH government, the Programme also supported training in VCT for doctors who will manage government VCT sites. This reflects the flexibility of the Programme to maximize additional opportunities to fulfill its capacity building mandate.

For the primary health care (PHC) sector, a needs assessment is being conducted in April 2005 in BiH and Kosovo with dentists, family practice physicians, nurses and gynaecologists to provide input to the design of the TOT course. This TOT course will be designed based on PH's extensive experience of TOT courses for physicians and nurses. This new TOT aims at training PHC providers and infectious disease specialists, so they are capable of training providers at the primary care level. It will take advantage of the professional continuing education structures available in BiH and Kosovo. The first TOT training is planned to start in September 2005 in both BiH and Kosovo. These two countries have family medicine retraining programmes with an existing network of trainer with training skills. Additional countries will begin their TOT in the second half of 2005 based on the results of the first TOT training.

The Prevention component

The prevention component pertains mainly to the NGO Trust Fund. Despite the delayed start up of this component, all but 2% of the Trust Fund has been allocated as of December 2004 to seventeen NGOs. With exception of one or two, the rest of these NGOs will conclude their efforts by December 2005. There are significant deviations in the implementation of this NGO Trust Fund part of the Programme. The absence of an annual work plan for 2004 made it difficult to ascertain the decision process for the changes.

NGO assessments were carried out in BiH, Serbia and Macedonia in late 2004, half-way after the NGOs in these countries had been selected and began their TF supported activities. Instead of a staggered implementation of TF for the countries as specified in the proposal, the countries were put into two groups. The first group consisted of BiH, Serbia and Macedonia where PH had country offices at the time. Each country received only one round of TF. According to the TF manager, she was instructed by PH USA through the Regional Director for Europe to hasten the implementation of TF. The second group consisted of the remaining countries/territory covered by the Programme

With respect to NGO technical and managerial capacity-building, regional trainings in human resource management and financial management were conducted in Macedonia and Serbia in February 2005. This is done four months prior to the end of the currently supported NGO activities in these two countries. An IDU management training was provided by HOPS, a Macedonia NGO, to NGOs working with IDUs in Bosnia and Kosovo, which is an example of regional sharing.

TF grant review process

An announcement was advertised in the participating countries for the first round of TF solicitation. However, the TF manager later decided to only grant TF to three countries in the first round even though all had submitted a total of 222 proposals. According to the TF manager, the decision was made by her based on the presence of PH country offices as of June 2004, the quality of proposals and convenience to begin the process. Consequently, despite the large number of submissions, only those from BiH, Macedonia and Serbia were reviewed. The rest of the countries were informed to resubmit when the second round was announced. Based on discussions with the National HIV Coordinator and Sida, Croatia was excluded from both rounds in view of its receipt of GFATM support and the small number of submissions.

The proposals submitted were first internally screened by the TF manager in consultation with each country's programme coordinator, where applicable. The screening criteria were the priority populations being considered for the Programme (IDU, PWHA, Roma and other marginalized groups) and the quality of the proposal. Independent of the total number of submissions, approximately six proposals from each country were available for the Country Steering Committee review.⁸ The composition of the Steering Committee was sound. They included the National AIDS Coordinator, the UN Theme Group or UNICEF representative or UNAIDS and the key infectious disease specialist in the country dealing with HIV/AIDS. In addition, the TF manager and the CPC served as the Secretariat.

The announcement for the second round of TF was issued only in Kosovo, Montenegro and Albania with a total of 50 submissions received. Table 1 shows the number of proposals received from each country and the number accepted for TF support.⁹

No notes on the decision process for the initial screening. However, standard review criteria were followed by each Steering Committee reviewer for the proposals selected by the TF manager to be reviewed for the first round of three countries. In the second round of three countries (Albania, Kosovo and Montenegro), the standard review criteria had been abandoned. The justification given by the TF manager for not following standard criteria was the need for discussions. This justification is weak. The purpose of a face-to-face committee meeting to select proposals is to allow for Committee member discussions. There is no reason a standard set of criteria cannot be used while supplemented by further deliberations by the Committee. This short-cut to the

⁸ The name "Steering Committee" has subsequently been changed by the TF manager to be called "Advisory Board".

⁹ Some of the data and information were kept by the TF manager and not available in the official Programme records.

established governance procedure and lack of clear record of deliberations for reaching the final decisions make the process vulnerable to potential criticisms. The proposal review process took less than one month for each group of countries.

Table 1. Summary of NGO proposal selection¹⁰

Country	First round of review			Second round of review		
	<i>Received</i>	<i>Committee reviewed</i>	<i>Funded</i>	<i>Received</i>	<i>Committee reviewed</i>	<i>Funded</i>
Albania	9	0	0	21	8	4
BiH	43	5	3	--	--	--
Croatia	3	0	0	--	--	--
Kosovo	25	0	0	21	6	3
Macedonia	87	5	3	--	--	--
Serbia and Montenegro	55	6	2	8	4	2

Fund allocation

The total amount (266,836 euro) granted to NGOs in the second round of smaller countries with less HIV prevalence is larger than the amount (237,402 euro) granted to larger countries with more concentrated epidemics in the first round. However, both Macedonia and Serbia from the first round, received GFATM support for NGOs. In addition, Sida specifically indicated to PH that Albania is a priority country. These factors influenced the allocation considerations.

A total of 533,333 euro was available for the TF. It represents over 50% of the Programme activity budget, excluding personnel and operations costs. A total of 504,238 euro had been granted to seventeen NGOs as of December 2004. Over half of which had been spent in 2004. There is only 2% or less than 10,000 euro left for the remainder of the Programme. Many NGOs received more funds than the advertised ceilings of 30,000 euro for activities of 12 months or less. The TF grants ranged from 17,320 euro for one NGO for 14 months to 43,938 euro for one NGO for 12 months. Four NGOs received around 20,000 euros for 12 months activities whereas six NGOs received nearly 30,000 or more euros for 11 to 13 months of activities. Four NGOs received approximately 40,000 or more euros for about 12 months. Half (seven out of 16) of the NGO activities funded would conclude by June 2005, the remainder, by December 2005 or January 2006. Comments on costs vs. results and details of allocation for each NGO by country are provided in Annex I.

Five of the NGOs are dealing with outreach to Roma populations, six on VCCT, six with IDUs, three with MSM and four with PWHAs. Some NGOs deal with more than one target population. Most of the NGOs selected are reputable. Nevertheless, most are entering new grounds, such as establishing VCCT centres, PWHA and MSM networks, IDU support groups and outreach to CSWs and Roma populations. These are critical gaps identified for these countries and this region. For example, one NGO's IDU network is the first in the country, another is about to establish the very first VCCT for

¹⁰ The exact number of proposals for Steering Committee review ranged from 4 to 6 with Albania having 8.

Montenegro and, yet another, will be establishing the first PWHA network in BiH. The exhaustion of TF in just two rounds reflects the big gap to be filled in this region.

In view of the new area of function by most of these NGOs, there is a need for technical capacity strengthening among the well-selected NGOs. The area of technical capacity building relates to: VCCT services; how to find potential linkages and formulate true, not pseudo, PWHA networks; IDU peer support and services; outreach to MSM and CSWs; establishing meaningful linkages with Roma communities that builds the capacities of Roma populations; and continuing service/care/support for migrants and the sustainability of NGO operations. PH will begin to address these identified technical gaps through NGO capacity building, regional networking and liaising with clinical support. Others are new areas to be covered requiring further resources for needs assessment, design of feasible and practical responses while providing technical advice from PH to the NGOs.

Eight of the NGOs are well-established and have funding support from other sources to continue their services. Some have now been utilized by PH as regional resources for the other NGOs. PH in 2005 will facilitate such NGO networking, starting from within the countries with these existing NGOs and expanding to the regional network of VCCT, PWHA, IDU, MSM, etc.

TF implementation and coordination with other components of the Programme

The Programme is designed to have a parallel combination of NGO and clinical activities. This design creates a critical synergy for building a continuum of HIV/AIDS prevention, care and support network between the clinical and community sectors. Such synergy had not been explored in 2004.

Two NGO capacity building trainings were held in February to March 2005 while half (seven out of 16) NGO activities are finishing within six months after such training.¹¹ The lack of logical progression from assessment, to selection, to parallel capacity building for implementation of NGO activities reduced the potential strength of this Programme. However, this situation can be remedied in 2005 and 2006 if additional resources can be mobilized. Most of the established NGOs in the countries still need technical capacity building in HIV/AIDS prevention, care and support. Furthermore, to have real impact, particularly in the critical area of IDU services, PWHA network and VCCT services, these initial efforts must be supported to scale. In view of the large gaps yet to be filled in NGO responses and capacities, it is necessary to review the existing PH resources to extend the coverage of several critical NGO activities currently supported by the TF. It is also necessary to find additional resources to continue supporting these critical services in 2006 thus facilitating their potential sustainability.

¹¹ This is one NGO grant which proposes to start in June 2005 for only four months.

CARE AND SUPPORT COMPONENT																			
Purpose	Objectives	Expected results	Actual results	15 months of activities (planned vs. implemented)															
				2004												2005			
				1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	
<ul style="list-style-type: none"> Strengthen health sector's ability to diagnose, care and support through specialists training, linking clinical services to NGO community support and in-clinic social referral system 	<ul style="list-style-type: none"> Promote a consistent and cost-effective approach to care and support of PWHAs Enhance clinical skills of infectious disease specialists in diagnosis of HIV and treatment of AIDS and OI. 	<ul style="list-style-type: none"> National treatment protocols in use in each country at end of project Trained HIV specialists/country Curriculum developed 1st regional training (5days) Training report with lessons learned Training f/u practicum 	Hire clinical coordinator																
			Specialist training needs assessment																
			ARV treatment access assessment																
			Lab needs assessment + report																
			One regional course in October 2004																
			Practicum in Serbia and Croatia																
<ul style="list-style-type: none"> Strengthen primary health care providers ability to recognize warning signs, referral to specialists, participate in care without fear and discrimination 	<ul style="list-style-type: none"> Support the establishment of multidisciplinary approaches to HIV area and support through training of health personnel Infection prevention & workplace safety system to reduce risk of transmission Improve primary health care providers knowledge & ability in early diagnosis, transmission and basic clinical 	<ul style="list-style-type: none"> Curriculum 2nd level developed 2nd level training course (5 days) Select fellows and partner institutes Fellowships Primary provider trainers with a TOT course can implement as trainers HIV course for peers/country 1-2+ provider courses for 40-50 participant/country on HIV infection, 	Seek political agreement on assessment																
			General assessment started in April																
			The following will be implemented in 2005																
			Select/develop appropriate course material																
			Course 1 (1 week or combination with Family Medicine)																
			Follow-up (1wk)																

	<p>management & HIV specialist referral</p> <ul style="list-style-type: none"> • Assure rights of PWHAs through education to reduce stigma & discrimination among primary and tertiary care providers • Improve care and support network of PWHAs 	<p>control, stigma and patients rights</p> <ul style="list-style-type: none"> • Plan for provider training developed and submit to health authorities 	<p>TOT training (1wk)</p> <p>Course II (1wk)</p> <p>Follow-up (1 wk)</p> <p>Course III (1wk)</p> <p>Material developed for providers</p> <p>Add 3 more countries with plan in year 2</p>																			
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- National working group to develop clinical protocol: countries are developing protocols with WHO thus not to duplicate work. PH dropped this item.

C. Programme staffing structure and management oversight

Programme staffing structure

Croatia has received the GFATM grant. Croatia has existing expertise and experience in both the Ministry of Health and in the NGO sector for HIV prevention and AIDS treatment/care and support. PH, in consultation with Sida, has agreed not to establish an office and staff in this country to avoid duplicative efforts. However, the expertise and experience from Croatia is valuable to the rest of the Western Balkans region. PH is utilizing such regional resources in implementing the Programme. Table 3 shows the original vs. current staffing structure.

Table 3. Planned vs. current staffing structure¹²

STAFFING STRUCTURE							
European regional director							
Country director (BiH) Yes		Project manager ¹³ (vacant, being recruited)			Country director (Macedonia) Yes		
Trust fund/NGO manager (since May 2004)			HIS specialist (since October 2004)		Clinical coordinator (May to August 2004) Left due to health reasons		
	Albania	BiH	Croatia	Kosovo	Macedonia	Montenegro	Serbia
Country director	X	See above		X	See above		X
Country programme coordinator	Y	Y	X	Y	Yes	X	Yes
Administrative/finance	X	Yes		X	Yes		

X = planned but abolished; Y = new; Yes = as planned and filled.

Project manager (PM)

The post is currently under recruitment. Project HOPE USA began recruitment but never completed its offer to the finalist. The Switzerland office, once given the authority, reopened the recruitment in November 2004. Currently, there are two finalists under consideration.

Key issues regarding staffing structure are: absence of a project manager; subsequent absence of a clinical coordinator; slow response in getting technical and administrative inputs from Project HOPE USA; abdication of responsibility regarding technical and administrative decisions from the European Regional Director to junior staff; and absence of information flow to the Switzerland office up until December 2004. The European Director appointed the TF manager to be “deputy project manager” with salary increase.

Clinical coordinator

A clinical coordinator was hired from May to July 2004. The person left due to health reasons. The Programme was implemented at the time WHO launched its 3X5 initiative.

¹² Refer to page 36 of the Project Document.

¹³ The role of Programme director is now commonly called “project manager” within the Programme. Therefore, the term “project manager” will be used from henceforth to reduce confusion in terminologies.

Many countries with the availability of funds for ART began recruiting ART specialists. The total global availability of well-trained and qualified ART specialists is few. Due to the rapidly changing technical knowledge in ART, most specialists would prefer to be affiliated with an active treatment centre. These issues hampered recruitment for the post. The function has been partially covered by the Macedonia office. The vacancy resulted in delay of the Training of Trainers (TOT) courses. The course planning and preparations are now on track.

Country director

Only BiH and Macedonia retains the country director posts.¹⁴ This reflects an adjustment of staffing taking into account the pre-existing PH country office staffing by cost-sharing with other projects. This results in an efficient management structure for the Programme.

Country programme coordinators

The Croatia post has been abolished. The country programme coordinator (CPC) positions have been filled for the other countries. The programme coordination for Montenegro is covered by the CPC for Serbia. Considering the cost of establishing an office and hiring a full-time staff, the volume of work and the Programme already half-way in its implementation, it is not cost-effective at this stage to have a full time CPC in Montenegro.

Please refer to Section IV on recommendations for project staffing structure.

Management oversight

The conflict between Project HOPE US and the Switzerland office is common. Today, most international NGOs are decentralizing. Decentralization ensures flexibility in response and being closer to the people where the action is taking place. The current solution where the Switzerland office assumes full management oversight for the Programme is consistent with the international standard for good NGO governance. This, however, does not prevent these two entities to continue collaborating and to maximize the potential synergy and sharing of technical and management resources under a local governance concept. However, such collaboration should be based on mutual support and partnership which enables the local NGO offices to fulfill the agreed upon performance to the donors.

The USA office contributed to clinical input and provided highly technical and state-of-the-art information in the infectious diseases theoretical training. During the USA office's management in 2004, decision on field staff recruitment were delegated to junior staff of the regional programme office, whereas contracting of international staff was centralized in the USA office.

In the short time since the switch of management to the Switzerland office, many changes are already visible. Communication between country staff and the Switzerland office has now been established. An accountability structure is taking shape. There is technical

¹⁴ The country programme managers are now called "country directors". Henceforth the title country director (CD) will be used to reduce confusion.

review and oversight process for Programme implementation (e.g review of assessment instruments, staff report and feedback). Such technical backstopping enables the country staff to provide improved quality in technical support to their partners.

IV. CONCLUSIONS & RECOMMENDATIONS

A. Conclusions

The Programme start-up took approximately five months which is within the normal range of starting up a new regional programme. Unfortunately, a dispute between the USA and Switzerland offices hampered the Programme in terms of staffing and technical inputs in 2004. With the agreement reached, the Switzerland office took over the Programme management in January 2005. The technical and administrative processes are being strengthened by the Switzerland office. The financial reporting is now streamlined resulting in a consistent accountability between country offices and the Switzerland office. Since 2005, technical inputs are being provided to ensure quality of tools for assessment, improvements in monitoring, accountability of staff performance and administrative oversight. Such clarity is timely as 2005 is an important time to support the NGOs and the clinical networks.

The exhaustion of the NGO TF points out the existing gap in the region for NGO support. Good initiatives have begun by several selected NGOs. These important efforts must be continuously nurtured in the next three years to ensure they become sustainable and to facilitate scaling-up. These areas include NGO operated VCCTs, PWHA networks, MSM networks, IDU support groups and Roma community access to services.

Additional identified gaps include that of a continuum of prevention-care-support for migrants in the region. For example, there is a large Albanian migrant population, including seafarers, that moves in and out of the country. They are highly vulnerable to HIV. Some acquired the infection from abroad. They might receive treatment in the host countries. It is important to ensure that they will not be lost in treatment follow-up when returning home. It would require an appropriate assessment, design of suitable responses and resources to build capacities of government and NGOs in response to this gap. Although migrants have been identified in most of these country's national strategy for AIDS as a priority vulnerable population, none had included them in their GFATM proposals.

This Programme has been praised unanimously by all partners (i.e. governmental, UN and NGOs) as the most responsive and professional partner in the region. There are still gaps in clinical and NGO sector capacities. The regional dimension of responses is crucial in this stage of the HIV epidemics. In view of the lag time for GFATM support to fill some of the gaps, this Programme has played a significant role and is very much in demand. In addition, the Serbia experience has shown that even with GFATM support, the Programme is still covering a critical gap. The GFATM PR informed the evaluator that they are incapable of fulfilling some of the gaps. This is particularly so in NGO

capacity strengthening, primary-care provider stigma/discrimination reduction and the development of networks to ensure prevention, care and support from the clinic back to the communities in the next five years.

B. Recommendations

The following recommendations are made taking into account the current HIV/AIDS situation in the countries and territories covered, the NGOs being funded, the other actors in the region working on HIV/AIDS-related programmes, as well as the capacity of the PH team.

The recommendations for each area are further divided into two categories:

1. Suggested future directions for the Programme
2. Additional need for resources identified which ideally should begin to be filled during this Phase of the Programme

1. Regional perspective

Suggestions for the Programme

The Programme should make an effort in collecting and sharing of tools, IEC materials, particularly language versions of materials currently being developed or used by the NGOs. This includes proposed Briar versions of materials for the blind. The new Programme website launched in April can be one of the places for dissemination. It is also relevant for the Programme to have a central portfolio of all available materials in hard copies for those who do not have access to the web. This is not limited to those developed through the Programme, but should also include relevant ones from the region as well as from beyond. It would require the Programme staff and consultants to review and coordinate thus ensuring dissemination of relevant resources to people who need them, particularly among the NGOs. This applies also to the trainers, trainees and the training course materials.

Requiring additional resources/funding

Improve laboratory capacity and training of laboratory staff. Based on the findings from the laboratory needs assessment, to ensure appropriate support for VCCT confirmatory tests, ART treatment monitoring and diagnosis of OIs and treatment monitoring, it is critical that improvements are made regarding laboratory equipment, personnel training (both in laboratory procedures and workplace infection prevention) and laboratory protocol (including protection of confidentiality). These gaps should be filled as part of the overall package of improving HIV/AIDS prevention, care and support.

2. Prevention component including the TF

Most of the activities supported by the TF are filling a real gap in these countries. The exhaustion of TF at this early stage of Programme reflects the fact that the actual needs of NGO support exceeded the current allocation of TF. This is particularly true for countries where there is no GFATM support. It is also a reflection of the initiatives that

address the most vulnerable groups previously marginalized and not covered by other existing services.

Suggestions for the Programme

- a. Provide technical capacity building, particularly in the following areas:
 - To establish VCCT quality standards, including procedures, ethics, training and quality assurance of counsellors and staff. NGO operated VCCTs have the advantage of being close to the community. It is, however, critical to ensure quality standards to avoid unnecessary difficulties.
 - To create an enabling environment for PWHA networks, preferably through the PWHAs themselves.
- b. 2005-2006 regional conference(s)
 - Utilize lessons learned, findings and outputs from TF supported NGO activities. This can be an opportunity to show-case good practice examples of NGO-clinical partnerships.
- c. Discontinue NGO assessments
 - The current TF has already been spent and most NGO supported activities end in 2005. Among the NGOs selected, their needs and capacity have been identified through their selection, monthly monitoring and this review. Should future funding support for NGO become available, more in-depth technical capacity assessments could be conducted for potential new NGOs to be considered for funding support.

Requiring additional resources/funding

- a. PH to urgently review existing Programme budget to shift some resources in order to support new and worthy initiatives. Furthermore, if additional support is not available, to use current resources to continue to support projects where TF funds will expire in June 2005.
- b. Explore with Sida for possible replenishment of the TF for 2006 to continue a selection of worthy and cost-effective NGO initiatives currently supported by the TF but ending by December 2005 (unless additional support becomes available). These NGO activities are mainly on VCCT, PWHA networks, Roma community support and, to a lesser extent, IDU and MSM.
- c. New gaps identified and technical and capacity building for NGOs needed in the following:
 - To increase technical support to respond to migrants for continuity of services (prevention to treatment, care and support) between home country and host countries. This is critical to prevent potential drug resistance from developing, should these people discontinue their treatment.
 - To strengthen collaborative partnerships between Roma community and primary health care providers in HIV prevention.

3. Care and support component

Suggestions for the Programme

a. Theoretical training in ARV Therapy

- Most young infectious disease clinicians trained in October 2004 have not utilized their learning. This is due partly to the slow case detection based on a passive surveillance system and partly, the small number of cases currently detected. In view of the rapidly changing technology and knowledge-base of ARV, the second round of ARV training should be postponed until 2006 to capture the new knowledge being developed and for clinicians to have adequate basic case volume to remain competent in their practice.

b. Practical training

- For those who have already received theoretical training, emphasis should be placed on ensuring sufficient practical training during 2005.

c. Primary health care providers training

- This is a real gap being filled by PH in all countries covered including Croatia. It is important to promote a team approach between primary health care providers (physicians, nurses, dentists, gynaecologist, etc.) and infectious disease specialists who deal with HIV/AIDS. This team approach would aid in early detection and diagnosis and provide a supportive environment for patients under treatment, but requiring other medical services.

d. Training of trainers

- PH can introduce a vigorous quality assurance requirement at the certification level. Instead of granting all those participating in the training a certification, only selected participants, who have demonstrated competence in trainer skills would be granted certification of trainer status. Others could be provided with proof of participation.

e. Primary health care level training

- PH to identify and determine local partners and institutions that can provide training within the context of continuing professional education.

Requiring additional resources/funding

The laboratory capacity building is still a gap that needs to be filled in these countries. It would be necessary to provide training to key selected laboratory personnel, not only in appropriate procedures, patient confidentiality protections, but also in workplace safety and prevention of transmission of infections in health institutes, as well as proper testing to identify opportunistic infections and their variants.

4. Programme staffing structure and management oversight

Staffing structure

Project manager

Appoint an acting project manager, effective immediately. This will establish a clear channel of communication and accountability structure. In view of both administrative and programmatic oversight required for this position, a regional programme director with country director responsibility is appropriate to fill this role. This will reduce perceived and actual conflict of interest in financial decisions and accountability.

Decide and finalize recruitment by end of April 2005 from the current pool of finalists. If finalists are not suitable, reopen recruitment process and make an interim arrangement.

Clinical coordinator

Split the function into two. One is the trainer's function. Recruit a part-time trainer to assist in the TOT courses. Trainers without specialization in HIV or ARV therapy are more readily available. The other part is the clinical specialist function. Engage a qualified clinical specialist as a consultant in determining the design, content and conduct of the training. This would eliminate the difficulty of attracting currently active practitioners to abandon their clinical practice and allow for flexible recruitment of quality clinical inputs.

Montenegro CPC

There are three options:

1. Establish an office and hire a full-time CPC as proposed.
2. Share office space with one of the NGOs currently receiving the Trust Fund and recruit a part-time liaison officer.
3. Continue current arrangement of the CPC for both Serbia and Montenegro.

The evaluator's recommendation would be the third option, as it is the most cost-effective.

Management oversight

- a. Revive the country steering committee
 - The steering committee is meant to advise the Programme's direction and activities. It is not meant to be a one-time event for one round of the TF. The steering committee could be called upon to review important reports produced by the Programme in each country, review the Programme's progress and give suggestions as to any adjustments or directions needed. It is suggested that at least once a year the steering committee should meet at the in-county level. As a strengthened governance process, some of the members from the country steering committee might be selected to form a balanced regional Programme steering committee for the Programme's annual internal review.
- b. Develop the Programme 2005 work plan
 - A programme wide work plan should be developed, taking into account recommendations made in the mid-term evaluation report. There should be a

detailed plan for the remainder of 2005 and a projection for 2006. In addition, develop a work plan for each staff, based on the Programme work plan. The staff work plan should provide further details on activities and dates. For 2005, there should be detailed activity plans for each three-month period based on the 2005 plan. As activities progress, the three-month plan will be adjusted accordingly, with specific dates, activities, staff movements and reports. One must link the plans to inputs. The inputs include financial and staff travel commitments. Activities will be approved and resources allocated based on approved work plans. Deviations, including changes or new activities, will be considered on a case-by-case basis, in accordance with the staff's job description, overall responsibility and the office coverage commitment. Staff vacation or leave days should also be provided for the year and clear records established.

c. Plan and prepare the 2005 regional conference

- Plans should begin for the preparation of the 2005 regional conference. This first 2005 regional conference could cover the prevention, care and support continuum. It will be a combination of sharing of experiences, as well as skills building. International and regional resource experts could be engaged. This conference should be open to all and not restricted to those receiving PH support. In addition, some sessions should include beneficiaries, such as PWHAs, if feasible. The timing of the 2005 conference is such that the first round of NGO funding will have ended, thus providing at least eight sets of activities for reporting. These would be presented during the conference. Some work in progress by other NGOs could also be shared. It would be useful to consider sessions on VCCT, PWHA network building, MSM, IDU support and Roma communities. In addition, good practice examples of primary health care and infectious disease specialist service collaboration and coordination could be identified and presented.

Details of planning for this 2005 conference should be part of the 2005 work planning exercise.