



HIV/AIDS



EVALUATION OF UNDP'S ROLE AND CONTRIBUTIONS IN THE HIV/AIDS RESPONSE IN SOUTHERN AFRICA AND ETHIOPIA





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FOREWORD

Data from UNAIDS show that sub-Saharan Africa is disproportionately affected by HIV/AIDS. Sub-Saharan Africa has just over 10 percent of the world's population, but is home to more than 60 percent of all people living with HIV—25.8 million. Southern Africa remains the epicentre of the global AIDS epidemic. The Evaluation Office undertook this strategic evaluation in ten countries—nine of which are in Southern Africa—Angola, Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe—and Ethiopia in the Horn of Africa.

UNDP has been advocating for action against HIV/AIDS for more than two decades. Since 2000, HIV/AIDS has become one of UNDP's top organizational priorities, and it has worked towards integrating it into broader efforts to support effective democratic governance and poverty reduction. During the second multi-year funding framework period (2004-2007) Responding to HIV/AIDS became one of UNDP's five core goals. This is expected to contribute directly to Millennium Development Goal 6 on combating HIV/AIDS.

The purpose of the evaluation was to assist UNDP in positioning the selected UNDP country offices for a more effective role in response to the crisis. Its findings are expected to contribute to the formulation of future UNDP strategies at the country level in combating HIV and AIDS. The evaluation shows that UNDP has played multiple roles in the HIV/AIDS response at the country level, and UNDP country offices were engaged at various levels in stimulating HIV/AIDS policy development, planning and action at the country level. Important contributions and outcomes were identified by the evaluation, including capacity development and policy support to national HIV/AIDS commissions and councils, support to decentralized HIV/AIDS responses at all levels of government and down to the local level, support for elaboration of HIV/AIDS-related policies, actions related to gender and stigma, support for civil society organizations and their HIV/AIDS responses, leadership development programmes for HIV/AIDS, and Community Conversations to engage and stimulate HIV/AIDS-related initiatives.

The evaluation emphasizes the need for country offices in the case-study countries to demonstrate a much higher level of urgency in their work on HIV/AIDS. Findings reveal that there is a disconnect between the UNDP

corporate strategy for HIV/AIDS and implementation by country offices and little evidence of integration of corporate, regional and country level strategies and activities. There is also a disconnect between Country Cooperation Frameworks and actual activities. Wide variations exist in the technical and organizational capacity of the country offices to support national HIV/AIDS responses.

The Evaluation Office invited observations on the final draft report from two distinguished experts in the field, Dr. Sigrun Mogedal, HIV/AIDS Ambassador, Government of Norway and Professor Lincoln Chen of Harvard University. Both commentators were overall positive, but found the terms of reference for the evaluation ambitious, as did the evaluation team. Both expressed concern—a concern shared by the evaluation team and the Evaluation Office—about the adequacy of the data underlying the evaluation. Prof. Chen noted in particular the weaknesses in data on UNDP resources devoted to HIV/AIDS.

Both reviewers regretted the lack of comparative understanding and full analysis of the roles of other actors beyond UNDP. Prof. Chen found himself confused on the relative roles of UNAIDS, WHO, UNDP, and other UN bodies working on AIDS in the case study countries. Dr. Mogedal found the largest weakness of the report to be its focus on UNDP without dealing much with the rest of the ‘inner circle’ of actors, even within the UN family itself. Prof. Chen considered the finding “reasonably credible” that UNDP has an “important role to play, exercised this role in a responsible manner, and seemed to generate some impact, however imperfectly measured.” To him the “recommendation for stronger UNDP leadership especially at the country level seems appropriate.” For Dr. Mogedal, the main findings and observations are “of great importance” and “very much in line with my own findings and experience.” For her, they call to mind the challenge of UN reform for “a UN presence that is dynamic, able to analyze, adapt and give substantive advice.”

The evaluation is the result of the dedication, commitment and contributions of a number of people. We are deeply indebted to all the people who worked tirelessly to complete this evaluation, especially the evaluation team members led by Dr. Sulley Gariba.

Team members were Ms. Ikwo Arit Ekpo, Mr. A. Edward Elmendorf and Dr. Anthony Kinghorn. Dr. Gariba coordinated preparation of the initial draft of the report, and Mr. Elmendorf served as coordinating author of the report.

I wish to acknowledge with great appreciation the support of the United States Agency for International Development's Regional Center for Southern Africa for contributing the valuable services of Ms. Ikwo Arit Ekpo, Sr. Regional HIV/AIDS Adviser.

The evaluation draws heavily on the work of ten national consultants who elaborated country assessments of UNDP HIV/AIDS activities in each of the case study countries: Ms. Yema Ferreira (Angola), Mr. Simon Muchiru (Botswana), Dr. Yayehirad Kitaw (Ethiopia), Ms. Keiso Matashane-Marite (Lesotho), Mr. Steven Chizimbi (Malawi), Ms. Scholastika Ndatinda Ipinge (Namibia), Mr. Shaun Samuel (South Africa), Ms. Dumisile Shabangu (Swaziland), Mr. Mukosha Bona Chitah (Zambia), and Ms. Anna Cletter Mupawaenda (Zimbabwe). The country assessments are being published as a separate volume. The international team members led an orientation workshop of the national consultants in Johannesburg, South Africa at the start of the evaluation. The contributions of Mandisa Mashologu, Senior Policy Advisor/NPO, UNDP Lesotho, are acknowledged for her insights at both the orientation workshop for national consultants and the writers’ workshop, as well as for work on the annexes.

I am very grateful to all UNDP colleagues at headquarters, the Regional Centre and country offices who supported the work of this evaluation. My special thanks go to all the Resident Representatives and the staff of the case study countries, the Director of the Bureau for Policy Development (BDP) and the HIV/AIDS Group, senior representatives of the Regional Bureau of Africa and staff, and other colleagues from Development Group Office and Bureau for Crisis Prevention and Recovery who provided vital feedback to the team and the Evaluation Office. We owe a great deal of gratitude to the numerous government officials, partner organizations, donors, and members of civil society organizations, whose insights were invaluable to the evaluation team.

The team's two researchers Mr. Anselme Sadiki and Ms. Afiya McLaughlin-Whyte, who were guided by Ruth Abraham of the Evaluation Office and by Mr. Elmendorf, produced useful background work. I also extend appreciation to those in the Evaluation Office who provided technical, administrative and logistical assistance. In particular I would like to mention Evaluation Office colleagues Mahahoua Toure, Immaculee Ilibagiza, Hajera Abdullahi and Anish Pradhan for their untiring support. I also thank Margo Alderton, editor of this report.

Finally I would like to thank my Evaluation Office colleague Ruth Abraham, task manager for the report, who ably managed the evaluation.



Saraswathi Menon
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EXECUTIVE SUMMARY

INTRODUCTION

RATIONALE

Southern Africa is the subregion where the HIV/AIDS pandemic is the most devastating in the world and where the danger to sustaining development achievements is the greatest. The subregion is also suffering from the effects of poverty, drought and famine, and the severe erosion of human capacities. A number of factors, including social circumstances, economic conditions and population mobility, have increased the severity of the epidemic. Further, gender differences are at the root of a number of social, economic and political factors that drive the HIV/AIDS epidemic and result in a disproportionate number of affected women and adolescent girls. Without an understanding of the complex relationship between gender and HIV/AIDS, strategies to tackle the epidemic are not likely to succeed.

The Evaluation Office undertook a strategic evaluation of the role of United Nations Development Programme (UNDP) and its support in addressing HIV/AIDS in 9 countries in Southern Africa: Angola, Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. Ethiopia, in the Horn of Africa, was also included in the evaluation since it is estimated to have the second highest number of HIV/AIDS-infected people in Africa.

OBJECTIVES

The purpose of the evaluation was to assess the role and contributions of UNDP in the achievement of key outcomes at the country level. This included a review of the UNDP role and contributions in the policy and planning choices made by countries in relation to HIV/AIDS. The terms of reference called upon the evaluation to assess whether UNDP was targeting the right areas and taking the correct approach, and to assess the outcomes of its strategy, programmes and projects in addressing HIV/AIDS at the country level. The terms of reference also called for the evaluation to be strategic and forward-looking. It was expected to assist the UNDP country offices (COs) concerned in taking an increasingly effective role in HIV/AIDS, with appropriate contributions from corporate units and the Regional Centre for Southern Africa. The findings were also expected to contribute to future UNDP strategies and programmes on HIV/AIDS.

CONCEPTS AND METHODOLOGY

The evaluation covered the period 1999 through 2004, but the report takes into account many critical developments in the HIV/AIDS response in 2005. The evaluation included an overview of the Strategic Results Framework (SRF) in 1999 and included an overview of budgeted activities that were either ongoing or had not yet begun. It reviewed outcome evaluations conducted by UNDP at the country, regional and subregional levels. It also reviewed the contributions of UNDP towards the Multi-Year Funding Framework (MYFF) 2004-2007, in which responding to HIV/AIDS was a separate corporate-level goal. The focus of the evaluation was at the country level.

The evaluation used a variety of approaches and data sources, which allowed the team to triangulate its research and arrive at robust findings. These included:

- A preliminary review of internal UNDP documents.
- Country assessments by national consultants in ten countries and six country visits by international consultants. The assessments involved interviews and focus groups, and included views of UNDP and other United Nations (UN) staff, donors, government officials, people in community based organizations, women's organizations, and academics.
- Policy interviews in New York and several other locations with key personnel from UNDP, other UN bodies, and partner organizations.

The evaluation focused largely on UNDP contributions and outcomes and the environment in which UNDP HIV/AIDS activity at the country level has taken place.

The contributions and outcomes analyzed in the evaluation identified notable changes in responses to HIV/AIDS. However, at the time of the evaluation, many interventions had not been implemented for an extended period, so findings on outcomes were often limited. There were limitations on ability to triangulate and validate views. Validation was made more difficult by a scarcity of quantitative evidence. Since HIV/AIDS activities of other donor partners were not assessed, the team was unable to gain as much understanding of partner activities as would have been desirable for a thorough assessment of UNDP comparative advantages with respect to HIV/AIDS. Weaknesses in monitoring and evaluation at

the CO level also impeded the evaluation task. Additional limitations were encountered because UNDP was often only one of several players associated with an outcome. Nonetheless, the review of contributions and outcomes is sufficiently robust to present a number of conclusions and raise key strategic issues that have implications for strengthening the role played by UNDP in the HIV/AIDS response.

CONTEXT

THE GLOBAL CONTEXT

Heads of State from around the world adopted the Millennium Declaration in September 2000. Included in it are eight development goals, comprising an ambitious agenda for reducing and ultimately eliminating poverty. Of these, Goal 6 calls for halting and beginning to reverse the spread of HIV/AIDS, malaria and other major diseases by 2015.

In June 2001, at the special session of the General Assembly on HIV/AIDS, heads of state and government adopted by acclamation the Declaration of Commitment on HIV/AIDS, "Global Crisis — Global Action" (resolution S-26/2) to express their commitment to addressing the HIV/AIDS crisis. The Declaration articulated measurable goals to reverse the epidemic, including targets in several key areas. It also called for a fundamental shift in the global response to HIV/AIDS as not only a public health dilemma, but also a global economic, social and development issue of the highest priority, and the single greatest threat to the well-being of future generations. A commitment was also made at the special session to create the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), in the recognition that if brought to scale, efforts to prevent and treat HIV/AIDS, tuberculosis and malaria could change the course of these diseases.

THE UNDP INSTITUTIONAL AND POLICY ENVIRONMENT

UNDP has been advocating for action against HIV/AIDS since the late 1980s. In 2000, it made HIV/AIDS one of its top organizational priorities, integrating it into broader efforts to support effective democratic governance and poverty reduction. Since June 2001, several Executive Board sessions have been devoted to reviewing UNDP contributions towards

reversing the HIV/AIDS pandemic within the context of the UN System Strategic Plan for HIV/AIDS for 2001-2005. This culminated in the decision to make HIV/AIDS a vital consideration for UNDP during the second MYFF period (2004-2007), and one of five core goals for the organization — Goal 5: Responding to HIV/AIDS. This will contribute directly to Millennium Development Goal (MDG) 6 on combating HIV/AIDS. The HIV/AIDS service lines were consolidated from five to three areas under the second MYFF: leadership and capacity development to address HIV/AIDS; development planning, implementation and HIV/AIDS response; and advocacy and communication to address HIV/AIDS.

GROWTH IN EXTERNAL FINANCIAL RESOURCES TO FIGHT HIV/AIDS

Considerable growth in external financial support for the fight against HIV/AIDS was seen at the country level during the review period. This has led to dramatic increases in total public expenditure on health in some case-study countries (potentially as high as 700 percent in Zambia, for example). The consequences include new challenges for developing countries in managing public finances and ensuring that donors respect country priorities. This implies, also, changes in the needs of UNDP's national partners, which now require more support for the mobilization and the effective use of new external financial resources for HIV/AIDS.

Headquarters data suggest that between 1999 and 2004 total UNDP planned spending from its own resources for HIV/AIDS projects and activities was at least \$3 million per year in the 10 case-study countries. Cost-sharing resources brought the total to nearly \$6.5 million per year, or a minimum of \$21 million in the case-study countries during the period of the evaluation. In contrast, GFATM commitments to the case-study countries amounted to \$312 million for signed grants as of April 2005. Thus, UNDP is becoming a smaller player on the HIV/AIDS scene than it was in the 1990s. However, the evaluation found that UNDP has had important accomplishments in relation to the size of its funding.

UNDP, THE UN SYSTEM, AND THE INTERNATIONAL COMMUNITY

The central position of UNDP Resident Representatives and UN Resident Coordinators in the international

system of development support is almost universally recognized. In the case-study countries, the UNDP coordination role sometimes extended beyond UN organizations to include additional partners, especially where new financial resources were programmed by non-UN organizations.

UNDP comparative advantages in the fight against HIV/AIDS

The comparative advantages of UNDP in the HIV/AIDS response vary from country to country. Nonetheless, there was one key comparative advantage that is institutional in character: The position of UNDP as coordinator and voice for the UN system and UN country teams. The evaluation perceived a UNDP comparative advantage in facilitating the effective involvement of other smaller UN organizations and donors, especially in smaller countries and where major donors are relatively less active. However, as financial resources from non-UN institutions assume greater prominence, UNDP risks losing relevance at the country level unless it gives greater attention to coordination beyond the UN system.

The generally strong relationships between UNDP and governments represent another key comparative advantage, but it has been under-used in the case-study countries. The ability to promote and facilitate mainstreaming and integration of HIV/AIDS issues into development and poverty reduction strategies should be a comparative advantage of UNDP in all countries, as was the case in Angola and Swaziland.

UNDP was also thought to have a comparative advantage in addressing certain aspects of AIDS-related governance issues, including decentralized support to the HIV/AIDS response, the human rights dimensions, and gender.

Finally, the evaluation found that UNDP should have a comparative advantage in capacity development, as in its work for decentralized HIV/AIDS responses in Botswana and Zambia. Developing and using all of its potential comparative advantages at the country level poses continuing challenges.

It was not clear whether the comparative advantage of UNDP was viewed as actual or only potential. Too often, UNDP leadership was seen as bureaucratic and diplomatic rather than substantial and development-oriented. UNDP might achieve development results

as much by trust and facilitation as by the provision of financial resources. The Secretary-General has called for the creation of joint UN HIV/AIDS teams at the country level. UNDP must be at the heart of the implementation of this new arrangement.

FINDINGS

The relevance, effectiveness and sustainability of UNDP HIV/AIDS responses represent core issues for the evaluation. They are discussed in the following three sections: key contributions and outcomes of UNDP engagement in HIV/AIDS; UNDP HIV/AIDS strategy and management of the UNDP HIV/AIDS response; and monitoring, evaluation, and sustainability of the UNDP HIV/AIDS response.

KEY CONTRIBUTIONS AND OUTCOMES OF UNDP ENGAGEMENT IN HIV/AIDS

UNDP has played multiple roles in the HIV/AIDS response at the country level. In general, the roles and contributions of UNDP were relevant to the situations of its partner countries, but they risk losing relevance as the environment for UNDP engagement changes. It was too soon to assess the effectiveness of the UNDP response in achieving development impact in a number of areas, but certain important contributions and outcomes were identified, along with some missed opportunities and marked inter-country variations in programmes and results. UNDP effectiveness and sustainability of UNDP interventions were limited by lack of attention to monitoring, evaluation and exit strategies.

Overall, the evaluation found that UNDP is supporting those programmes and activities that it said it would support. Activities--frequently at the pilot level--included leadership development programmes for HIV/AIDS; Community Conversations to engage and stimulate HIV/AIDS-related initiatives at the community level; capacity development and policy support to national HIV/AIDS commissions and councils; support to decentralized HIV/AIDS responses at provincial, district and local government levels; support for the elaboration of HIV/AIDS-related policies, including action related to gender and stigma; support for civil society organizations (CSOs) in their HIV/AIDS responses; generation of knowledge through activities such as national human

development reports related to HIV/AIDS; mainstreaming or facilitating integration of HIV/AIDS issues into activities beyond the traditional HIV/AIDS 'sector;' support for workplace HIV/AIDS responses in the UN family of institutions; and partnership actions for country results.

Beyond the activities that UNDP financed, UNDP CO managers and staff were engaged at various levels in stimulating HIV/AIDS policy development, planning, and action at the country level.

The signal accomplishment of UNDP lies in moving HIV/AIDS paradigms from biomedical towards development perspectives in almost all the case-study countries. The shift was part of a global change, but UNDP was widely considered to have been instrumental in successfully advocating for it within countries and for helping to institutionalize this shift in development planning and management. Support at the country level in systematically promoting the shift has been significant. However, UNDP has achieved only limited change in translating awareness and policy acceptance into actions, especially beyond the HIV/AIDS sector. In addition, the recent growth in external financial resources and resulting prominence of treatment creates the danger that developmental approaches to combating the epidemic may lose attention.

Relevance and effectiveness of UNDP role and contributions

Five themes were used as the organizing framework for the evaluation—governance in relation to HIV/AIDS, HIV/AIDS leadership, mainstreaming HIV/AIDS into other development activities, capacity development for HIV/AIDS response, and partnerships for country results.

Governance, including gender and CSO engagement

UNDP contributed substantially to the paradigm shift from biomedical to developmental perspectives on HIV/AIDS and greater commitment of governments and their partners towards policies, strategies, structures and processes that shape national responses. Three significant outcomes stand out: changing national policies and strategic frameworks for managing HIV/AIDS; strengthening decentralized HIV/AIDS institutions; and increasing the presence and voice of CSOs and vulnerable groups in advocacy and

participation. The quality, effectiveness and sustainability of changes in these three areas were mixed.

There are ongoing challenges to enhancing the roles of national HIV/AIDS commissions and decentralized structures, and the participation of key stakeholders, including vulnerable groups. The quality of country strategies to address these issues in the case-study countries could be improved, and plans to translate these strategies into action were often not well developed.

The reputation of UNDP for strong links with government created unexploited opportunities for influence on HIV/AIDS governance. Many other development partners have become involved in strengthening national HIV/AIDS structures and governance, often with larger financial and human resources than UNDP has available.

Gender and HIV/AIDS are inextricably linked. Gender inequality is a key factor in the HIV/AIDS epidemic among women, and young girls in particular, are disproportionately affected by the pandemic. Several UNDP initiatives, particularly at the community level, have positively and markedly influenced gender dynamics. However, it was difficult to establish that UNDP programmes changed gender-related issues concerning HIV/AIDS on a significant scale. In a number of countries, UNDP has promoted increased recognition of the rights and roles of women, people living with HIV/AIDS and CSOs in governance and in multisectoral responses. UNDP spearheaded initiatives to establish and strengthen umbrella or coordinating CSOs, but did not provide enough support to achieve measurable impact, especially at the peripheral levels where populations most need support from CSOs.

Leadership

UNDP has helped strengthen HIV/AIDS-related leadership through programmes that develop leadership among politicians and government officials, community and civil society bodies, and some private-sector entities. In addition, the UNDP COs themselves, through the interventions of Resident Representatives, Resident Coordinators and CO staff, have contributed to HIV/AIDS leadership. However, there is still a great need to enhance HIV/AIDS-related leadership in the case-study countries.

The evaluation found inspiring examples of leadership 'breakthroughs,' particularly in the UNDP Community

Conversations and leadership development programmes. However, at the time of the evaluation, it was uncertain whether UNDP interventions, including its Leadership Development Programme, had achieved sufficient scale and depth to respond fully to leadership needs.

It was difficult to verify that effective interventions received adequate support, and that interventions that were supported represented true areas of comparative advantage for UNDP in relation to its other HIV/AIDS work and the work of its development partners. The UNDP concentration on individual leadership development needed to be complemented by emphasis on group leadership.

Mainstreaming

UNDP has contributed to acceptance of the multisectoral nature of the epidemic and the need for mainstreaming--inclusion of HIV/AIDS issues in policies, plans and action in government responses beyond the health and HIV/AIDS sectors; enhancement of the roles of non-governmental partners and successes in facilitating mainstreaming in policy statements, implementation of mainstreaming in multisectoral responses; and emergence of workplace programmes in UNDP COs and in public and private sector entities. However, despite the initiatives of UNDP and its partners, and successes in facilitating mainstreaming in policy statements, implementation of mainstreaming was still at an early stage in most case-study countries, especially in key areas such as poverty reduction strategies.

HIV/AIDS deepens poverty and increases inequalities at every level. It is critical to integrate HIV/AIDS priorities into poverty reduction strategies to help create an enabling policy and resource environment. UNDP was influential in integrating HIV/AIDS into poverty reduction strategy documents in several countries, working closely with governments and national partners. However more needs to be done in this area.

UNDP mainstreaming contributions seemed unlikely to have substantial impact. Very little attention was paid to gender and HIV/AIDS mainstreaming, even at the government policy level. Where this was done, as in Botswana, follow-through was limited. While the problem of making the leap from policy language to follow-up implementation is not unique to UNDP, there is a long way to go to achieve full

integration of HIV/AIDS into poverty reduction strategies, papers, processes and outcomes.

Though UNDP leadership has triggered some important changes through the UN 'We Care' workplace programme in some countries, in others, UNDP was seen more as a participant than a leader. There were missed opportunities for UNDP COs and other UN partners to learn from each other in this regard. COs did not integrate this activity systematically into their own activities and programmes.

The limited mainstreaming of HIV/AIDS into other UNDP programmes and activities is of particular concern. This suggests limited ownership of the HIV/AIDS agenda among UNDP CO staff beyond those immediately responsible for HIV/AIDS response.

Capacity development

Capacity development is a top priority for UNDP in supporting programme countries. While results differed among countries, both institutional and individual capacity at all levels, from national and decentralized to the community level, has been strengthened by UNDP. In particular, UNDP has enhanced capacity to respond to HIV/AIDS in the following areas: individual and institutional capacity in national HIV/AIDS commissions and ministerial departments; capacity for decentralized planning, management and implementation; capacity of HIV/AIDS-related CSOs and community level capacity; empowerment of people living with HIV/AIDS and others vulnerable to effects of the epidemic; and knowledge relating to HIV/AIDS to guide responses. In some countries, UNDP appears to have missed opportunities to deal with larger-scale capacity problems in public sector management, particularly related to human resource planning, development and management.

UNDP has had notable achievements at the community level and at decentralized levels of government, where limited ability to promote activity is often a major gap in national response. However, results related to gender and HIV/AIDS and the development of the capacity and involvement of women have not featured prominently in many countries.

Serious constraints so far on outcomes of capacity building with CSOs and other players are: inadequate consideration of sustainability plans, inexistent exit strategies, and achieving the required scale of impact.

An increasingly prominent area of capacity development is building country capacity to mobilize and manage external HIV/AIDS resources. UNDP has begun to grapple with this issue, particularly through its GFATM principal recipient (PR) role. In the past, insufficient emphasis had been given to moving resources (such as GFATM) beyond the national level to decentralized and community levels. UNDP assumed a major capacity development role through its PR responsibility for GFATM resources in two of the case-study countries, where it is likely that without UNDP support no access to GFATM would have been possible. However, while the importance of UNDP's capacity development contributions as GFATM PR was underscored, UNDP's assumption of this role raised concerns among some stakeholders as to whether it created a conflict of interest with other UNDP activities, particularly with its role of neutral advisor to the public authorities.

Approaches to UNDP HIV/AIDS capacity development innovations were sometimes weak in strategic focus, leading to limited sustainability and impact. Issues of scale and sustainability were raised with respect to Community Conversations in several countries. The role of UN Volunteers, which had been successful in achieving urgent outcomes, needs to be more strategic. UNDP training in several countries lacked coherent planning and follow-up. These issues were thought appropriate for action by the UNDP Southern African Capacity Initiative (SACI).

The scale and range of HIV/AIDS capacity challenges in the case-study countries remains huge. UNDP risked spreading itself too thin as a result of limited prioritization, limited consolidation of capacity development agendas, and limited reinforcement and exchange of experience among countries. Stakeholders found a possible role for the UNDP Regional Centre for Southern Africa in cross-country experience sharing.

HIV/AIDS partnership coordination

In nearly all the case-study countries, UNDP has played an important role in partnership coordination for the achievement of country results. This was most evident in financial resource mobilization from the GFATM in Angola and Zimbabwe. UNDP assisted some countries in obtaining increasing government financial allocations to HIV/AIDS, but the amounts were dwarfed by the larger funding from external partners such as GFATM and the US President's Emergency Plan for AIDS Relief (PEPFAR).

BOX E.1 PROMISING PRACTICES AT THE COUNTRY LEVEL

As an indication of the importance and value of monitoring, evaluating, and disseminating promising practices, this box summarizes one example from each of the case-study countries documented in the main report, in the country summaries contained in Annex 6, and in the national consultant assessments.

ANGOLA: Mainstreaming HIV/AIDS into the education system—

UNDP trained social actors (teachers, community leaders, armed forces, civil society and the media) on human rights, peace, gender and HIV/AIDS. This contributed to establishment and strengthening of community social networks for dialogue and provision of services to adolescent mothers, orphans and people living with HIV/AIDS.

BOTSWANA: Advocating and supporting the establishment of NAC and civil society coordinating organizations—

Consistent support by UNDP for the national AIDS coordinating organization started with the AIDS/STI Unit within the Ministry of Health, and was eventually instrumental in the establishment of the National AIDS Council, chaired by the President, and NACA, with its Director elevated to the status of Permanent Secretary to provide high profile and commitment to AIDS. Similar support and advocacy also led to the establishment of key civil society coordinating bodies for PLWHA, ethics and AIDS service organizations.

ETHIOPIA: Strengthening capacity for community driven solutions through Community Conversations (CC)—

in Alaba and Yabello districts, communities certainly not used to discussing such matters, the partic-

ipatory process of CC enhanced knowledge on AIDS and helped to break the silence, reduced stigma and led to greater support for PLWHA and increased Voluntary Counselling and Testing uptake. At the time of the evaluation the CO was generating lessons on how CC can be sustained and rolled out on a larger scale.

LESOTHO: Creating partnerships for leadership engagement and social mobilization—

a new UNDP Resident Coordinator used her position as co-chair of an Expanded HIV/AIDS Theme Group to forge partnerships with development partners, engage donor support and mobilize national leadership commitment on AIDS. She used the platform to mobilize resources for crafting and publishing a widely used review 'Turning a Crisis into an Opportunity'. Working collaboratively with other partners, the Resident Coordinator launched the book and used it as a tool for mobilizing national action against AIDS.

MALAWI: Supporting the design of the AIDS SWAp—

UNDP support for the AIDS Round Table facilitated early engagement of development partners and led to the creation of a donor funding basket or AIDS SWAp, with about \$400 million in pledges.

NAMIBIA: Engaging the private sector to mobilize the business community on AIDS—

grant support to the National Business Coalition on HIV/AIDS (NABCOA) led to increased awareness about AIDS. Training of employees and development of a toolkit resulted in the expansion of programmes and the mobilization of businesses at the national and municipal levels,

through AMICALL (Alliance of Mayors Initiative for Community Action on AIDS at the Local Level).

SOUTH AFRICA: Reducing stigma in the workplace through GIPA—

focusing on decentralization themes as a result of its collaborative arrangements with the government, UNDP provided support to both the private and public sector through workplace programmes for PLWHA. It was successful in reducing stigma and empowering PLWHA to live productive lives.

SWAZILAND: Using leadership training to facilitate scaling up AIDS awareness for the Police Force—

as a result of UNDP training, the Assistant Commissioner of Police scaled up training and established a Committee on AIDS. He expanded AIDS activities to all four regions of the country, thus increasing awareness.

ZAMBIA: Using underutilized national human resources as UN Volunteers (UNVs), to meet the demand for AIDS Programming—

through careful assessment and in response to national requests, national UNVs were deployed to act as catalysts for facilitating district AIDS action plans, and thereby facilitated access to resources available through the World Bank.

ZIMBABWE: Staying the course in challenging circumstances—

consistent support to the NAC and the country during trying times has resulted in successful mobilization of funds through the GFATM. UNDP started developing increasing capacity of the NAC to assume responsibility for managing funds.

UNDP made important contributions in some of the case-study countries in strengthening interagency synergy among UN organizations and official development partners, as exemplified by the effective functioning of HIV/AIDS Theme Groups. Obstacles to effective partnerships included: inadequate communication, inadequate agency role definition and resulting tensions, limited UNDP assertiveness, and excessively project-focused approaches. Differences

among UNDP headquarters staff in their personal commitment to the corporate HIV/AIDS agenda were also cited as a reason for inter-country differences in the UNDP HIV/AIDS response.

UNDP's HIV/AIDS practice is a part of a larger joint UN programme—UNAIDS—of which UNDP is one of 10 co-sponsors. At the country level, they form the UN Theme Group on HIV/AIDS. For

UNDP, the most significant institutional change during the period of this evaluation was the striking growth of the UNAIDS Secretariat and the expansion of its presence in the field. In many countries, the UNAIDS Secretariat has recruited Country Coordinators, while UNDP has only part time HIV/AIDS focal points. Tensions undermined synergies between the two in some countries.

Many stakeholders would like UNDP to provide more leadership in partnership coordination for country results in the HIV/AIDS response. Strategies to strengthen partnership development roles require the consideration of several factors including: specific circumstances and opportunities in each country; capacity of COs and the skills and attitudes of specific Resident Representatives, Resident Coordinators and staff; clarification of roles between UNAIDS and UNDP at the country level; and improved design and communication of the UNDP CO HIV/AIDS strategy.

The positive partnership coordination outcomes documented in the evaluation were widely thought to have been accomplished with less-than-adequate CO and Regional Centre staff and coordination—a view shared among CO staff and many development partners. The newly established Regional Centre was seen by many as an important complement to the CO, but its role was not well understood. CO capacity might be strengthened by ‘projectizing’ support and thereby removing it from the constraints of the UNDP CO administrative budget. Data from the last year of the evaluation indicate that the share of UNDP HIV/AIDS spending increased in only four of the ten case-study countries, and actually declined in six.

STRATEGY AND MANAGEMENT OF THE UNDP HIV/AIDS RESPONSE

UNDP has made significant efforts to mobilize resources for its interventions in the fight against HIV/AIDS. It operates at three levels—corporate, regional and national. Resources are mobilized through different funding sources: the Global Thematic Trust Fund set up in 2002 to support Global Cooperation Framework resources; projects at the regional level; and core and non-core resources at the country level.

Strategic focus

There was a disconnect between the UNDP corporate strategy for HIV/AIDS and implementation by COs,

and little evidence of integration of corporate, regional and country-level strategies and activities. A further disconnect existed between the country cooperation framework (CCF) and actual activities. Broad frameworks were not consistent nor did they adequately capture what UNDP actually planned and executed at the country level.

Such disconnects between CCFs and programme statements, compared to actual activities, might indicate adaptation, evolution and flexibility in the UNDP response. Alternatively, they might indicate disjunctions among the paradigms and strategies of UNDP COs, headquarters and the regional centre. Headquarters initiatives did not seem to be reliably consistent with country-level circumstances and capacity.

Funding by UNDP

The role of UNDP in HIV/AIDS substantially increased among the countries reviewed in this evaluation period, with many new activities being funded. Nonetheless, in some countries, HIV/AIDS still was not a central element in country programmes. A review of CCFs showed that discussions of HIV/AIDS were vague and somewhat limited.

UNDP spending on HIV/AIDS has substantially increased. Although financial information was not available to assess patterns and trends with a high degree of confidence, the evaluation found significant differences among the case-study countries in the amounts and shares of HIV/AIDS spending in total country programme spending. The low levels and small shares of HIV/AIDS in UNDP country programme spending in some countries as late as 2004 (6 percent to 9 percent in three countries) did not reflect the UNDP corporate priority and strategy on HIV/AIDS at the country level. The very high share in other countries (as high as 62 percent in one country) suggests that determined leadership by the UNDP Resident Representative or the UN Resident Coordinator can make a significant difference.

CO HIV/AIDS capacity

Wide variations exist in the technical and organizational capacity of the COs to support national HIV/AIDS responses, as well as the determination of CO managers and staff to take action. The difficulty in obtaining financial and other data on UNDP HIV/AIDS projects and programmes from headquarters databases and from the COs themselves

raises questions about the capacity of UNDP to be accountable and manage resources in an effective and timely manner.

Statements and performance

Despite UNDP's achievements in making HIV/AIDS a development issue, there were serious gaps between statements made by UNDP and its performance. The soaring rhetoric of senior management statements and UNDP publications on HIV/AIDS was inadequately matched by comparable CO performance in the design and execution of UNDP activities. Overall, there were large delivery gaps in translating policies into actions.

Implementation was given inadequate attention at two levels: UNDP projects and programmes require greater support from COs to reduce delays in execution; and, as increasing external financial resources were being promised by donors for the HIV/AIDS response, UNDP was not yet providing the new types of support needed for the execution of country HIV/AIDS programmes in the public and private sectors, including the non-governmental organization community.

MONITORING, EVALUATION, AND SUSTAINABILITY OF THE UNDP HIV/AIDS RESPONSE

The limited quantity of monitoring and evaluation data imposed serious constraints on the evaluation and raised questions regarding the sustainability of the UNDP HIV/AIDS response. Weaknesses were observed in the lack of outcome-oriented evaluation at the CO level (with one or two exceptions), and quantified or clearly documented evidence was scarce. The concept of outcome evaluation was not firmly anchored in UNDP--to the extent that CO understanding of an independent evaluation, and the level of support it received, varied greatly from country to country.

UNDP HIV/AIDS projects, which frequently took the form of pilot projects, generally lacked evaluation and exit strategies and seemed simply to come to a halt. One exception in this area was the UNDP Ethiopia's Community Conversations programme. However, without carefully planned and executed evaluation and exit strategies, the chances of sustaining UNDP projects and activities beyond the period of UNDP financial support are low.

RECOMMENDATIONS

This evaluation has one overarching recommendation: In Southern Africa—where the HIV/AIDS epidemic is the most severe in the world—the COs in the case-study countries must demonstrate a much higher level of urgency in their work on HIV/AIDS.

Urgency should be measured, *inter alia*, by use of resources, leadership, people, time and money. Total UNDP spending on HIV/AIDS overall is not large enough to have a significant impact on the epidemic at the country level. It is therefore particularly important that it use HIV/AIDS resources, both human and financial, in a strategic manner. It is critical to develop coherent approaches to leveraging partner resources in order to achieve the scale of outcomes required in countries with very severe epidemics.

With support of an agile team drawn from all concerned headquarters units and the Regional Centre, each UNDP CO and each of the other units concerned should develop, by September 2006, a monitorable action plan through which to implement the specific recommendations detailed in the evaluation report. These specific recommendations are:

COUNTRY OFFICES

Clarify strategic direction

COs should formulate or update UNDP country HIV/AIDS strategies and integrate them into national HIV/AIDS strategies and programmes. Strategies should:

- Include UNDP inputs from the Regional Centre and headquarters units, and promote mainstreaming, especially the full integration of HIV/AIDS into poverty reduction strategies.
- Draw upon initiatives from the headquarters Bureau for Development Policy (BDP) and the Regional Centre, where those initiatives are relevant to the country's situation.
- Be based on country demand and need rather than UNDP supply; take into account implementation of the 'Three Ones' principles; support donor harmonization; support integration of HIV/AIDS into poverty reduction strategies; and associated actions should feature prominently in UNDP country HIV/AIDS strategies and programmes.
- Integrate all UNDP financial resources for HIV/AIDS, whether managed at country, regional or headquarters level, and whether core resources or trust funds.

Shift programme focus

- Give central attention to supporting implementation of country HIV/AIDS programmes, especially at decentralized levels.
- With support from the Regional Centre, assist partner countries in designing, financing and executing programmes that take actions successfully piloted by UNDP and other external partners to scale on a country-wide basis.
- Assist partner countries with mobilization, disbursement and effective utilization of external financial resources for HIV/AIDS, with support from the Regional Centre.

Strengthen HIV/AIDS capacity

COs should strengthen their HIV/AIDS capacity, with support from the Regional Centre for Southern Africa and headquarters. CO HIV/AIDS capacity should include budgets; staff skills, attitudes and deployment; staff incentives; organization for HIV/AIDS work; and internal and external leadership. Leadership by example rather than by mandate should characterize UNDP cooperation with UN organizations and other partners. In their HIV/AIDS work, COs should go beyond UNDP projects and should plan, draw upon and facilitate deployment of the entirety of the institutional resources available to UNDP through UNAIDS and the UN system.

Foster a culture of monitoring and evaluation

Such a culture should be fostered by strengthening monitoring, evaluation, exit strategies, and especially learning from experience, with an expectation of measurable results from each UNDP HIV/AIDS project or intervention. Specific recommendations include:

- Review each ongoing UNDP HIV/AIDS project or activity for adequacy of its monitoring, evaluation and exit strategy. Projects should not simply end but should have a planned exit strategy involving evaluation and transfer of responsibility.
- Establish successful work on monitoring and evaluation as a criterion for positive evaluation of staff performance.
- Draw upon the monitoring and evaluation work of the Regional Centre for methodology to synthesize monitoring and evaluation analysis in forms usable by others, and to establish and disseminate good practices and lessons learned.

REGIONAL BUREAU FOR AFRICA

Assume new HIV/AIDS leadership roles

- Support stronger HIV/AIDS leadership on the part of Resident Coordinators and Resident Representatives. The Regional Bureau for Africa (RBA) should support and promote proactive leadership on HIV/AIDS through job design, staff selection and performance appraisal, and through support with other UNDP units and external partners.
- Review and revise SACI and ARMADA strategies and mandates in close cooperation with the Regional Centre, to prioritize supporting country HIV/AIDS programmes with particular reference to monitoring and evaluation, and disseminating good practices; support expansion of pilots evaluated as successful; design and support public management actions necessary for scaled-up HIV/AIDS programmes; and contribute to formulating and executing CO HIV/AIDS strategies and programmes.
- Lead a task force for the independent assessment of HIV/AIDS capacity in COs, the regional centre, and RBA with the participation of RBA, BDP, the Bureau of Management, the Regional Centre, and COs.

BUREAU FOR DEVELOPMENT POLICY

Review corporate HIV/AIDS strategy

Review the corporate HIV/AIDS strategy of UNDP in the light of the evaluation report to support implementation of country HIV/AIDS programmes and poverty reduction strategies.

- Focus on the two themes of: support to implementation of country HIV/AIDS projects and programmes, and support to integration of HIV/AIDS into poverty reduction strategies. UNDP/BDP HIV/AIDS programmes outside the two central themes should gradually be consolidated and transferred to other partners, except to the extent that they are directly responsive to country demand and have been evaluated as being successful. The revised corporate strategy should encompass a review of UNDP approaches to mainstreaming.
- Assist the Regional Centre, and especially COs, with HIV/AIDS country strategy formulation and implementation.
- Weigh the HIV/AIDS capacity of BDP, including budgets, staff skills, attitudes, incentives,

and links with other UNDP units and partners, against the changing needs. BDP should give particular attention to capacity for monitoring and evaluation.

BUREAU OF MANAGEMENT

Accelerate implementation of financial management improvement programme

The financial management strengthening programme should make it possible for users in BDP, regional bureaux and COs to access and effectively use real-time, consistent, comparable financial data on the full range of UNDP HIV/AIDS activities.

OFFICE OF THE ASSOCIATE ADMINISTRATOR

Clarify working relationships

Examine and, where necessary, revise internal HIV/AIDS working and reporting relationships and external partnerships. The Office of the Associate Administrator should position UNDP for increasingly effective engagement on HIV/AIDS.

- Take the lead in defining CO standards and procedures for resolving problems that arise in implementing the division of HIV/AIDS-

related labour among UN organizations that was recently agreed upon in follow-up to the work of the Global Task Team on Improving AIDS Coordination. Particular attention is needed to ensure effective cooperation between UNDP and the UNAIDS Secretariat.

- Review collaboration and reporting relationships among the concerned headquarters offices and bureaux, the Regional Centre and the COs. Establish the principle that the COs are supported by the other units within the framework of agreed strategies.
- Review UNDP's role as PR for the GFATM for conflict of interest. If that role is retained, guidelines should be established to ensure its separation from UNDP advisory functions, and there should be a concentrated focus on capacity development for early phase-out at the country level.

EXECUTIVE BOARD

Request a report on the implementation of the recommendations for the annual session in 2007. Monitor implementation of the recommendations and commission a further evaluation at a convenient mid-point between 2006 and 2015.

THE EVALUATION CHALLENGE



HIV/AIDS presents profound development challenges throughout the world, especially in Africa. These challenges transcend the boundaries of medicine into governance, human development, economic development and growth, employment, culture and traditions. Yet, more than any other epidemic, HIV/AIDS has also given the global community a renewed sense of purpose—addressing the dual scourge of poverty and disease.

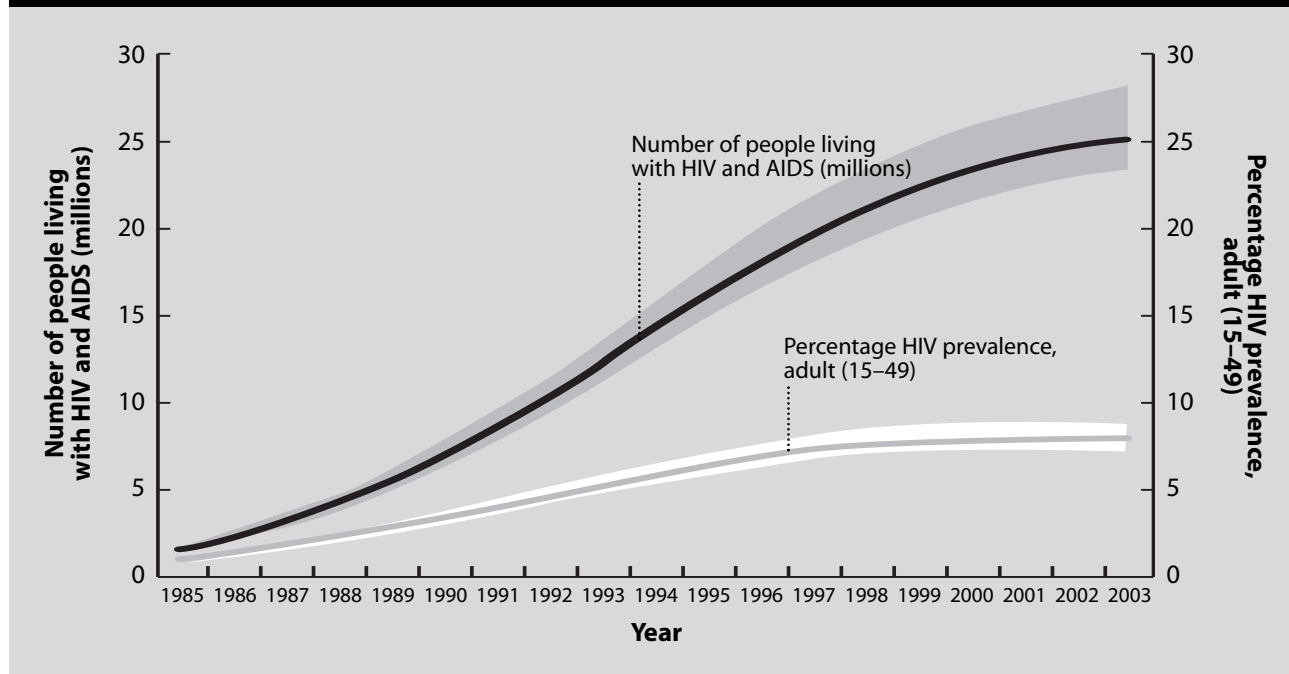
The HIV/AIDS response has led to diverse partnerships between governments, civil society, the private sector, and external agencies, and between natural and social scientists. UNDP is a broker and actor near the centre of this complex and continuously evolving network of relationships.

Since the late 1980s, UNDP has been among the global actors advocating and mobilizing others in the HIV/AIDS response. It has paid particular attention to the links between HIV/AIDS, poverty and development. In 2000, UNDP made HIV/AIDS one of its top institutional priorities. It aimed to integrate it into broader development programmes and activities, in support of policy and programming coherence for sustained poverty reduction. In operational terms, UNDP has launched initiatives at the corporate, regional and country levels. Its aims were to be achieved through support to policy change, programme design and implementation, and partnership coordination.

AIDS was considered a vital issue in the second Multi-Year Funding Framework (MYFF) period from 2004-2007. Initiatives from headquarters were launched to stimulate local AIDS-related leadership development. Regional projects were created. A new Southern Africa Capacity Initiative (SACI) was established to respond to serious capacity depletion. UNDP has also deployed thematic trust funds and other non-core sources of funding.

In late 2004, the UNDP Evaluation Office launched this evaluation of UNDP's role and contributions in the HIV/AIDS response in 10 African countries to determine lessons for future application in UNDP support to the HIV/AIDS response. This report synthesizes the evaluation team's results. It addresses the environment for the HIV/AIDS response in African countries; it covers the context necessary to understand UNDP's roles and contributions to the HIV/AIDS response; and it contains recommendations for action by UNDP.

FIGURE 1.1 THE AIDS EPIDEMIC IN SUB-SAHARAN AFRICA, 1985-2003



Source: UNAIDS, "2004 Report on the Global AIDS Epidemic," 2004.

This chapter introduces the evaluation study. It sets forth the challenges faced by the evaluation team. It summarizes the epidemic in Sub-Saharan Africa and it shows the great variations among the countries that have been the focus of the evaluation. The chapter describes the goals and methodology of the evaluation and presents lessons derived from the present evaluation for future UNDP evaluation work. The chapter concludes with an outline of the evaluation report.

1.1 HIV/AIDS IN SUB-SAHARAN AFRICA

Sub-Saharan Africa, particularly Southern Africa, has been the region most severely affected by HIV/AIDS. According to UNAIDS, in 2004, the total number of people living with HIV rose to an estimated 40 million, approximately 5 million people were newly infected with HIV, and globally, AIDS killed 3 million people that year alone. Sub-Saharan Africa remains by far the worst affected region, accounting for 25 million people living with HIV at the end of 2004 and more than three quarters of all women living with HIV.

On the surface, the epidemic in Sub-Saharan Africa appears to be stabilizing. Average HIV prevalence was about 7 percent for the entire region at the end of 2003 (Figure 1.1). The highest prevalence levels are

in Southern Africa, which accounts for approximately one third of all AIDS deaths globally.¹ Regardless of any stabilization of the epidemic, the social, economic and other costs of HIV/AIDS will continue and increase for many years.

HIV/AIDS has a devastating impact on life and livelihoods. It represents enormous human development threats—losing adults in the most productive age groups, placing great burdens on already strained community capacity for coping, and further contributing to chronic poverty. At a time when the need for social services is increasing, social service delivery capacity is being weakened by the epidemic. The effects of HIV/AIDS have also combined with poverty, limited capacity for effective governance, and food crises in several Southern African countries and Ethiopia to create a human development crisis that threatens the ability of countries to achieve the Millennium Development Goals (MDGs).

1.2 CASE-STUDY COUNTRIES AND THE VARIATIONS AMONG THEM

The focus of this evaluation is at the country level and recognizes the variations among countries and

1 UNAIDS, "AIDS Epidemic Update: December 2005."

the concentration of UNDP activities at that level. Nine countries in Southern Africa (Angola, Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) and one country in the Horn of Africa (Ethiopia) were chosen for country case studies. The overall rationale for this selection was the severity of the HIV/AIDS pandemic in Southern Africa and the wide variations among country experiences.

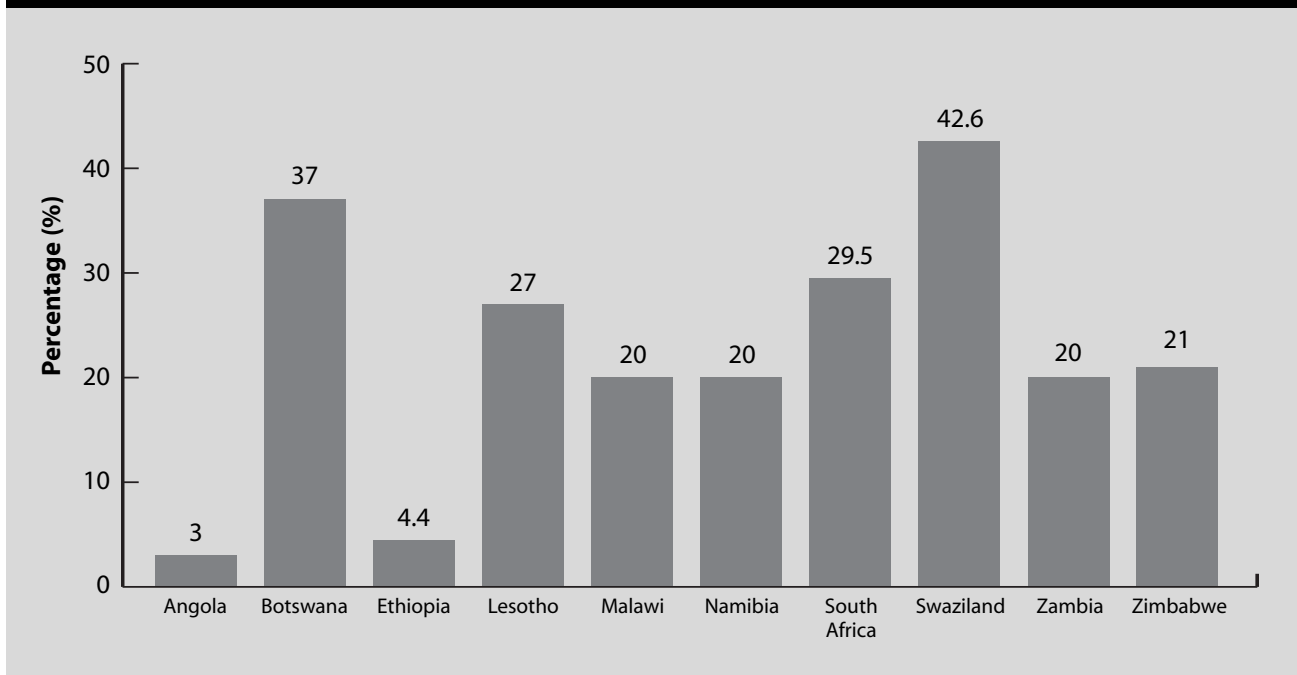
The 10 case-study countries display great differences. Several countries represent environments where the HIV/AIDS epidemic is particularly severe and requires particularly urgent responses. As shown in Figure 1.2, eight of the countries in this report show HIV prevalence rates among pregnant women attending antenatal services of 20 percent or more. In two of the countries (Botswana and Swaziland) antenatal HIV prevalence rates currently exceed 30 percent, and in two countries (South Africa and Lesotho) they are nearly 30 percent. In four countries (Malawi, Namibia, Zambia, and Zimbabwe) rates of approximately 20 percent reflect a median in Southern Africa that far exceeds the Sub-Sahara Africa average of 7 percent. Angola and Ethiopia are the only two countries in this evaluation with

antenatal HIV prevalence rates of 3 percent and 4 percent for 2004, significantly lower than the Sub-Sahara Africa average.

Socio-political conditions differ widely among the case-study countries. Beyond HIV prevalence, income and population size also vary significantly (see Table 1.1). While Angola is in transition from a civil war that lasted almost three decades, Zimbabwe is experiencing a rapid socio-economic decline and political crisis. In other countries, such as Ethiopia, Malawi and Zambia, democratic transitions are in nascent stages. These countries are fraught with vacillating relationships between governing and opposition parties. Botswana, one of the most stable countries politically, shares its political and economic stability with Namibia and South Africa. The only two monarchies, Lesotho and Swaziland, are adjusting differently to pressures for increased democratization.

Governance indicators also reveal wide variations among the 10 case-study countries and have shown some overall decline. Case-study country averages are somewhat more favorable, compared to Sub-Saharan Africa as a whole. In a recent study, government

FIGURE 1.2 HIV PREVALENCE RATES AMONG PREGNANT WOMEN ATTENDING ANTENATAL CLINICS IN CASE STUDY COUNTRIES, 2004²



Source: UNAIDS-AIDS Epidemic Update: December 2005 Sub-Saharan Africa 5.

2 Some countries rates refer to 2003, as 2004 survey statistics are not available.

TABLE 1.1 VARIATIONS AMONG CASE-STUDY COUNTRIES IN ANTENATAL HIV PREVALENCE, INCOME AND POPULATION

Country	Greater than 30% HIV prevalence	10-30% HIV prevalence	Less than 10% HIV prevalence	Middle income	Low income	Extremely small population
Angola			X		X	
Botswana	X			X		X
Ethiopia			X		X	
Lesotho		X			X	X
Malawi		X			X	
Namibia		X		X		
South Africa		X		X		
Swaziland	X			X		X
Zambia		X			X	
Zimbabwe		X			X	

Sources: Compiled from data from UNAIDS, World Bank data

effectiveness (which reflects the competence of the public bureaucracy and the quality of public service delivery, including HIV/AIDS services) was assessed to have been stable or improved in only 2 of the 10 countries, Angola and South Africa.³

1.3 EVALUATION GOALS AND METHODOLOGY

The purpose of the evaluation was to assess UNDP's role and contributions in the achievement of key outcomes at the country level through review of policy and planning choices made in relation to HIV/AIDS. The terms of reference (Annex 1) called upon the evaluation to assess whether UNDP was targeting the right things and doing things right, and to assess outcomes of UNDP's strategy, programmes and projects in addressing HIV/AIDS at the country level. The terms of reference also called for the evaluation to be strategic and forward-looking. It was expected to assist the UNDP country offices (COs) concerned in positioning themselves for an increasingly effective role in HIV/AIDS, with appropriate contributions from corporate units and the Regional Centre for Southern Africa. The findings were also

expected to contribute to future UNDP strategies and programmes on HIV/AIDS.

The evaluation covered the period 1999 through 2004. The evaluation team did not investigate UNDP activities prior to 1999, even though their results and contributions were visible. Because the evaluation was expected to have implications for future UNDP activities, the evaluation team did not establish a rigid cutoff date for new information at the end of 2004. The report takes into account many critical developments in the HIV/AIDS response in 2005.

The evaluation applied the principles and tools for outcome evaluation.⁴ Broadly defined, the outcome evaluation approach is one that moves away from assessing project development results against project objectives, towards assessing how these results have contributed to changes in development conditions.⁵ The real challenge lies in understanding the nature of the changes⁶ and in grasping the extent of UNDP association with any changes. In many cases, as

3 Kaufmann D, Kraay A, Mastruzzi M, "Governance Matters IV: New Data, New Challenges," World Bank, 2005, available at www.worldbank.org/wbi/governance/pubs/govmatters4.html.

4 UNDP Evaluation Office, "Guidelines for Outcome Evaluators: Monitoring and Evaluation Companion Series #1," 2002; UNDP Evaluation Office, "Handbook on Monitoring and Evaluation for Results," 2002; and HIV/AIDS Group, Bureau for Development Policy, "Responding to HIV/AIDS Measuring Results," 2005.

5 UNDP Evaluation Office, "Guidelines for Outcome Evaluators: Monitoring and Evaluation Companion Series #1," 2002, p. 6.

6 HIV/AIDS Group, Bureau for Development Policy, "Responding to HIV/AIDS Measuring Results," 2005, p.7.

discussed in Chapter 3, it was impossible to delimit outcomes or results with a high degree of specificity. Thus, this report discussed UNDP contributions as well as outcomes. One consequence of the focus on UNDP contributions and outcomes was an inability of the evaluation to give significant attention to UNDP's plans and intentions.

The evaluation involved both an international consultant team and national consultants. It required the international team: to establish outcome measures that extend beyond traditional records of the processes and outputs of project interventions; and to determine plausible associations between UNDP's role and contributions and the outcomes—or lack of outcomes—in the area of HIV/AIDS.

In each of the 10 countries, the evaluation commissioned a country case study led by a national consultant. A member of the international team was able to visit six of the 10 countries during the work of the national consultant. Resource limitations made it impossible to visit the other four countries. The countries visited were chosen by the Evaluation Office as follows: *Angola*—selected on the basis of its emergence from conflict, a country of low HIV/AIDS prevalence rates, and a lusophone country; *Ethiopia*—low prevalence of HIV/AIDS but high absolute number of infected people and reported to have contributed innovative approaches to HIV/AIDS programming, the only case-study country in the Horn of Africa; *Lesotho*—relatively high prevalence of HIV/AIDS, low income, small population, innovative UNDP experience; *Zambia* and *Malawi*—relatively mature HIV/AIDS epidemics, substantial current rates of infection, and very low incomes and worsening poverty levels; *South Africa*—middle-income, relatively high rates of HIV/AIDS infection, unique UNDP role.

The evaluation followed this sequence:

- Building consensus between the commissioners of the evaluation (the Evaluation Office) and the independent evaluators about the range of outcomes or 'results' to emphasize in assessing progress;
- Participating in selection, training and collaborating with national consultants undertaking country assessment studies;
- Gathering evidence on activities, especially on outcomes, of UNDP's work at the country level;
- Analyzing and validating influencing factors at the country level;

- Assessing contributions of UNDP to identified changes; and
- Reviewing findings to identify UNDP's comparative advantages, associated constraints, and missed opportunities.

In parallel with the country studies, members of the international consultant team interviewed key UNDP personnel at the regional level. They also interviewed UNDP corporate staff and external partners for their understanding of UNDP's contributions to country-level results and feedback on UNDP's strengths, weaknesses, and comparative advantages in HIV/AIDS.⁷ The full team then held a writers' workshop to build a common understanding of the evidence and to allocate roles and tasks in preparation of the evaluation report.

At the inception of the task, the international team had a day of intensive briefings by UNDP Headquarters staff on its HIV/AIDS work in Africa. These discussions, examination of relevant documents, and consultations with the Evaluation Office led the international consultant team to establish five outcome themes as the framework for its work (Box 1.1).

Early in the fieldwork, it became apparent that the outcome theme categories were not exclusive. Some of the national consultants found it difficult to work within them, in part because the initial definitions lacked specificity. The outcome themes were defined in more detail at the writers' workshop, after most

BOX 1.1 FIVE OUTCOME THEMES

At the inception of the evaluation, the international consultant team, in consultation with the UNDP Evaluation Office, identified five outcome themes for the evaluation:

1. Governance in relation to HIV/AIDS
2. Leadership for development with an HIV/AIDS focus
3. Capacity development in relation to HIV/AIDS
4. Mainstreaming HIV/AIDS response into development and poverty reduction
5. HIV/AIDS partnership coordination for country results

The scope of each of these themes is discussed in Chapter 3.

7 See Annex 7 for a synthesis of interviews.

data collection was complete but before drafting of major portions of the report. The final definitions and issues considered under each theme are presented at the beginning of each section of Chapter 3.

The evaluation gathered evidence for the analysis of contributions and outcomes at three levels:

1. *Key institutions and individuals at the policy level.* This work consisted of discussions in UNDP Headquarters, with its partner agencies, and within the case-study countries—UNDP CO management, development partners, and government, civil society and private sector leaders who shape public policy and responses to HIV/AIDS.
2. *Implementing institutions and individuals at the intermediate level.* This included UNDP CO focal persons and other partners whose programmes contribute to achieving HIV/AIDS results related to the five outcome areas.
3. *Community-level assessments.* These focus group discussions explored the perspectives of community leadership, community-based organizations and people who are infected or affected by HIV/AIDS, or are at risk of infection.

The evaluation team compared this evidence with information gleaned from documents produced by UNDP and others to establish the veracity of outcomes and their plausible association with UNDP. By this approach, the analysis of outcomes went beyond what UNDP stated as planned or actual outcomes of its interventions. The evaluation process endeavored to capture changes that might not have occurred without UNDP's role as well as missed opportunities where UNDP might have been able to contribute to results but did not. Triangulation of information from several data sources at the country and international levels was used to validate outcomes and confirm the significance of various views on strategic issues for UNDP. At the end of most country assessments, a stakeholder workshop was used to verify the reported changes (outcomes) and their plausible association with UNDP.

On the basis of their country visits and the draft national consultant assessments, members of the international team compiled a detailed matrix of UNDP contributions and results for each case-study country under the five outcome themes for the evaluation. This matrix was an essential transition tool for drafting of the overall evaluation report.

Members of the international consultant team reviewed the national consultant assessments in detail. Feedback on the national consultant studies was

obtained from the UNDP CO. The final version of the national consultant assessment was then completed. While the main report commits the international consultant team, responsibility for the country assessments lies with the national consultants.⁸ These assessments are being published separately.

Members of the international team have summarized the team's assessment of UNDP's HIV/AIDS roles and contributions in each of the case-study countries in Annex 6. In an endeavour to provide further guidance to UNDP and its COs, the team has prepared a brief box at the beginning of each country summary on the international consultant team's views of strategic issues and key implications of the evaluation study for UNDP action in that country. In some cases, these lessons may also have wider application.

1.4 LIMITATIONS OF THE EVALUATION AND LESSONS FOR FUTURE EVALUATIONS

The contributions and outcomes analyzed in the evaluation reflect notable changes that were identified. However, at the time of the evaluation, many changes were intermediate, incremental and/or limited in scale and scope. Validation of contributions and outcomes and their association with UNDP was largely based on triangulation by the evaluation team. Frequently and strongly articulated views of informants were an important factor. Further validation was often not possible due to scarcity of quantitative or other clearly documented evidence. Weaknesses in monitoring and especially in outcome-oriented evaluation at the CO level greatly impeded the successful accomplishment of the evaluation task. Additional limitations were encountered because UNDP was often only one of several players. Indeed, associations with UNDP were generally difficult to discern in the case-study countries, because other influential players also tended to be engaged in areas of UNDP involvement. This made it impossible in most cases to specify how UNDP made a difference, with detailed disaggregation of the roles of UNDP and other partners. Finally, in a number of instances, there were gaps in knowledge of UNDP work among some key stakeholders and informants. Nonetheless, the evaluation team considers the review of outcomes to be sufficiently robust to permit presenting a number of conclusions and raising key strategic issues that are likely to be

⁸ In a few cases, members of the international consultant team have joined as co-authors of the National Consultant reports.

valid and have implications for strengthening roles played by UNDP in the HIV/AIDS response.

The evaluation has probably underestimated the importance of UNDP's country partners in the changes that it reports. This is a consequence of the evaluation's focus on UNDP and its roles and contributions, rather than on the case-study countries themselves. The evaluation was also largely unable to assess the ultimate impact of UNDP contributions to the HIV/AIDS response, even when it was able to reach outcomes. In light of the overall importance of UNDP contributions in key areas, such as the development of the National AIDS Commissions, this is an area for future evaluations that might be considered by UNDP.

In addition to assessing UNDP's role and contributions in the HIV/AIDS response at the country level, the evaluation also sought to contribute to the methodology for results-oriented evaluation. UNDP is seeking to position itself as a broker of ideas, a catalyst for innovation, and a guardian of principles of country-owned development. The evaluation team believes that UNDP can and should integrate lessons learned from the evaluation in the design, staffing and budgeting of future evaluations.⁹

One major finding of the evaluation is that, although there is a commitment to shift away from traditional project evaluation at the corporate level, outcome evaluation methodology is not yet firmly anchored in UNDP. At the country level, outcome evaluation is a very recent innovation. Generally, it is still viewed as an outside consultant exercise, rather than part of a process of learning and knowledge management integral to the work of UNDP COs. The level of support for the evaluation varied from country to country. This seemed related to CO capacity and understanding of outcome evaluation.

The familiarity and capacity of national consultants to use the outcome evaluation methodology was a constraint. Although a training workshop was conducted prior to launching the country assessments, considerable further effort was required to establish a shared understanding of the concepts and tools. Even then, gaps in understanding remained, which delayed completing the national consultant assessments. Of the 10 countries, the international team was able only to visit six. This limitation may also account for some disparities in the consistency of evidence gathered and analyzed and in the quality of the country assessment reports.

⁹ A separate and more detailed discussion of the terms of reference, methodology and constraints was submitted to the Evaluation Office at its request as part of the Draft Report.

Several other important constraints and limitations should be considered in interpreting findings and conducting future evaluations:

- The timing of the evaluation can impose important limitations. In this evaluation, the brief and highly variable period of implementation of many UNDP interventions limited the ability of the evaluation team to identify the emergence, scale, depth and sustainability of changes and outcomes.
- Specific programmes and activities were not analyzed separately, and analysis focused on 'what changes UNDP made' in the five outcome theme areas. Use of broad outcome theme categories and open-ended enquiry as the starting point for assessment is, arguably, methodologically desirable: It helps to identify unintended outcomes and the most prominent outcomes rather than what is 'expected,' and it also reduces risk of focus on programme evaluation rather than outcome evaluation. However, this approach led to frustrated expectations at the country and programme level. Some stakeholders wished a more project-based approach, with more explicit acknowledgement of processes, activities and outputs, and more specific guidance and commentary on country-level programming¹⁰.
- Limitations of monitoring and evaluation (M&E) data related to inputs, processes and outputs also imposed important constraints on the evaluation. More conventional M&E data can add substantially to the ability to draw conclusions about association, attribution, scale and depth of outcomes, but their infrequent availability at the country level became a major limitation. Where such data were available, as in recent evaluations conducted in some countries, such as Zimbabwe, and by UNDP's Bureau of Development Policy (BDP), their results were used to enrich the analysis of outcomes and UNDP contributions.
- The Regional Centre and the Advancing Resource Mobilization and Delivery for Africa (ARMADA) and SACI initiatives have the potential to play major roles in achieving development outcomes and addressing the strategic issues emerging from the challenges posed by HIV/AIDS in Southern Africa. However, at the time of this evaluation, they were still being established and defining their roles. The ability of the evaluation team to draw

¹⁰ This frustration was expressed by a number of stakeholders, especially CO and some Headquarters staff, who subsequently provided useful additional information to facilitate further understanding of outcomes. The focus of the evaluation remained at a strategic rather than project level.

conclusions on outcomes of their work was therefore limited, although clearer definition of their roles should be facilitated by the findings and recommendations of the evaluation.

Reflecting on the terms of reference for the evaluation, the evaluation team drew three overall conclusions:

- While the team has been able to carry out an outcome-oriented evaluation of UNDP's role and contributions, the original terms of reference were overly ambitious. The full terms of reference (only a summary is presented in Annex 1) amounted to more than 12 pages. To explore fully a number of issues in the terms of reference would have required methodologically distinct evaluations or detailed sub-evaluations.¹¹
- The evaluation required resources in time, personnel and funds significantly in excess of those initially planned by UNDP. Future evaluations should anticipate a need to provide for more training of national consultants, more engagement of the international team with national specialists at all stages of the evaluation, and a period of joint analysis of results. The evaluation team considers a writer's workshop an essential tool to bring evaluation personnel together from distant countries and experiences to compare and share experiences, to build a common understanding of the raw evaluation data, and to agree on assignments for drafting of the evaluation report.
- Early desk compilation of relevant data, including financial data committed to programmes at the country level were difficult to obtain, and when they were available, revealed grave inconsistencies. Future evaluations will need to be informed by such documentation, prepared by UNDP staff rather than external consultants, prior to the commencement of the assignment.

Overall, the evaluation mandate to focus on roles, contributions and results, combined with the devastating impact of HIV/AIDS and the great differences among the case-study countries, constituted a formidable challenge. Box 1.2 highlights some additional lessons for future UNDP evaluations.

1.5 OUTLINE OF THE EVALUATION REPORT

The following chapters synthesize the findings of the evaluation. Chapter 2 sets UNDP's role and contributions in the rapidly changing global context of HIV/AIDS responses. The chapter examines the evolution of global consensus around the millennium

BOX 1.2 METHODOLOGY LESSONS FOR FUTURE UNDP EVALUATIONS

This evaluation's experience suggests several lessons for future UNDP evaluations.

- **Choose timing carefully.** The present evaluation took place so early in the execution of many UNDP interventions that it proved very difficult to collect data on UNDP outcomes.
- **Manage expectations of all stakeholders.** Several COs expected the present study to focus more on individual projects and programmes than on the results of UNDP work.
- **Guard against excessively ambitious evaluation mandates.** The original terms of reference for this evaluation called upon the international team to undertake methodologically distinct evaluations and sub-evaluations that were not feasible within the time and other resources available.
- **Plan more carefully, particularly for work by national consultants.** More training and supportive supervisory engagement by the international team would have been appropriate in the present case.
- **Assemble, collate and review available UNDP information before launching an evaluation.** In the case of this evaluation, the international team—at a comparative disadvantage relative to UNDP staff—devoted substantial time late in the work on the report to collecting and reviewing information that should have been available at the outset.

challenges, the momentum built around HIV/AIDS, and the evolving role and associated challenges to UNDP. It contains basic information on UNDP AIDS-related programmes and activities at the country level, and comparative data.

Chapter 3 analyzes major UNDP contributions and outcomes associated with support to country-level responses to HIV/AIDS. This Chapter is organized around the five main themes of the evaluation. It analyzes changes that can be plausibly associated with UNDP as well as missed opportunities that might have improved results.

Chapter 4 summarizes major findings of the evaluation team, reviews UNDP's comparative advantages in addressing HIV/AIDS at the country level, and presents recommendations for future UNDP action.

11 Activities of other donor partners at the country level are a case in point. While the international team was able to collect overall data on partner financial engagement in the health sector in some of the case-study countries, as shown in Chapter 2, the work of team members with donor partners at the country level inevitably had to concentrate on their perception of UNDP activities instead of the activities of the partners.

UNDP'S ROLE AND ACTIVITIES IN THE HIV/AIDS RESPONSE



This chapter examines the role of UNDP, within the context of rapid worldwide change, in the HIV/AIDS response and provides an overview of UNDP's engagement in HIV/AIDS in the case-study countries. It summarizes the growing importance of HIV/AIDS in the global political dialogue, identifies significant changes in the institutional landscape concerning HIV/AIDS, provides data on recent massive increases in external financial support for the fight against HIV/AIDS, and examines shifts in donor programming policies and practices. It includes information on donor engagement in the case-study countries. It also summarizes UNDP's corporate, regional and country-level strategies and UNDP activities in the HIV/AIDS response in the case-study countries. The chapter concludes with the evaluation team's assessment of the urgency accorded to HIV/AIDS by the UNDP COs in each of the case-study countries.

2.1 CONTEXT: RAPID CHANGE IN THE ENVIRONMENT

2.1.1 GROWING IMPORTANCE OF HIV/AIDS IN THE GLOBAL POLITICAL DIALOGUE

During the period under review, HIV/AIDS has become an increasingly central theme in the global political dialogue. In January 2000, the first discussion of a single disease—HIV/AIDS—took place in the United Nations Security Council. The MDGs emerged from the work of the United Nations General Assembly at its Millennium Summit in September 2000. The MDG targets for 2015 include halting the spread of HIV/AIDS and beginning to reverse it. In June 2001, world leaders gathered in the General Assembly of the UN to hold a special session (the United Nations General Assembly Special Session on HIV/AIDS [UNGASS]) and adopted a Declaration of Commitment (see Box 2.1).¹² The Declaration contributes to HIV/AIDS awareness among political leaders and has substantially informed UNDP's activities in the countries covered by this evaluation.

¹² UN, "The UN General Assembly Declaration of Commitment on HIV/AIDS—Global Crisis-Global Action," Document A/RES/S-26/2, 2001.

BOX 2.1 THE UN GENERAL ASSEMBLY DECLARATION OF COMMITMENT ON HIV/AIDS—GLOBAL CRISIS-GLOBAL ACTION

In June 2001, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) declared a commitment by political and other leaders to implement multisectoral national AIDS strategies and integrate HIV/AIDS into the mainstream of development planning, including poverty reduction, by 2003. The UNGASS Declaration of Commitment saw care, support and treatment as fundamental elements of an effective response. It called for the realization of human rights and fundamental freedoms for all, including empowering of women, as essential to reducing HIV/AIDS vulnerability. The Declaration expressed the view that to address HIV/AIDS is to invest in sustainable development. It stated that the HIV/AIDS challenge cannot be met without new, additional and sustained resources. The Declaration supported the establishment of the Global Fund and anticipated a world-wide fundraising campaign by 2002. It called for conducting periodic national reviews of progress in meeting commitments in the Declaration with the participation of civil society. A high-level UN meeting in May-June 2006 is expected to review progress on the Declaration of Commitment and to keep attention focused on HIV/AIDS globally and at the country level.

In its 2000 report, the High Level Panel on Threats, Challenges and Change established by the UN Secretary-General included HIV/AIDS as a threat faced by the international community. The Panel called on the Security Council to examine the future effects of HIV/AIDS on states and societies, to generate research on the problem, and to identify critical steps towards a long-term strategy for diminishing the threat to international peace and security.¹³

Regular discussion of HIV/AIDS has taken place at the Summit meetings of the G7 and G8 major industrial countries. In 2001, together with the UN Secretary-General the G7 launched the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).¹⁴ In July 2005, the leaders at the G8 Summit agreed to aim as close as possible to universal access to

treatment of HIV/AIDS in Africa by 2010. They also agreed to double official development assistance to Africa between 2004 and 2010.¹⁵

In December 2004, the UN Millennium Project submitted its report to the Secretary-General. It argued that the MDGs should serve as the foundation for country development strategies and for the determination of the level and allocation of external development assistance support. It called for each donor to increase Official Development Assistance (ODA) to 0.7 percent of gross national product (GNP) by 2015, with 0.54 percent devoted to the MDGs largely as grants-based budget support.¹⁶

In March 2005, the UN Secretary-General released his report 'In Larger Freedom' in follow-up to the Millennium Summit and the report of the High Level Panel on Threats, Challenges, and Change, and in preparation for the September 2005 Millennium Summit Plus Five review by the UN General Assembly. The report highlighted HIV/AIDS and called on the international community to provide resources for an expanded response, as identified by UNAIDS and its partners, and to provide full funding for GFATM.¹⁷ The Outcome Document for the Millennium Summit Plus Five review re-committed political leaders to the UNGASS Declaration. It called for countries to come as close as possible to the goal of universal access to AIDS treatment by 2010. It engaged leaders in working actively to implement the 'Three Ones' Principles,¹⁸ and welcomed and supported the recommendations of the Global Task Team on Improving AIDS Coordination.¹⁹

2.1.2 CHANGES IN THE INSTITUTIONAL LANDSCAPE

There have been many changes in the international institutional landscape concerning HIV/AIDS during the period under review, including:

13 High Level Panel on Threats, Challenges, and Change, "A More Secure World: Our Shared Responsibility," UN Document A/59/565, December 2, 2004.

14 University of Toronto G8 Information Centre, "Introduction to G7/G8 Commitments, 1975-2002, Appendix B, list of Individual Commitments." Available online at www.g7.utoronto.ca/datasets/allcommitments/app_b_cycle4.html, accessed April 9, 2005.

15 Available online at http://www.fco.gov.uk/Files/kfile/PostG8_Gleneagles_Africa,0.pdf, accessed August 10, 2005.

16 Available online at http://www.unmillenniumproject.org/reports/recom_07.htm, accessed April 23, 2005.

17 UN, "Report of the Secretary General: In Larger Freedom: Towards Development, Security and Human Rights for All," Document A/59/2005, pg. 16.

18 The Three Ones Principles include the following: a single agreed strategic framework, a single national AIDS coordinating authority, and a single agreed country-level monitoring and evaluation system

19 UNGA, "2005 World Summit Outcome," Document A/RES/60/1 para. 57.

- The creation of the GFATM is a particularly notable development.
- Both the Bill and Melinda Gates Foundation and the Merck Foundation have each donated USD 50 million for AIDS in Botswana.²⁰
- The Clinton Foundation is giving particular attention to AIDS care mainly in Africa under the general umbrella of its health security programme.²¹
- The George W. Bush initiative of the United States has taken institutional form in the President's Emergency Plan for AIDS Relief (PEPFAR), with support targeting 15 focus countries, including 5 of the 10 countries covered by this evaluation.²²

From the standpoint of UNDP, the most significant institutional change during the period of this evaluation is the striking growth in UNAIDS—a joint programme co-sponsored by 10 UN agencies, including UNDP and the World Bank. UNAIDS has developed its role in advocacy, in the facilitation of coordinated action, and in technical support. The UNAIDS Secretariat has increased its field presence to facilitate support to enhance national responses. While the core Unified Budget and Workplan (UBW) resources for the Secretariat have not grown, the budget for country-level work grew 76 percent in the UBW for 2004-2005. The core UBW for 2006-2007 foresees 28 percent overall growth over the 2005-2006 period, to a total of USD 320 million.²³ In many countries, the UNAIDS Secretariat has recruited full-time Country Coordinators whereas UNDP has only part-time HIV/AIDS focal points.

The growing importance of the civil society, globally and within individual developing countries, is another important element of the changing institutional HIV/AIDS landscape. In South Africa, a wide variety of civic groups, including organizations formed by those infected or affected by HIV/AIDS, constitute a growing militancy. In several other countries, such as Botswana, the emergence of civil society has been more oriented towards the mobilization of resources and partnerships, as well as

direct service roles in HIV/AIDS. UNDP has reflected this growing importance of civil society roles through support to civil society organizations in the case-study countries.

2.1.3 INCREASES IN EXTERNAL FINANCIAL SUPPORT FOR THE FIGHT AGAINST HIV/AIDS

Pledges and commitments of external financial support for the fight against HIV/AIDS have grown greatly in the 1999-2004 period. In 2000, the World Bank initiated its Multi-Country AIDS Programme (MAP), to provide grants and soft loans to support AIDS programmes in Sub-Saharan Africa. By January 2004, the World Bank had committed more than USD 820 million to 24 countries under the MAP Programme. In early 2003, United States President George W. Bush pledged USD 15 billion to respond to AIDS in low and middle-income countries. Approximately USD 9 billion of this sum is new money, earmarked for 12 African countries plus Guyana and Haiti.²⁴ By the end of 2003, the GFATM had approved 227 grants totaling USD 2.1 billion in 124 countries. Approximately 60 percent of these resources were earmarked for AIDS programmes, and 60 percent of the total is allocated to Africa.²⁵ By early 2005, GFATM had approved \$1.8 billion in grants to Sub-Saharan African countries.²⁶

2.1.4 SHIFTS IN DONOR HIV/AIDS PROGRAMMING AND PRACTICES

In the mid to late 1990s, donor funding priorities in HIV/AIDS tended to focus on delivering public goods and services, such as surveillance, and on prevention interventions, including behaviour change. Since the late 1990s, greater focus has been placed on mainstreaming HIV/AIDS into programmes and policies across a variety of sectors in order to make use of their comparative advantages to strengthen national responses to HIV/AIDS. There has also been increasing emphasis on the need to address issues such as governance and poverty in order to reduce vulnerability to HIV/AIDS. However, recent focus on treatment has led to a partial redefinition of HIV/AIDS as a health issue.

20 Available online at <http://www.achap.org/index.htm>, accessed April 23, 2005.

21 Available online at <http://www.clintonfoundation.org/programmes-hs.htm>, accessed April 23, 2005.

22 Available online at http://www.usaid.gov/our_work/global_health/aids/, accessed April 23, 2005.

23 UNAIDS, Programme Coordinating Board, "Unified Budget & Workplan 2006-2007," Geneva, Document UNAIDS/PCB(17)/05.4, June 27-29, 2005.

24 UNAIDS, "2004 Report on the Global AIDS Epidemic," July 2004.

25 Ibid.

26 Data from Global Fund website, accessed April 23, 2005. In some cases, AIDS and TB are shown together, and in these cases the entire sum is allocated to AIDS.

In 2004, UNAIDS and its partners adopted the Three Ones Principles—a single agreed strategic framework, a single national AIDS coordinating authority, and a single agreed country-level M&E system.²⁷ Exemplifying these trends, the March 2005 Paris Declaration on Aid Effectiveness committed participants to address “insufficient integration of global programmes and initiatives into partner countries’ broader development agendas, including critical areas such as HIV/AIDS.”²⁸ Moving donor funding from a project to a programme approach is increasingly being accepted, in principle. At the country level, donors are trying to work within the framework of AIDS Sector Wide Approaches (SWAps),²⁹ involving common donor modalities in support of a given sector programme and, where possible, pooling funds into a common account. Malawi is a case in point, where donors have pooled resources to support a unified national plan for HIV/AIDS.

2.1.4 DONOR ENGAGEMENT IN CASE-STUDY COUNTRIES

Total commitments of official development assistance for HIV/AIDS in the case-study countries have averaged about USD 280 million per year.³¹ Total approved grants from GFATM in case-study countries for HIV/AIDS amount to more than USD 400 million (Annex 5c).

There is enormous variation in the engagement of donors, including the principal external financiers GFATM, PEPFAR and MAP, in HIV/AIDS programmes in the case-study countries (Table 2.1). GFATM is the only principal financier engaged in all 10 case-study countries, but there has also been considerable variation in its grants by round. Only two of the case-study countries are receiving funding from all three principal external HIV/AIDS financiers—Ethiopia and Zambia.

27 UNAIDS, “2004 Report on the Global AIDS Epidemic.”

28 High Level Forum, “Paris Declaration on Aid Effectiveness: Ownership, Harmonization, Alignment, Results and Mutual Accountability,” March 2, 2005. Participants in the Paris meeting included five of the case-study countries for this evaluation—Botswana, Ethiopia, Malawi, South Africa, and Zambia—and all of the main bilateral donors. The 26 participating organizations included the UN Development Group.

29 Sector Wide Approach refers to the coordination of multi-donor support to a country’s development programme in a given sector.

30 Round 3 was for Tuberculosis, but is mentioned here because of the inclusion of combined AIDS/TB components.

The significant growth in overall external financing available for HIV/AIDS in developing countries has its counterpart in dramatic increases in external HIV/AIDS financing and in total public expenditures on health in some of the case-study countries (Figure 2.1). In Zambia, for example, the programmed increase in annual external HIV/AIDS funding from 2000–2002 to 2002–2004 was estimated to be nearly 700 percent (Figure 2.2). The consequences of this dramatic increase in financing include new challenges in managing public finances and ensuring respect for country priorities, which risk being distorted as a result of new external resources. In addition, there are a number of challenges in moving from pledged and programmed resources to legal commitments, to disbursements to the country, to effective utilization for widespread service provision and positive development results.

These shifts in the environment for development cooperation have profound implications for UNDP. While the specific consequences vary from country to country, there is a global shift in the needs of UNDP’s developing country partners from advocacy to implementation (including effective use of newly programmed and pledged external financial resources).

TABLE 2.1 ENGAGEMENT OF PRINCIPAL EXTERNAL HIV/AIDS FINANCIERS AMONG CASE-STUDY COUNTRIES

Country	GFATM Round ³⁰	US PEPFAR	World Bank MAP
Angola	4		X
Botswana	2	X	
Ethiopia	2,4	X	X
Lesotho	2		
Malawi	1		X
Namibia	2	X	
South Africa	1,2,3	X	
Swaziland	2,3,4		
Zambia	1,3	X	X
Zimbabwe	1		

Source: Donor agency reports

31 Data from OECD/DAC database; see Annex 5.

FIGURE 2.1 EXTERNAL AIDS FUNDING'S IMPACT ON PUBLIC EXPENDITURE ON HEALTH³²

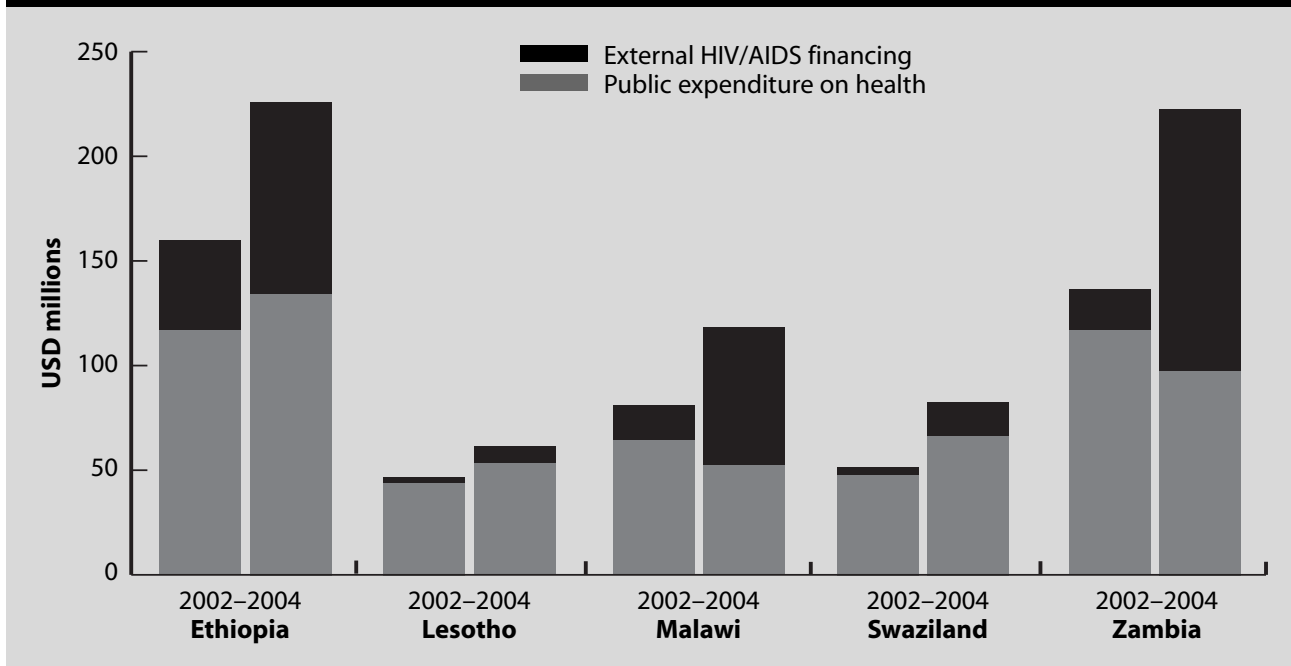
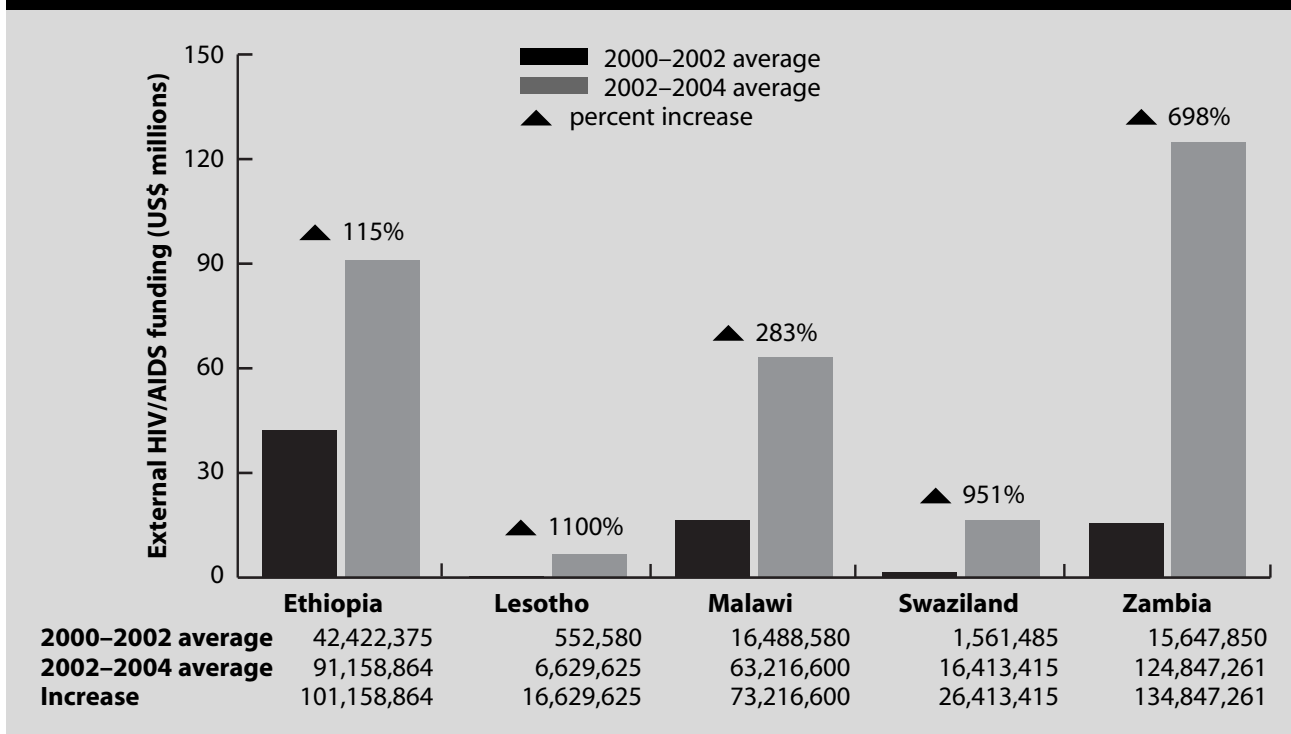


FIGURE 2.2 CHANGES IN EXTERNAL HIV/AIDS FUNDING FOR CASE-STUDY COUNTRIES³³



32 Lewis M, "Addressing the Challenge of HIV/AIDS: Macroeconomic, Fiscal and Institutional Issues," Working Paper 58, Centre for Global Development, April 2005.

33 Ibid.

2.2 UNDP'S HIV/AIDS RESPONSE: CORPORATE AND REGIONAL STRATEGIES AND PROGRAMMES

During the period covered in this evaluation, UNDP's role in HIV/AIDS has substantially increased. HIV/AIDS has gained higher priority in UNDP, with many new activities. Initially, HIV/AIDS fell under the category of 'Economic and social policies and strategies focused on the reduction of poverty'—the second of UNDP's six corporate goals. Only at the level of sub-goal one, which called for comprehensive strategies to prevent the spread and mitigate the impact of HIV/AIDS,³⁴ did AIDS have early prominence. When the Annual Reports for 2002 and 2003 were issued, HIV/AIDS rose in priority, as one of six independent practice areas, though there was no systematic discussion of results in this area.³⁵ The 2005 Annual Report emphasizes leadership and capacity development, development planning centered on HIV/AIDS, and advocacy and communication.³⁶ HIV/AIDS has been highlighted repeatedly by the UNDP Administrator as a corporate priority and as "an unparalleled crisis."³⁷

Working as a co-sponsor of UNAIDS, UNDP established a corporate HIV/AIDS strategy that gives particular attention to creating the policy, legislative and resource environment essential for effective development planning, and for a multisectoral response to the AIDS epidemic. The strategy called upon UNDP to be fully mobilized at the country level to meet its obligations as a UNAIDS co-sponsor. UNDP proposed to make a difference by promoting leadership and developing capacity to respond to the epidemic at all levels, by strengthening development planning and systems to address HIV/AIDS, and by generating responses that are gender-sensitive and respectful of people's rights. The strategy set out three service lines: leadership and capacity development; development planning, implementation and HIV/AIDS responses, including mainstreaming; and advocacy and communication.³⁸

The 2004 evaluation of the 2nd Global Cooperation Framework by the UNDP Evaluation Office described UNDP corporate strategy and service lines as founded on the organization's strengths, and considered them to have provided a solid foundation for actions to address the epidemic. The report called for the strategy to "be expanded globally and scaled up within countries." However, evidence collected by the evaluation team suggests that, as of late in 2004, most interventions remained at limited project and pilot levels. This is discussed in more detail in Chapter 3.

UNDP's statement in the UNAIDS 2006-2007 UBW presents an expansive vision of UNDP's roles and expected results in relation to HIV/AIDS, including: strengthened leadership and capacity of governments, CSOs, development partners, communities and individuals, to respond to AIDS; implementation of AIDS responses as multisectoral and multilevel national, district and community actions that mainstream AIDS into national development plans, budgets and instruments; reduction of stigma and discrimination; human and institutional capacity building for AIDS programmes; and support to the UN Resident Coordinator system. Further insight into UNDP's vision of its role in HIV/AIDS is contained in the division of labour, specifying core functions of various UN Agencies in the fight against HIV/AIDS. This was concluded in follow-up on the work of the Global Task Team established early in 2005 under the auspices of UNAIDS. UNDP was designated as the lead agency for 'HIV/AIDS and development, governance and mainstreaming, including instruments such as PRSPs and enabling legislation to address human rights and gender.'³⁹ In addition, UNDP was identified as a "main partner" on 5 of 17 other areas in the agreed division of labour. While this effort has reaffirmed the role of UNDP as the lead agency for AIDS and development, AIDS-related governance, and HIV/AIDS capacity development, it is unclear to the evaluation team how the many roles specified in the UBW statement could be absorbed within UNDP's existing human resource and financial constraints.⁴⁰

34 Goals and sub-goals as cited in ROAR 2001, UNDP, 2002. Available at www.undp.org

35 UNDP, "Annual Report 2002," UNDP, "Annual Report 2003."

36 UNDP, "A Time for Bold Ambition—Together We Can Cut Poverty in Half," UNDP Annual Report 2005.

37 Message of the UNDP Administrator Mark Malloch Brown for the World AIDS Day, December 1, 2004. World AIDS Day Statement, 2004.

38 UNDP, "Corporate Strategy on HIV/AIDS—Leadership for Results," no publication date.

39 UNAIDS, "Technical Support Division of Labour, Summary and Rationale," 2005.

40 UNAIDS, "Report of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors," June 2005.

At the regional level, UNDP's second Regional Cooperation Framework (RCF) for Africa 2002-2006, identified the reduction of the HIV/AIDS threat in Africa as one of five strategic areas.⁴¹ Under the umbrella of a large project providing AIDS-related services in 7 of the 10 countries covered by this evaluation,⁴² UNDP has supported four HIV/AIDS objectives targeted in the RCF. These are to: harmonize and strengthen national strategic plans; research, develop and disseminate cross-country methodologies and approaches; strengthen capacities of regional institutions; and build regional consensus on strategies for managing the epidemic.

Beyond the RCF, UNDP has initiated cooperation on HIV/AIDS with countries covered by this evaluation under SACI and the ARMADA Project. Covering all of the case-study countries but Angola⁴³ and Ethiopia, SACI endeavors to respond to the threats to African capacity from HIV/AIDS. However, the project is too new for this evaluation to be able to report outcomes.⁴⁴ UNDP's ARMADA Project is even newer than SACI, as the Project Document was only signed in November 2004. The Project aims to strengthen the capacity of UNDP COs for financial and procurement management under external assistance.

2.3 OVERVIEW OF UNDP'S ROLE AND ACTIVITIES IN THE HIV/AIDS RESPONSE

This section examines the UNDP country cooperation frameworks (CCFs) in the case-study countries, summarizes available data on UNDP activities, and presents information on UNDP spending on HIV/AIDS projects and programmes.⁴⁵ The chapter concludes with a comparative assessment of the urgency accorded to HIV/AIDS in the work of each of the case-study COs of UNDP.

41 UN, "Second Regional Cooperation Framework for Africa (2002-2006)," UN document DP/RCF/RBA/2, November 21, 2001.

42 Angola, Malawi and Namibia are the exceptions.

43 The Resident Representative in Angola expressed concern that Angola is not eligible for SACI support.

44 The first SACI annual report and the work of this evaluation team at country level indicate that the SACI activities are only at the initial stage. Source: UNDP, "Southern Africa Capacity Initiative, First Annual Report, March 2004-March 2005."

45 Elements of the UNDP response to HIV/AIDS in each case-study country are set out in more detail in Annexes 3, 4, and 5.

2.3.1 COUNTRY COOPERATION FRAMEWORKS, STRATEGIES AND HIV/AIDS PROGRAMMES

The evaluation found it difficult to obtain a clear picture of UNDP's country HIV/AIDS strategies, programmes and activities in the case-study countries. UNDP's overall CCF documents have given increasing attention to HIV/AIDS in the case-study countries, as seen from extracts in Annex 3. Nonetheless, HIV/AIDS in some countries still seems to be a less-than-central element in the CCFs, when viewed in the light of UNDP's corporate priority on HIV/AIDS and, especially, the huge negative development effects of the disease in nearly all of the case-study countries. Reviewing the CCFs against actual experience at the country level, the evaluation team found that the CCFs often gave a limited idea of what was intended. Planned objectives and results were very general, with scant definition of 'intermediate' results. Consequently, the CCFs have not necessarily been consistent or adequately captured what UNDP has actually planned and executed at the country level. For example, in the case of Lesotho, there has been much more activity, and many more outcomes, than would be expected even from the revised CCF for 2002-2004.

Beyond the CCFs, which are understood to be formulated at a fairly high degree of generality, the team examined available overall data on UNDP country-level HIV/AIDS programmes (collated in Annex 4). This material did not include all programme components, including cornerstones such as the Leadership Development Programme and Community Conversations. These disconnects between CCF and programme statements, compared to actual activities, might indicate adaptation, evolution, and flexibility in UNDP's response. However, they also suggest possible disjunctions among the paradigms and strategies of UNDP COs, its Headquarters, and its Regional Centre.

2.3.2 WHAT DID UNDP DO AT THE COUNTRY LEVEL?

Table 2.2 summarizes UNDP's areas of support and activities at the country level from the country assessments,⁴⁶ the country summaries (Annex 6), and the country visits of evaluation team members. It

46 To be published separately.

TABLE 2.2 UNDP SUPPORT AND ACTIVITIES IN CASE-STUDY COUNTRIES

Country	LDP	CC	NAC	Decentralized HIV/AIDS structures	Policy and Rights	CSO	Knowledge generation	Mainstreaming and development planning	Work-place response	Partnership structures and roles
Angola			X			X	X	X	X	X
Botswana	X		X	X	X	X	X	X	X	X
Ethiopia	X	X	X	X	X	X	X	X	X	X
Lesotho	X		X	X	X		X	X	X	X
Malawi			X		X	X		X		X
Namibia			X	X	X		X	X	X	X
South Africa	X	X						X	X	
Swaziland	X	X	X		X	X	X	X	X	X
Zambia			X	X	X	X	X	X	X	X
Zimbabwe			X	X	X		X	X		X
Total countries	5	3	9	6	8	6	8	10	8	9

Source: Country assessments and evaluation team country visits.

Note: Areas of support are not exclusive. Thus one UNDP country-level activity may actually fall in two areas of support.

Abbreviations: LDP—Leadership Development Programme; CC—Community Conversations; NAC—National AIDS Commission/Council; CSO—civil society organization.

shows UNDP engaged in a wide range of HIV/AIDS-related activities and roles. However, the table reveals that UNDP has not been active in each area in each country. It also shows that UNDP is doing what it said it would do and supporting what it said it would support.⁴⁷ The table does not capture the prominence, depth, or financial commitments of UNDP in each area, nor does it present the roles played by the UNDP CO beyond financing of HIV/AIDS activities.⁴⁸ Thus, it must be considered indicative rather than exhaustive.

2.3.3 FINANCIAL DATA ON UNDP HIV/AIDS PROJECTS AND PROGRAMMES

In attempting to place UNDP HIV/AIDS activities and outcomes at the country level in context, the evaluation team reviewed financial data on the amount and share of programming resources devoted to HIV/AIDS at the country level.⁴⁹ Obtaining

consistent, timely financial data on UNDP HIV/AIDS projects and programmes in the case-study countries proved impossible within the resources in time and money allocated to the evaluation. The evaluation team is concerned that this situation raises issues of UNDP's capacity to be accountable and to manage resources for optimal effect.

To the extent that the evaluation team could gather relevant information, UNDP HIV/AIDS projects in the case-study countries and their planned spending for the period 1999–2004 are shown in Annex 5a.⁵⁰ The grand total of UNDP planned spending on these projects, from its own resources, is USD 17 million, or approximately USD 3 million per year. Cost-sharing resources bring the total to almost USD 39 million, or approximately USD 6.5 million per year. Actual spending data on the projects were not available.

On the basis of reports from the UNDP COs, the evaluation found significant differences among the case-study countries in the amounts and shares of HIV/AIDS spending in the total UNDP country

47 Beyond answering the question whether UNDP “did the right thing,” as the evaluation does here, the evaluation was also asked to answer the question whether UNDP “did things right.” The team was unable to answer this second question, because it would require a level of familiarity with UNDP processes and management policies that external consultants could not achieve without undertaking a separate, special study.

48 The non-financial roles of UNDP leaders and CO staff are, however, discussed in this chapter under the appropriate outcome themes.

49 Gathered from UNDP COs and Gateway and Atlas databases.

50 UNDP Headquarters maintains financial data on UNDP projects, in two databases, Gateway and Atlas, covering different periods; these data are not mutually consistent among themselves, nor with data from other sources.

TABLE 2.3 UNDP SPENDING ON HIV/AIDS IN CASE-STUDY COUNTRIES, 2002-2004

Country	2002 HIV/AIDS amount (USD)	2002 HIV/AIDS share of total UNDP country programme (%)	2003 HIV/AIDS amount (USD)	2003 HIV/AIDS share of total UNDP country programme (%)	2004 HIV/AIDS amount (USD)	2004 HIV/AIDS share of total UNDP country programme (%)
Angola	15,541	<1	562,937	7	720,257	7
Botswana	3,085,324	61	3,416,443	57	1,980,693	62
Ethiopia	353,350	3	907,908	9	1,000,628	6
Lesotho	88,676	5	521,406	17	921,738	42
Malawi	309,705	5	689,126	9	885,643	6
Namibia	40,515	5	360,152	22	207,941	9
South Africa	2,875,417	37	2,465,223	36	3,352,447	30
Swaziland	167,135	39	132,135	28	70,914	18
Zambia	1,034,701	37	1,411,313	47	1,529,000	28
Zimbabwe	737,398	11	423,952	6	2,227,026	22
Total	8,707,762	NA	10,890,595	NA	12,896,287	N/A
Average	N/A	20	N/A	20	N/A	23

Source: UNDP country offices.

Notes: N/A indicates not applicable. 1) All currency is in US dollars, at current exchange rates. 2) For some countries, 2004 spending data are preliminary, not final. 3) Excludes UNDP CO staff and other overhead costs; to this extent it represents a lower bound of UNDP programme spending on HIV/AIDS. 4) Includes country-specific spending on regional projects, such as the Southern Africa Capacity Initiative, to the extent that it is included in country programme accounts maintained by the country office. 5) Table includes all programme spending on HIV/AIDS, regardless of source of funds; thus it includes trust funds. 6) Country programme shares are based on total country programme spending on HIV/AIDS, except for Swaziland, where the programme total used to calculate the share is limited to the poverty reduction and mainstreaming programme and does not include expenditure by the governance and gender mainstreaming programme. Thus the average HIV/AIDS share figures should be considered to represent an upper bound, and could be somewhat lower. 7) Namibia figure represent core resources only. 8) Since the unit of concern is the country, average shares are computed by country by weighting population.

programme spending (Table 2.3).⁵¹ These data represent a reasonable, but imperfect and difficult to interpret, approximation of the priority accorded to HIV/AIDS in UNDP country programmes. The small levels and shares of UNDP's spending in some countries, as reported by the COs, raise questions

about whether actual resource allocation adequately reflected UNDP corporate strategy and priority on HIV/AIDS at the country level. The very high share in other countries suggests that determined leadership by the UNDP Resident Representative or UN Resident Coordinator can make a difference.⁵²

51 Note: Upon review of a draft of this study, the UNDP Finance Office reported variances between its data and information received from some COs sufficiently important to take the position that it cannot endorse the expenditure data in this report. It observed that the variances would require further investigation and reconciliation with the COs. The evaluation team spent many weeks endeavoring to obtain complete and consistent data from the Finance Office and COs. Since it has not been feasible to complete the reconciliation of data during the period of this evaluation with the available resources, the evaluation team has chosen to rely on the CO data as a reasonable approximation and to retain the information on planned projects and spending in Annex 5A as indicative. The UNDP Finance Staff were able to reconcile Headquarters data with the CO data from some but not all of the countries in Table 2.3. The Finance Staff reported that UNDP has taken steps to ensure that financial reporting by substantive area will improve. Project trees have been set up in Atlas that capture UNDP's goals, service lines and core results. All UNDP projects are to be tied to these trees, allowing budgetary and expenditure reporting by substantive area.

It appears that UNDP spending on HIV/AIDS during the period covered by this evaluation has increased overall in absolute terms and fluctuated in share of the UNDP programmes in the case-study countries. In seven countries, the level of spending increased from 2002 to 2004, and in three countries it decreased over this period. Similarly, in six countries, the share of HIV/AIDS activities in UNDP spending rose from 2002 to 2003, and in four countries it declined. From 2003 to 2004, however,

52 The comprehensive summary in Annex 5B of UNDP's country programme on HIV/AIDS in Lesotho in the context of its total country programme, is a case in point. If time and available human resources had allowed, this table should have been completed by each CO.

TABLE 2.4 URGENCY ACCORDED TO HIV/AIDS BY UNDP COUNTRY OFFICES, 1999-2004

Country	Earlier in evaluation period*			Later in evaluation period*		
	little	medium	high	little	medium	high
Angola	X				X	
Botswana			X			X
Ethiopia	X				X	
Lesotho	X					X
Malawi		X			X	
Namibia	X				X	
South Africa	X				X	
Swaziland	X				X	
Zambia	X				X	
Zimbabwe	X				X	
Total	8	1	1	0	8	2

Source: Judgment of international consultant team, based on Table 2.2 (UNDP spending on HIV/AIDS in case-study countries), Annex 3 (UNDP Country Cooperation Frameworks in case-study countries), Annex 4 (UNDP HIV/AIDS Programmes in case-study countries), Annex 5a (UNDP HIV/AIDS projects in case-study countries, 1999-2004), and Annex 6 (Country Summaries).

*The evaluation team has not assigned years to the columns because of inter-country variation and to avoid creating an impression of unjustified specificity.

the share increased in only four countries, and it declined in six countries. It would be difficult to conclude from these data that—overall—the COs in the case-study countries gave great urgency to UNDP spending on HIV/AIDS during the period covered in this evaluation.⁵³

Table 2.3 indicates that UNDP's total spending on HIV/AIDS is not large enough to have a significant impact on the epidemic. This makes strategic use of its HIV/AIDS resources particularly important.

2.3.4 URGENCY OF HIV/AIDS IN THE WORK OF UNDP COs

Pulling together the wide range of available planning, programming and financial information on UNDP's work on HIV/AIDS through the COs, the evaluation team prepared a comparative assessment of the urgency accorded to HIV/AIDS in UNDP's work at the country level. The results (Table 2.4) show modest growth in the urgency accorded to HIV/AIDS in the 10 countries during the period covered by the evaluation. Eight COs showed low

urgency, one (Malawi) exhibited medium urgency, and one (Botswana) demonstrated a high level of urgency to HIV/AIDS early in the period. By the end of the evaluation period, the COs revealing medium urgency grew to eight and high urgency to two (Botswana and Lesotho).

2.4 CONCLUSION

There were dramatic increases in global political attention to HIV/AIDS during the period covered in this evaluation, along with significant increases in external funding for HIV/AIDS globally and in the case-study countries. It is not clear how successful UNDP has been in strategically adapting its HIV/AIDS responses to the dramatically changing global and country-level environment for HIV/AIDS programmes. While UNDP corporate strategy gives priority to HIV/AIDS, the breadth of UNDP's HIV/AIDS-related activities, in relation to its limited human and financial resources, raises questions for the evaluation team concerning the adequacy of focus and continuity.

The evaluation team was unable to identify documentation that brought together at the country level the various strands of UNDP HIV/AIDS

53 It should be noted that during the period in question, the amounts of external resources available from other external partners of the 10 countries for HIV/AIDS rose greatly, much more than UNDP's spending.

activities sponsored from UNDP Headquarters, from the Regional Centre for Southern Africa, and from the COs. There was little evidence of integration of corporate, regional and country-level strategies and activities—this integration is both an important challenge and a future opportunity for UNDP.

The priority given by UNDP to HIV/AIDS increased overall, and especially at Headquarters and regional levels, during the evaluation period. However, this higher priority was much less clear at the country level, from the country-level documentation analyzed in

this chapter.⁵⁴ In light of the stated corporate priority for HIV/AIDS, of the potential synergy between responses to HIV/AIDS and other development challenges, and of the development disaster that the disease now represents in nearly all of the case-study countries,⁵⁵ the evaluation team concluded that HIV/AIDS should receive significantly greater urgency and prominence in the work of UNDP at the country level, with clearly integrated country-level strategies and activities and increasingly strategic use of UNDP's limited resources.⁵⁶ Urgency should be measured inter alia by resources in people, time and money.

54 The recently completed UNDP Evaluation Office examination of gender mainstreaming by UNDP found, similarly, that “the strength and emphasis of the AIDS programme directed from New York did not seem to be matched by work at the country level.” UNDP, “Evaluation of Gender Mainstreaming in UNDP,” January 2006.

55 Angola may be an exception, since HIV/AIDS prevalence is low. In Ethiopia, prevalence is also relatively low but translates into a large absolute burden due to the country's large population.

56 The urgency given HIV/AIDS by UNDP in the work of its COs is not autonomously determined by the COs, since the UNDP programme is determined in consultation with the public authorities and partner governments.

KEY CONTRIBUTIONS AND OUTCOMES OF UNDP IN THE HIV/AIDS RESPONSE AT THE COUNTRY LEVEL

3

This chapter analyzes key contributions and outcomes of UNDP in the HIV/AIDS response at the country level in the 10 case-study countries under the five themes presented in Chapter 1—HIV/AIDS in relation to governance, leadership, mainstreaming, capacity development, and partnership coordination. Reviewing the contributions and outcomes by theme, each section of the chapter begins with a definition of the theme for the purpose of this evaluation. A box summarizes key contributions and outcomes under the theme. Strategic issues and ongoing challenges relating to the theme are presented at the end of each section. Country cases are cited in the text, with examples in boxes to illustrate innovative approaches and specific experiences and constraints.

3.1 GOVERNANCE

For the purposes of this evaluation, the governance theme encompassed:

- Strengthening of policy and strategic frameworks that shape and manage HIV/AIDS responses. These include national HIV/AIDS-related policies, strategies, laws and regulations, and policies and plans that reflect the UNGASS agenda.
- HIV/AIDS planning, including operational planning and decentralized planning.
- Institutional reform decisions, including changes to National AIDS Councils/Commissions (NACs) and other fora, and allocation of responsibilities.
- Action on human rights, women and gender dimensions, stigma and discrimination, including greater involvement of people living with HIV/AIDS (PLWHA).
- Public-private partnerships in the fight against HIV/AIDS, including policy and attitude shifts among business, media and policy makers that facilitate these partnerships.
- Civil society empowerment, inclusion and participation, including support to non-state actors to influence policy and actions, and responses related to arts and media.
- Public resource allocation decisions, including allocation of budgets and human resources.

BOX 3.1 KEY CONTRIBUTIONS AND OUTCOMES OF UNDP IN HIV/AIDS GOVERNANCE

UNDP has contributed substantially to three outcomes related to HIV/AIDS governance:

- Strengthening policies and strategic frameworks for managing national responses to HIV/AIDS.
- Strengthening decentralized HIV/AIDS planning.
- Increasing the presence and voice of civil society organizations and vulnerable groups, including PLWHA and women, by advocating for their rights and facilitating their participation. Empowerment of women was noted as a prominent contribution in communities targeted by UNDP's Community Conversations.

Governance issues in relation to HIV/AIDS remain a great challenge. Despite support from UNDP and other partners, AIDS policies and institutions remain weak and, in some cases, relatively ineffective. UNDP has not fully exploited its strong relationships with governments, and many opportunities exist to help to strengthen governance, particularly at decentralized levels, in relation to gender issues and in facilitating development of civil society and community involvement in HIV/AIDS governance.

The evaluation team discerned three significant UNDP contributions and outcomes to governance at the country level. This does not suggest that UNDP was inactive or ineffective in other areas, only that the results stand out in three specific areas—strengthening national policies and strategic frameworks for managing HIV/AIDS, strengthening decentralized HIV/AIDS institutions, and increasing the presence and voice of CSOs and vulnerable groups in advocacy and participation.

3.1.1 STRENGTHENING NATIONAL HIV/AIDS POLICY AND STRATEGIC FRAMEWORKS

Although there has been substantial inter-country variation, UNDP has actively engaged in advocacy and support for sound public policy and strategic frameworks for managing the HIV/AIDS pandemic in Southern Africa and Ethiopia. At the national level, UNDP was often influential, during the period covered in this review, in promoting development of policies and plans related to HIV/AIDS. UNDP contributed to developing or refining national HIV/AIDS strategic planning frameworks in Botswana, Ethiopia, Lesotho, Malawi, Namibia, Swaziland, and Zimbabwe. While the extent of

UNDP influence and the final results of UNDP's involvement were difficult to discern, the evaluation team concludes that they have led to increasing soundness and coherence in national responses to the pandemic in case-study countries.⁵⁷

UNDP's signal accomplishment, revealed in the country case studies and the evaluation team's visits, lies in moving HIV/AIDS paradigms from biomedical perspectives towards development perspectives. This was the case in all case-study countries except South Africa. While this shift was part of a global change, UNDP was considered by many informants to have been instrumental in successfully advocating for this paradigm shift within countries and for institutionalizing this shift in development planning and management. Support at the country level in systematically promoting the shift has been significant. It has encompassed a mix of interventions, including impact studies, situation analyses, start-up of new institutions such as the NACs, planning support to make these institutions functional, and actions of CO leaders and staff. In part due to UNDP involvement, the evaluation team found AIDS strategies in the case-study countries to be relatively less health-sector focused than prior to UNDP involvement and to give more emphasis to decentralized systems to manage and coordinate national HIV/AIDS responses.

UNDP contributions seem to be limited in the areas of legislative and regulatory change. The slow pace of associated national processes was cited as an explanation for delays in Namibia and Ethiopia.

In each of the case-study countries, except for Angola and South Africa, UNDP is reported to have been instrumental in helping orient development policy and planning towards the UNGASS agenda. This may have led to increased government focus on AIDS-related donor policy and planning, but there were minimal indications as to how far such initiatives have led to changes in country priorities and practice, or contributed to accelerating progress towards targets.

Reforming public sector institutions for coordinating policy and managing resources has been a crucial aspect of UNDP's governance support in relation to HIV/AIDS. UNDP contributions across all countries under review, except South Africa, have

⁵⁷ The evaluation team does not suggest that relevant national policies and institutions are entirely sound and coherent, only that UNDP has contributed to greater soundness and coherence than would otherwise be the case.

BOX 3.2 ZIMBABWE: MAINTAINING SUPPORTIVE HIV/AIDS GOVERNANCE UNDER CHALLENGING CONDITIONS

In Zimbabwe, UNDP has contributed substantially to maintaining supportive HIV/AIDS governance under challenging circumstances.

The national HIV/AIDS response during the period under review has been undermined by a drastic deterioration in the economy, political conflict, a 'brain drain' of skilled personnel, and reduction of support by a number of development partners. In this environment, UNDP has had a prominent role in interactions with the government and other stakeholders in HIV/AIDS. UNDP has used upstream policy advocacy and capacity development to strengthen national and local governance institutions to effectively coordinate a multi-sectoral and multilevel response to HIV/AIDS. This has contributed to a more supportive governance environment related to HIV/AIDS than would otherwise have been expected.

At the national level, UNDP support played a critical role in maintaining HIV/AIDS programme sustainability. Contributions included supporting the NAC's ability to plan and implement the national multisectoral and multilevel response, including development of functional administrative and financial systems. An important contribution of UNDP was also advocacy to parliamentarians, which facilitated the establishment

of the National AIDS Levy, a 3 percent payroll tax. The Levy has provided some resources to maintain the national response. Further, UNDP was appointed as Principal Recipient of Zimbabwe's Global Fund Round 1 grant. The grant provides access to resources that many feel Zimbabwe could not have secured without UNDP.

Further contributions to a supportive HIV/AIDS environment include UNDP's critical role in enabling government ministries to develop policies, plans and capacity through appointment of focal persons and task forces. In addition, UNDP helped to mainstream HIV/AIDS into key development policies through support to the national MDG task force, developing the influential Zimbabwe Human Development Report 2003 'Redirecting our Responses to HIV/AIDS Towards Reducing Vulnerability—The Ultimate War for Survival', and backstopping the macroeconomic framework development process.

At the decentralized level, UNDP played a key role in contributing to enhanced capacity of sub-national HIV/AIDS structures at provincial, district, ward and village levels. A major input was the deployment of national UN Volunteers (UNVs) to 10 provincial offices. They worked closely with provincial administrators and were the driving force behind

the provincial planning and implementation processes that encompassed both the provincial and the village level. UNDP also helped to implement participatory planning, starting from the community level and moving upwards, that incorporates the views of various stakeholders at each level. This produced a five-year National Strategic Plan as well as strategic and annual plans for every district and province.

Despite these UNDP contributions, Zimbabwe's capacity, resources and systems remained too limited to plan and implement an adequate HIV/AIDS response. Many structures from the national to the local level functioned poorly. Obstacles perceived during the evaluation included prevailing macroeconomic conditions; limited effectiveness of national and sub-national structures in articulating and carrying out their coordination roles; location of the NAC within the Health Ministry, which predisposed policy to medical approaches; the NAC's limited ability to retain key staff; and limited coordination with civil society groups active in HIV/AIDS. Regular, critical review of UNDP strategy will be required to ensure that UNDP contributes optimally to meeting Zimbabwe's HIV/AIDS-related needs under such challenging circumstances.

helped facilitate the establishment of new national mechanisms for coordinating multisectoral HIV/AIDS responses. These mechanisms generally have a similar governance character. Typically there is a NAC chaired by a senior politician or public figure. It usually consists of representatives of key institutions and sectors—government, private sector, and civil society. There is also a Secretariat managed by professionals, sometimes located within the Ministry of Health and sometimes under a higher cabinet level office or the Presidency.

These UNDP-supported institutional reforms have resulted in the establishment of platforms for

multisectoral and development-oriented HIV/AIDS planning at the highest levels of government. However, these institutions are still evolving. Critical governance challenges remain, as NACs have often had difficulty establishing their roles, authority and capacity, and are sometimes seen as donor-driven. In many cases, including Botswana and Zambia, technical assistance and other support from UNDP have helped to address such problems and consolidate change, but the effectiveness of NACs remains problematic in many of the study countries.⁵⁸

58 Detailed assessment of NAC effectiveness was beyond the scope of the evaluation but would be worth pursuing in light of UNDP's widespread support for NACs.

In Botswana, Ethiopia, Lesotho, Swaziland, Zambia, and Zimbabwe, UNDP has helped influence decisions by Ministries of Finance and other sectors to allocate percentages of line ministry budgets to HIV/AIDS. However, it is not clear how successful such budget interventions have been. There were indications that funds have been insufficient to meet needs and were often used ineffectively. Nonetheless, budget work is an important area for the future, in cooperation with other partners and especially where the international financial institutions are not engaged.

3.1.2 STRENGTHENING DECENTRALIZED PLANNING FOR AN EFFECTIVE HIV/AIDS RESPONSE

National AIDS coordinating structures often have decentralized equivalents at all levels of governance—provincial, district and, in some cases, community. Progress in establishing sub-national AIDS planning

and structures has been unsystematic. At the time of the evaluation, many were either dormant or functioning sub-optimally. UNDP has made important contributions to addressing these problems.

In Botswana, some success was achieved in decentralized HIV/AIDS planning through support to District Multisectoral AIDS Committees (DMSACs) (see Box 3.3). In Zambia, UNDP deployed national UNVs within District Commissioners' Offices and provided other support to facilitate the HIV/AIDS responses of District Development Coordinating Committees (DDCCs) and District AIDS Task Forces (DATFs). The evaluation found that AIDS-related planning and coordination infrastructure was being better integrated into district development efforts. In turn, greater functionality of DATFs has enhanced citizen demands for HIV/AIDS services and rights in district work plans and improved financial resource flow to support HIV/AIDS

BOX 3.3 BOTSWANA: STRENGTHENING HIV/AIDS GOVERNANCE AT NATIONAL AND DECENTRALIZED LEVELS

In Botswana, UNDP has contributed greatly to development of HIV/AIDS governance since the late 1990s.

Initially, UNDP supported the AIDS/STD Unit in the Ministry of Health, which at that time drove the national response to HIV/AIDS. UNDP had a key role in helping to redefine institutions and to develop a more participatory, decentralized approach to the management and implementation of the national response.

UNDP advocacy and support contributed substantially to establishing and strengthening Botswana's NAC, National AIDS Coordinating Agency (NACA), Department Committees and more decentralized structures and support groups. UNDP advocacy contributed to the President's decision to chair and provide leadership in the NAC. The authority of HIV/AIDS structures has also been enhanced by situating NACA in the Office of the State President, elevating the NACA National Coordinator's position to Permanent Secretary level, and appointing District Commissioners or Council Secretaries as the Co-

Chairs of DMSAC. UNDP also supported processes to develop and refine the National Policy on HIV/AIDS and the National Strategic Framework, which provide guidelines on the roles and responsibilities of these institutions.

At the district and community level, DMSACs and Village AIDS Committees facilitate coordination and implementation of HIV/AIDS interventions. UNDP provided technical support to 10 districts (later expanded to 16) to establish DMSACs and to develop district based HIV/AIDS interventions. UNDP placed a UNV in each of the districts, and provided finance, training and technical assistance through the AIDS/STD Unit of the Ministry of Health to strengthen decentralization. Funds were also used to support the formation of Community Home Based Care and PLWHA support groups. Several districts were assisted by UNDP and SIDA to conduct situation and response analysis and to develop strategic plans. District AIDS Coordinators have been appointed to coordinate district level HIV/AIDS

programmes. In some districts, they have taken on roles previously held by UNVs.

A key role that UNDP played through training, workshops and other means of information dissemination was changing the perception of policy and programme leaders of HIV/AIDS as only a health issue, not a development issue.

At the time of the evaluation, there was still lack of clarity on the institutions' roles and responsibilities, and effective functioning of many components of the AIDS-related governance system was an ongoing challenge. However, overall, UNDP support resulted in improved coordination and community mobilization, along with greater involvement of civil society organizations, local authorities and private sector institutions in decisions and policy making at each level. Ownership of interventions was gradually moving to the communities, and PLWHA were increasingly assuming leadership roles in programmes at national and community level.

projects at the community levels. When asked about the nature of communities' relationships with the District Council in rural Zambia, a woman community leader pointed to a Zambian UNV as their link to the District, demonstrating how key the UNV is within the District governance structure. Nevertheless, effective planning and implementation have been hampered by limited linkages of these institutions to the local government system, including formalization of accountability and authority. This is either a missed or emerging opportunity for UNDP to use its governance experience to address such problems.

The experience of UNDP support for Community Conversations (CC) in Limpopo Province, South Africa is another example of ways to increase support for community-driven systems and responsibility for HIV/AIDS accountability. CC brought local government officials to interact with community leaders around issues of municipal services for the poor and the marginalized. These interventions resulted in communities holding dialogues and developing action plans to address their own HIV/AIDS problems.

3.1.3 INCREASING THE VOICE OF CIVIL SOCIETY AND VULNERABLE GROUPS IN THE HIV/AIDS RESPONSE

Increasing inclusion of PLWHA and their rights in HIV/AIDS policy and planning processes is an outcome of UNDP engagement. While there has been substantial variation among case-study countries, in each of the countries, there was some evidence of increased recognition of the rights, roles, and contributions of PLWHA in HIV/AIDS governance. In many cases, UNDP has been strengthening HIV/AIDS governance through advocacy and programmes for greater involvement of people living with HIV/AIDS (GIPA), helping to establish and support PLWHA organizations, media interventions to reduce stigma and discrimination, and interfaces with government for policy and planning inputs. In South Africa, UNDP supported GIPA programmes for both the public and the private sector, which contributed to reduced stigma and discrimination in the workplace while simultaneously providing income to PLWHA.

In Zambia, UNDP support to the Zambian Network of People Living with HIV/AIDS (ZNP+) and

recruitment of PLWHA as part of the District AIDS Planning Task Forces helped enhance PLWHA roles and visibility and inputs into plans and programmes. Support for other vulnerable groups has also been enhanced. Also, in Zambia, support for non-governmental organizations (NGOs) has increased effective advocacy and recognition of rights for workers and orphans and children affected by HIV/AIDS. In targeted communities in Ethiopia, CC has led to increased involvement, organization and community support of PLWHA.

The evaluation team found that the inclusion and participation of CSOs in HIV/AIDS governance has also improved, but the extent varied among the case-study countries, as has the role and contributions of UNDP. Participation and resolution of tensions in relations with government have not always been comprehensive. Examples were cited particularly in Zimbabwe, but also in Ethiopia and Swaziland. Yet, the increased advocacy of CSOs and their interaction with other governance institutions at the national level, including NACs and parliaments, have contributed to greater openness and plurality of debate about the direction and content of national responses.

Below the national level, good practices are emerging from UNDP pilot projects that enhance *community voice in demanding services and respect for rights*. The CCs have initiated dialogue on governance at the community level and raised the potential for sustained citizen demand of services and rights. However, these initiatives tended to be highly localized. Their impacts at the country level were minimal at the time of the evaluation. Moreover, the capacity of the government to facilitate and systematically respond to these demands and realize rights was often low and not specifically a subject of UNDP support. Although a minority view, some government officials in Zambia complained that more support was being provided to civil society than to the public sector.

A focus on *gender issues and involvement and empowerment of women* in combating HIV/AIDS was reinforced as a key theme of the UN and UNDP during the period covered by this review. Gender might be a specific area in which UNDP has a comparative advantage. In Ethiopia, Swaziland, and South Africa, empowerment of women was a prominent outcome in communities targeted by CC. In Ethiopia, the method led to open discussion and

signs of actual change around entrenched community norms such as female genital mutilation. In Botswana and Ethiopia, specific initiatives have systematically enhanced gender mainstreaming into HIV/AIDS programmes including formation of women's organizations and coalitions to lead HIV/AIDS responses, and strengthening of government ministries to address gender in HIV/AIDS responses. Similarly, in Namibia, UNDP advocacy led to increased representation of women as leaders. Women have been appointed regional AIDS coordinators and head most community-based organizations.

UNDP advocacy, research, human development reports and training were specifically noted to have resulted in greater inclusion of gender issues in HIV/AIDS responses in Botswana, Lesotho and Swaziland. Specific activities or outcomes in relation to gender were mentioned in half of the case-study countries. However, it was difficult to establish overall that UNDP programmes had achieved change in gender-related issues concerning HIV/AIDS on a significant scale. In Botswana and Zimbabwe, gender was mentioned as a specific area in which UNDP had missed opportunities to use gender to strengthen HIV/AIDS responses.

3.1.4 STRATEGIC ISSUES AND ONGOING CHALLENGES

UNDP has helped to stimulate paradigm shifts and greater commitment of governments and their partners to developing sound processes, structures, policies and strategies that shape national responses to HIV/AIDS. However, the quality, effectiveness and sustainability of these shifts were mixed. There are ongoing challenges to enhance roles and performance of NACs and decentralized structures and participation of key stakeholders, including vulnerable groups. In addition, the quality of strategies in the case-study countries could be improved, and operational plans to translate these strategies into action were not well developed.⁵⁹ Further efforts on gender and HIV/AIDS are clearly needed—a

59 For recent views on NACs and HIV/AIDS planning see the following sources: Putzel J, "The Global Fight Against AIDS: How Adequate are National Commissions?," *Journal of International Development*, 2004, 16:1129-1140; Mackay B, "Putting the 'Three Ones' to Work: National AIDS Commissions," *Futures Group Briefing*, February 2005; Mullen P, "Review of National HIV/AIDS Strategies for Countries Participating in the World Bank's Africa Multi-Country AIDS Programme (MAP)," (A Background Paper for the World Bank Operational Evaluation Department evaluation of World Bank AIDS assistance), September 25, 2003.

finding consistent with the recent evaluation of gender mainstreaming in UNDP.⁶⁰

Overall, there is a large 'delivery gap' in translating governance contributions into actions that mitigate and eventually reduce the incidence and impacts of the HIV/AIDS pandemic. Leveraging policy and strategic change has been easier in words than in action. One opportunity that seems to have been under-used is UNDP's generally strong relationship with governments. While UNDP's reputation for strong links with government looms large, its influence on HIV/AIDS governance decisions was mixed. More emphasis could have been placed on leveraging this influence.

UNDP has the potential to make important contributions in a number of areas of governance. Particularly interesting planning innovations have been developed at decentralized levels, where other donor activity was

BOX 3.4 KEY CONTRIBUTIONS AND OUTCOMES OF UNDP IN HIV/AIDS LEADERSHIP

UNDP has achieved results in strengthening HIV/AIDS-related leadership through the UNDP COs, through programmatic interventions building leadership among politicians and government officials at various levels, among community and civil society bodies, and among some private sector entities. There are many inspiring examples of leadership 'breakthroughs' in the case-study countries. However, at the time of the evaluation, it was uncertain whether UNDP interventions, including the Leadership Development Programme (LDP), have achieved a scale and depth of leadership development that has, or could achieve, outcomes that represent substantial, efficient responses to leadership needs. There remains a great need to enhance HIV/AIDS-related leadership in the case-study countries.

More in-depth monitoring and evaluation of UNDP leadership initiatives is desirable to ensure that strong interventions receive adequate support and funding, to review interventions if needed, and to ensure support to interventions that represent true areas of comparative advantage for UNDP in relation to its other HIV/AIDS work. In addition, in refining approaches to leadership development, use of individualistic leadership paradigms may need to be complemented by greater emphasis on collective paradigms. The approach of pooling leaders from various sectors together in LDP training sessions is a start. More sustained follow-up to assist and support these clusters of leaders in functioning is required.

60 UNDP, "Evaluation of Gender Mainstreaming in UNDP," January 2006.

limited. Many other development partners have become involved in strengthening national HIV/AIDS structures and governance, often with larger financial and human resources. Therefore, UNDP will need to be increasingly strategic in providing further support in HIV/AIDS governance.

3.2 LEADERSHIP

The evaluation understood HIV/AIDS leadership to cover:

- Leadership by the UNDP CO that galvanizes national leadership into action.
- Political and government officials' leadership at various levels.
- Private sector leadership.
- Community and civil society leadership.

In each of these areas, the evaluation sought evidence of demonstrated exercise of leadership, including leadership in commitment, support and/or advocacy, HIV/AIDS programmes or activities, planning and mainstreaming, and non-hierarchical leadership. In general, leadership results were extremely difficult to measure.

3.2.1 LEADERSHIP FROM THE COUNTRY OFFICE

The type of UNDP leadership on HIV/AIDS at the country level affected the national response in a variety of ways. Individuals can make an integral difference in crisis situations and responses. The leadership facilitation role of the Lesotho UNDP Resident Coordinator and CO was a striking example of supporting a major shift from inertia to action, and the transformation of policies and institutions to govern the national response for HIV/AIDS. Each crisis presents an opportunity to contribute. This can yield large dividends by supporting governments to seek and implement innovative approaches to respond to the great development challenges posed by HIV/AIDS.

In Angola, Botswana, Ethiopia, Lesotho, Malawi and Swaziland, the UNDP CO played a notable role in providing or facilitating leadership to strengthen the national or UN family response to HIV/AIDS. Most prominent leadership has been through the actions of the Resident Representative in countries such as Ethiopia, Lesotho, and Malawi. But UNDP

focal points and programme personnel also played important roles in some countries, such as Angola. Turnover of key staff in countries such as Angola and Ethiopia disrupted UNDP's ability to sustain strong leadership roles in the donor community and its own response to the epidemic.

3.2.2 LEADERSHIP DEVELOPMENT WITHIN GOVERNMENT, CIVIL SOCIETY AND THE PRIVATE SECTOR

At the most basic level, all UNDP COs have raised awareness among leaders in government, civil society and the private sector, about the imperatives for concerted actions on HIV/AIDS. The instruments for creating awareness have varied, including seminars, direct consultations, and institutional support for leaders to interact with partners at the national and international levels and share experiences that inform policies. Through the UNDP Leadership for Development Results (LDR) training sessions in Ethiopia and other countries, a process of awareness building was initiated, where participants were provided analytical and experiential learning tools. The expectation was that they would use the tools to transform their own decision-making and influence their organizations in a way that would deepen their engagement in the national response for HIV/AIDS.

There were indications that UNDP facilitated stronger leadership among national level politicians and officials in Botswana, Ethiopia, Lesotho, Malawi, Swaziland, and Zimbabwe. Unfortunately, the scale and depth of this were often difficult to determine. In some countries, it was clearly difficult to influence national level leadership, as in the case of South Africa, where UNDP's collaborative arrangements with government restricted UNDP leadership influence to the district level.

LDP, other training, advocacy and support for organizations have also targeted leadership in lower levels of government, faith-based organizations, civil society, the private sector, traditional structures and communities. In Botswana, Ethiopia, Lesotho, Malawi, Swaziland and South Africa, these interventions seem to have positively affected leadership in important target groups.

Many examples of striking changes in leadership and resulting actions arose from the LDP in this evaluation and more detailed assessments in Botswana, Lesotho,

BOX 3.5 NAMIBIA: LEADERSHIP IN ADVOCACY FOR PRIVATE SECTOR AND GENDER EMPOWERMENT

In Namibia, beyond an active role at the national level, UNDP has contributed leadership in advocacy for private sector engagement on HIV/AIDS and for involvement of women.

Namibia set the tone for leadership in AIDS advocacy by playing important roles in elaboration of the UN Millennium Declaration. The President and Prime Minister of Namibia served as co-chairs of the Millennium Summit and UN General Assembly. The UNDP CO used its position as chair of the UN Theme Group on HIV/AIDS to manage a consultative and multisectoral approach for the preparation of Namibia's HIV/AIDS Medium Term Plan III, while ensuring that the objectives of the MDGs, National Development Plan II and Vision 2030 were synchronized to meet national development goals. In addition, UNDP led the campaign that resulted in the decision to appoint focal persons for HIV/AIDS in all government ministries. NGOs and other private sector organizations were expected to follow suit.

UNDP grant support to the private sector, through the National Business

Coalition on HIV/AIDS (NABCOA) contributed to the mobilization of the private sector on AIDS issues. NABCOA has assisted firms in creating awareness by training employees to develop and distribute toolkits. The toolkits were used to generate additional funds to scale up the programme. The programme was replicated at the municipal level by the Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICALL). Municipal officials were able to create awareness, conduct research, carry out outreach programmes, and to provide home-based care in their communities.

UNDP's campaign and advocacy for the rights and empowerment of women has resulted in more involvement of women in AIDS advocacy. More women have been appointed Regional AIDS Coordinators and head most community-based organizations. They are widely consulted to provide direction to their communities on AIDS activities.

The contributions and particularly the outcomes of the UNDP CO on

HIV/AIDS have been limited by the duration of its involvement in HIV/AIDS programming in the country. AIDS only became a high priority during the second CCF for 2002-2005. The establishment and staffing of the HIV/AIDS Unit was only accomplished in 2003. Implementation of activities was limited to several years at the time of the evaluation. In addition, the programme has been beset with staff shortages. The plan to hire 1,800 UNVs to build capacity, some of them earmarked for HIV/AIDS, had not materialized when the country assessment was prepared. Only 18 UNVs were hired. It was therefore difficult to meet some of the programme goals. UNDP has also missed some opportunities. UNDP's advocacy on the rights of the poor and vulnerable groups has not been translated into HIV/AIDS action in the case of its support to public-private partnerships for the urban poor. A UNDP programme to increase basic environmental services to the urban poor failed to integrate HIV/AIDS.

South Africa, and Swaziland. In addition, in Ethiopia in particular, the evaluation found substantial demand from stakeholders to extend the LDP methodology, including requests to extend leadership training methodologies into general civil service training. This suggests that changes have undoubtedly occurred as a result of the LDP. In addition, regional capacity has now been developed to conduct further leadership training.

While, in some countries, substantial numbers of people participated in leadership training and have attested to its value in invigorating their commitment to HIV/AIDS, it was difficult to assess whether leadership 'breakthroughs' will have a broad impact. There is concern about possible effects of the loss of LDP "graduates" from ongoing involvement in HIV/AIDS activities, and about the need to reinforce gains through follow-up mechanisms such as alumni groups.

The financial resources allocated for LDP were an important influence on the scale of outcomes. Impact of leadership development in Botswana was greatly enhanced by supplemental government funding for the programme. Such synergies might be needed to give greater impetus to the innovations being introduced and to reinforce the national response beyond UNDP-managed pilots.

3.2.3 STRATEGIC ISSUES AND ONGOING CHALLENGES

There is a clear need to enhance leadership on HIV/AIDS in many sectors and at many levels in the case-study countries. UNDP interventions can enhance such leadership. Some UNDP COs have demonstrated strong leadership, but others have missed opportunities.

Recent assessments of LDP are encouraging, and there are many examples of leadership arising from

the programme, including the application of selective targeting to enhance the capacity of women in Lesotho.⁶¹ However, from the information available to the evaluation team, it was difficult to assess the depth, breadth, and sustainability of the leadership created by these programmes. While remarkable results are reported, the current and potential impact of the overall leadership interventions remains uncertain. Results were reported as ‘breakthroughs’ and reach was extrapolated to include ‘potential cycle of influence.’ This language may mask limited outcomes and sustainability of pilot initiatives. Further assessment of LDP outcomes is needed to ensure that strong interventions receive adequate support, to enhance effectiveness, and to ensure that LDP becomes an area of comparative advantage for UNDP in the HIV/AIDS response and for individual country programmes, or are shifted to other agencies better placed to achieve large scale results.

Currently, an ‘individualistic’ paradigm of ‘the leader’ underpins the notion of leadership and its development in many UNDP CO strategies. The LDP can contribute in this area. The profound challenges posed by the HIV/AIDS pandemic may, however, need to be complemented by a more culturally defined notion of leadership, which goes beyond the individual to “clusters of leaders.” Across Southern Africa, community-based organizations need to be animated to emerge and confront the pandemic. Traditional healers, known and respected for their wisdom and skills in divination, counseling and care are charismatic as individuals, but need to be organized and mobilized to share the common values and knowledge that bind them.⁶² There is a search for leadership in government, at central, provincial and municipal levels, but there is limited emphasis on leadership across government and between government and civil society. Where notions of leadership and its development have transcended the individual to the organizational level, there have been significant shifts in the emergence of a more robust and systematic approach to addressing responses to HIV/AIDS, as illustrated in Box 3.6.

61 Development Works, “Documenting the LDP in Lesotho,” March 2005 (draft); Pretorius J, Poppleton B, “Documenting L4R Results,” October 2004; Caplan G, “Towards a UNDP CO of the Future—Lessons from Lesotho,” November 10, 2004 (processed, report for the UNDP CO).

62 These were derived from conclusions of a focus group discussion among participants in the LDR programme in Limpopo Province, South Africa, February 26, 2005.

BOX 3.6 MALAWI: FROM INDIVIDUAL TO ORGANIZATIONAL LEADERSHIP

In Malawi, UNDP supported the NGO Salima AIDS Support Organization (SASO) as it moved away from reliance on leadership by an individual towards effective and more sustainable leadership by the organization as a whole.

In 1994, Catherine Phiri, a nurse who was infected by HIV/AIDS started a small support network, SASO, to raise HIV/AIDS awareness and mitigate the impact of the disease in a remote district in Malawi where her town, Salima, is located. Organizing a network of volunteers, SASO initiated a series of programmes that included: home-based care; linked orphan care to the traditional system of extended families; and initiated, for the first time, outreach activities that confronted ignorance and prejudice in society by raising awareness, and advocated behavioral change, especially among the youth.

The charismatic leadership of Catherine attracted attention worldwide. She won the ‘Race against Poverty Award’ in 2002. In a bid to support and institutionalize this leadership, UNDP helped SASO develop systems for managing its finances and increasing volunteers and personnel. However, the support needed at the time appeared to have been different—the community needed to develop more leaders, and, according to one of the leaders, to be “known, seen and counted.” Having an efficient institution with financial and administrative systems was not the priority. However, the combination of broadening the leadership base and strengthening the organization meant that, at the time of the evaluation, long after Catherine Phiri’s passing, SASO was a haven for community leaders committed to fighting HIV/AIDS and included 66 volunteers working in the service centre at Salima, more than 2,000 volunteers within villages, and 50 home-based care givers. After expanding and consolidating its leadership, by the time of the evaluation, SASO had credibility to negotiate with the District authorities and delivered badly needed services to the communities, which the District AIDS Coordinating Committee (DACC) had no capacity to deliver.

3.3 MAINSTREAMING OF HIV/AIDS

For the purposes of the evaluation, mainstreaming encompassed:

- Acceptance of the development and multisectoral nature of the epidemic.
- Inclusion of HIV/AIDS activities—beyond the HIV/AIDS ‘sector’—in policies, plans and action relating to poverty reduction, food security

and, more generally, national development.

- Enhanced roles of non-governmental partners.
- Integration of HIV/AIDS into other country-level UNDP programmes and activities.
- HIV/AIDS workplace programmes in public and private sector bodies.

Mainstreaming is defined by UNAIDS as a process.⁶³ The term is also frequently used to refer to the contents of activities aimed at integrating HIV/AIDS issues across a wider spectrum of development activity, beyond the HIV/AIDS sector. In the present discussion, the idea of mainstreaming is used in this wider sense, as both process and result.

BOX 3.7 KEY CONTRIBUTIONS AND OUTCOMES OF UNDP ON HIV/AIDS MAINSTREAMING

UNDP has contributed to:

- Acceptance of the multisectoral nature of the epidemic and of the need for mainstreaming.
- Some degree of inclusion of HIV/AIDS in policies, plans and action in government responses beyond the HIV/AIDS sector.
- Enhancement of the roles of non-governmental partners in multisectoral responses.
- Emergence of workplace programmes in UN COs, and in public and private sector entities.

Despite the initiatives of UNDP and its partners, integration of HIV/AIDS issues into broader development programmes, projects and strategies was still at an early stage in most case-study countries, especially in key areas such as poverty reduction. The very limited mainstreaming into other UNDP programmes and activities found by the evaluation is a particular concern. It suggests limited ownership of the HIV/AIDS agenda among UNDP CO staff beyond those immediately responsible for HIV/AIDS.

A review of UNDP work on mainstreaming is needed. This should provide a solid, evidence-based analytic framework for UNDP country mainstreaming strategies to ensure that UNDP can meet the challenges of translating awareness of mainstreaming into effective strategies for implementation and into action in the field. Key issues include possible targeting of areas where mainstreaming is most crucial or likely to succeed, UNDP's own capacity requirements to support its mainstreaming role, and clearer definition of where UNDP's comparative advantages lie in this area.

63 UNAIDS, UNDP, and World Bank, "Mainstreaming AIDS in Development Instruments and Processes at the National Level – A Review of Experiences," September 2005.

The evaluation found positive contributions and outcomes to mainstreaming, as well as missed opportunities, as discussed below.

3.3.1 ACCEPTING HIV/AIDS AS A DEVELOPMENT AND MULTISECTORAL ISSUE

By increasing awareness and knowledge at the international and national levels, UNDP has facilitated the acceptance of HIV/AIDS as a development and multisectoral issue. This leads to recognition of the need for mainstreaming. One informant in Zambia remarked, "I am a doctor. Working with UNDP [on HIV/AIDS] has led to a complete shift in me from a medical to a development perspective." This may seem a limited outcome at this stage in the pandemic, however, persistence of limited awareness, only basic knowledge, and minimal acceptance at national and lower levels was noted in several countries. Thus, reinforcement of this acceptance remains a valid objective in many countries.

In Angola, Botswana, Ethiopia, Lesotho, Malawi, and Swaziland, UNDP roles and contributions in increasing acceptance were substantial. Some of the earliest outcomes in this area were achieved through UNDP contributions in Botswana. Advocacy and impact studies helped to shift the national response from a health focus towards a multisectoral and multilevel participatory approach to HIV/AIDS. Marked changes have also occurred in Lesotho. Here, UNDP has been influential in the internalization of HIV/AIDS as a cross cutting human development issue, with the formal adoption of a multisectoral approach by government. In Swaziland, advocacy, policy support and impact studies supported by UNDP were important contributors to the broader understanding and acceptance of the epidemic.

Mainstreaming was hardly recognized as an issue in Ethiopia prior to 2003. UNDP's subsequent mainstreaming initiative helped to place it on the agenda of the government, sectoral agencies, and donors. UNDP action led to the formation of a Mainstreaming Task Force with multisectoral representation. In Malawi, UNDP involvement in developing national strategic frameworks and structures was important in effecting a qualitative shift from a biomedical to a multisectoral approach.

However, in Zimbabwe, UNDP missed opportunities to promote development and mainstreaming agendas, and in Zambia, it was not clear whether changes could be attributed to UNDP.

BOX 3.8 ANGOLA: MAINSTREAMING HIV/AIDS IN THE EDUCATION SYSTEM

UNDP has achieved positive results in mainstreaming HIV/AIDS in the education system in Angola.

In 2002 UNDP started a project with the Ministry of Education, Strengthening the Education System in Angola to Combat HIV/AIDS. The project aimed to fight the epidemic and causes of its growth by reducing its impact on the country's education system. It focused on three areas:

1. Training social actors, including teachers, community leaders, the armed forces, the church, and the media, in human rights, peace, gender and HIV/AIDS.
2. Building and strengthening community social networks where these themes are discussed and services provided to adolescent mothers, orphans, and women and men living with HIV/AIDS.
3. Strengthening capacity to design culturally sensitive educational materials for use by schools and the media.

Project activities include curriculum development, training of social actors to carry out prevention work through awareness raising, and producing learning materials. The project also sponsored a study of HIV/AIDS impact on the educational system.

The project first set up coordination structures. A national coordination team was established in Luanda. At the time of the evaluation, the team was building technical capacity for project continuity (Grangeiro, 2005). A group was created to develop and implement public policy concerning control of the epidemic in the education system. The project used the opportunity of ongoing curricular reform in the Angolan education system to integrate HIV/AIDS.

After effective establishment at the national level, the project was decentralized. Provincial nuclei were created, based in provincial Health Delegations. They were composed of teachers, civil society personnel, the media, the military, and community and religious leaders. The nuclei were subsequently responsible for identifying communities and social actors as well as coordinating and monitoring implementation at the provincial level. Partnerships with civil society were established by the project, particularly with organizations directly involved with PLWHA. The decentralization process allowed for greater community participation and capacity building at the provincial level, and for increased coordination and implementation of HIV/Sexually Transmitted Infection

control measures.

The project offered social actors a 78-hour training course over two weeks, which uses participatory methodologies with group dynamics. The content includes teaching methodologies and techniques, facts on HIV infection, human rights, gender, sexuality and ethics. The training also addresses planning of prevention activities and action plans for the following year. Participants have to submit an implementation report at the end of each year. In 2003 and 2004, 237 people were trained in five provinces. They included 160 teachers, 22 students and representatives of the military, the police, the media, health professionals and civil society organizations. Once the social actors were trained, they carried out prevention activities in the form of awareness raising in their communities, schools, NGOs, military bases and religious institutions. The level of implementation of the action plans has varied from one province to the next.

The project was well regarded among key Angolans. Unfortunately, the project had been poorly documented at the time of the evaluation and seemed destined to remain at the level of a promising provincial pilot.

In Botswana, Lesotho, Malawi, Swaziland, and Zambia, UNDP has played a role in facilitating transitions to the multisectoral national HIV/AIDS structures that reflect a move away from approaches to the epidemic dominated by the health sector. However, it was apparent that in these and other countries, there were persistent tensions and difficulties of coordination.

3.3.2 INCLUDING HIV/AIDS IN POVERTY REDUCTION STRATEGIES, NATIONAL DEVELOPMENT PLANS, AND OTHER NON-HIV/AIDS SECTORS

UNDP, and many other partners, have been able to effect relatively few changes in translating awareness and acceptance into effective inclusion of HIV/AIDS into policy, plans and actions beyond the HIV/AIDS

sector. UNDP Regional Centre staff described implementation of mainstreaming in this area as still being at the stage of raised awareness in most countries and sectors. Only a few countries have started to move beyond the stages of reflection and internalization to comprehend its implications for planning.

At the *national level*, in seven case-study countries—Botswana, Ethiopia, Lesotho, Malawi, Namibia, Zambia and Zimbabwe—UNDP support to the development of national AIDS policies, strategies and frameworks helped to strengthen a multisectoral approach. National level frameworks were clearly key steps in national responses. However, gaps between national level plans and the requirements for practical implementation at local levels tended to be large and were often not addressed.

Particularly in Botswana, but also in Angola, Ethiopia, and Swaziland, UNDP has also contributed to planning, research, and other processes that have facilitated more focused mainstreaming of AIDS into other sectors and government departments. These include public service management, labour, education, agriculture and finance. In Botswana, early responses facilitated by UNDP included the appointment of HIV/AIDS focal persons in ministries and the development of sector plans. UNDP was also instrumental in mainstreaming HIV/AIDS into education in Angola (see Box 3.8) and Ethiopia. Leadership training was reported in Botswana, Ethiopia, and Swaziland to have resulted in the clarification of roles of different sectors, and some inspiring anecdotes of individual initiatives to address AIDS within some sectors were reported in Swaziland (see Box 3.9).

There was a high degree of variability in the extent of HIV/AIDS mainstreaming across countries and sectors. It was difficult to establish that various initiatives have been consolidated and have led to effective multisectoral HIV/AIDS planning and action on a significant scale. In some countries, such as Ethiopia, UNDP mainstreaming initiatives were still at an early stage at the time of the evaluation. This further complicated assessment of the effects of current UNDP approaches to mainstreaming.

The evaluation found that UNDP has made some limited progress in mainstreaming HIV/AIDS into development and *poverty reduction strategies*. HIV/AIDS tend to be covered in the majority of Poverty Reduction Strategy Papers (PRSPs), and UNDP was influential in achieving this result in Angola, Botswana, Ethiopia, Lesotho, and Swaziland. Many National Development Plans and recent economic planning in Zimbabwe, which was supported by UNDP, have also taken HIV/AIDS into account. A notable exception, Malawi, was due to review its PRSP at the time of the evaluation. However, much remains to be done on mainstreaming HIV/AIDS into broader national development planning in the case-study countries, including especially their poverty reduction strategies and processes.

Overall, substantial impact seems unlikely on the basis of the UNDP mainstreaming contributions made during the period of the present evaluation, as the breadth and depth of substantial integration of HIV/AIDS into economic policies and poverty reduction strategies and thinking were very limited.

BOX 3.9 SWAZILAND: MAINSTREAMING HIV/AIDS IN THE POLICE FORCE

In Swaziland, UNDP has stimulated mainstreaming HIV/AIDS in the police force.

The Assistant Commissioner of Police, Mr. Siphon Dlamini, attended UNDP training on mainstreaming HIV/AIDS in 2003. Upon completion, he initiated a number of interventions that have led to marked changes in the police force's response to the pandemic. A Committee on HIV/AIDS was set up in the police force to initiate, coordinate and monitor activities aimed at addressing HIV/AIDS. In all four regions of the country, the police have initiated awareness and education training for all police officers. Training of police counselors was undertaken so that police can counsel all officers on various aspects of HIV/AIDS. From their experience, the Assistant Commissioner reported that although the counselors have been well trained by the Institute of Development Management, most police officers were still unwilling to attend counseling unless they were already sick. Awareness of HIV/AIDS and the importance of testing were, however, steadily increasing. According to Mr. Dlamini, "more and more healthy police officers are beginning to test for HIV." Police stations have condom dispensers and senior police officers are encouraged to use them, and to influence junior officers by example.

Other planned initiatives included attempts to address the increasing numbers of orphaned children of police force members, and the development of an HIV/AIDS policy for the police force. The police force policy, however, had to await the development of the national HIV/AIDS policy. Mr. Dlamini asserted that if the government took too long to formulate a national policy the police might be forced to go ahead and formulate their own "because people are dying."

Several PRSPs included AIDS as a brief chapter, but did not integrate it into other aspects of the plan. In some cases, such as Zambia, a persisting bio-medical bias in HIV/AIDS sections was noted, probably due to the health sector's continuing role as coordinator of the national response. The Regional Centre has issued basic guidelines on HIV/AIDS mainstreaming in PRSPs but noted that refinements in approach are likely to be needed.⁶⁴

UNDP has enhanced *mainstreaming and multisectoral involvement in HIV/AIDS at district and local level* in

64 Unfortunately, the Regional Centre was not involved in a joint workshop in South Africa on integrating HIV/AIDS in poverty reduction strategies conducted late in 2005 by UNDP, UNAIDS and the World Bank.

several countries. In Zambia, UNDP training, tools and other support to DATFs and Development Committee involvement have led to a more multi-sectoral response at the local level. Similarly, in Botswana, UNDP DMSAC initiatives have been a catalyst for enhanced understanding, planning and action at the District level. In South Africa, UNDP increased understanding of HIV/AIDS mainstreaming among provincial and local planners. In these countries and others, however, it was noted that obstacles remain to effective multisectoral action. So far, action by targeted authorities was uneven and often limited. Even when local government took note of HIV/AIDS, there was often limited change from a health-sector focus in HIV/AIDS projects and activities at that level.

3.3.3 SUPPORTING MULTISECTORAL RESPONSES THROUGH ENHANCED ROLES OF NON-GOVERNMENTAL PARTNERS

In all of the case studies except South Africa and Zimbabwe, UNDP achieved positive but varied results in promoting mainstreaming among NGOs, faith based organizations and private sector organizations. Details of NGO performance and scope of work were often not available. However, in Botswana, Malawi, and Swaziland, contributions have been made to a more holistic response to HIV/AIDS through UNDP support for umbrella NGO networks. In Botswana, Ethiopia, Malawi, Namibia, Swaziland, and Zambia, UNDP has enhanced activities of CSOs in HIV/AIDS at community and higher levels. In Botswana and Malawi, UNDP helped to achieve greater clarification of the roles of CSOs in the national response. In Angola, UNDP's work with the Ministry of Education helped create precedents for NGOs and PLWHA working with the government on HIV/AIDS. In Ethiopia, UNDP has helped to mobilize a promising formal programme of major faith-based organizations to address HIV/AIDS, although it was too early to assess results at the time of the evaluation.

3.3.4 MAINSTREAMING HIV/AIDS ACROSS OTHER UNDP PROGRAMMES AND INTERVENTIONS

Progress in mainstreaming HIV/AIDS across UNDP non-AIDS programmes and interventions, including governance, economic planning and poverty

alleviation, was disappointing. Nevertheless, some results had begun to emerge. In Zambia, Ethiopia and Malawi, changes had started to occur from leveraging other UNDP programmes, such as decentralization and civil service reform, to enhance HIV/AIDS responses. In Angola and Namibia, examples of integration of HIV/AIDS into UNDP agriculture, poverty, gender, decentralization and magistrate training programmes were identified.

Unfortunately, the evaluation was unable to draw clear conclusions on the effectiveness of these actions in generating substantial results. There was little indication that mainstreaming support by UNDP has been effectively used. An innovative effort to mainstream HIV/AIDS into Information and Communication Technology programmes took place in Swaziland, but there was no clear evidence about its effectiveness. In South Africa, opportunities have been missed in sharing innovations that were working well within HIV/AIDS programmes with other UNDP programmes related to poverty.

3.3.5 PROMOTING WORKPLACE HIV/AIDS RESPONSES

UNDP leadership has triggered some important changes through the UN's 'We Care' Workplace Programme, which was launched by UNDP Headquarters. In Angola, Lesotho, and South Africa, UNDP has had a key role in this area. In other countries, We Care did not feature highly in UNDP reports of achievements. In some of these cases, UNDP was seen more as a participant than leader in UN workplace programmes, as in Ethiopia, or action was reported to be weak, as in Zimbabwe. In Swaziland, limited resources and acceptance by UN partners were obstacles. There were also missed opportunities for UNDP COs and other UN partners to learn from and motivate each other to become model employers in this regard. The expectation of Headquarters that the COs would systematically integrate this activity into their own activities and programmes within a short period of time, following initial subsidization from New York, seems to have been over optimistic.

Beyond its own employees, UNDP has helped to facilitate the development of ministry workplace policies and programmes in Angola, Botswana, Ethiopia, Lesotho, Malawi, and Zimbabwe. Initiation of workplace responses to HIV/AIDS seemed to be

easier to achieve than mainstreaming into more general sectoral planning. This was especially striking in Ethiopia, where other aspects of mainstreaming were minimal. In several case-study countries, such as Botswana, Malawi and Swaziland, UNDP has assisted through supporting public service impact studies, development of policies and manuals, and motivating the designation of focal persons. In Botswana, Lesotho, Namibia, South Africa, Zambia, and Zimbabwe, support for groups such as labour, PLWHA and business coalitions has stimulated private sector awareness on workplace issues. In Botswana and Zimbabwe, UNDP has helped to promote the provision of antiretroviral treatment by employers.

Greater involvement of PLWHA has been an important contribution of UNDP workplace initiatives, along with greater awareness and adoption of rights-based approaches and interventions in the world of work. In South Africa, use of the GIPA principle appears specifically to have helped to produce results in reducing stigma in targeted UN and public and private sector workplaces. In Zambia, support for ZNP+ and the Zambian Business Coalition achieved some outcomes. Unfortunately, at the time of the evaluation, the GIPA programme appeared to have lapsed or was lapsing in a number of countries without much urgency in renewing or extending it into all UNDP activities.

Despite the efforts of governments, UNDP, and other development partners, the implementation of workplace interventions remained uneven and quite weak in many countries. For private sector initiatives, ability to substantiate results beyond awareness-raising and establishment of coalitions was often limited, although sometimes specific tool development and actions had occurred. This suggests a need to continue strengthening strategic approaches and methodologies in future workplace interventions supported by UNDP and other partners.

3.3.6 STRATEGIC ISSUES AND ONGOING CHALLENGES

Despite its successes, particularly in creating awareness of the development nature of HIV/AIDS and the importance of mainstreaming, UNDP has not yet made full use of its apparent comparative advantages in promoting mainstreaming. While basic advocacy and training are likely to be relevant for some time, new challenges are raised by the need to

translate awareness into action. Experience suggests that managing the inter-sectoral coordination of HIV/AIDS programmes, especially including the role of the health sector, is likely to continue to pose formidable challenges to UNDP and its country and international donor partners.

The very limited mainstreaming into other UNDP programmes, such as governance and poverty alleviation, represented an important and quite visible missed opportunity, especially since UNDP has greater control in this area than elsewhere. In general, there are opportunities for better coordination from the perspective of HIV/AIDS across UNDP country programmes, regional programmes (such as PRSP support), and activities promoted from Headquarters.

A review of UNDP strategy and methodologies around mainstreaming seems needed. It can build on the assessment of mainstreaming experience recently completed jointly by UNDP, UNAIDS, and the World Bank.⁶⁵ The review should, *inter alia*, examine whether focus should be on generating or facilitating impact, and the possibility of prioritizing areas where mainstreaming is likely to be most effective. It could also assess the UNDP capacity requirements and services needed to consolidate and implement mainstreaming, which may differ from those provided by the UNDP regional project. Greater clarity is also needed to determine exactly where UNDP's comparative advantages for mainstreaming lie, and whether UNDP should endeavor to address mainstreaming throughout societies and economies or focus only on more limited aspects such as poverty reduction strategies, priority sectors and workplace interventions.

3.4 CAPACITY DEVELOPMENT

For the purposes of this evaluation, capacity development was considered to include skills development, organizational development, institutional strengthening and planning, management and development of human resources. More specifically, it encompassed:

- Increasing national government ministerial capacity to respond to HIV/AIDS.
- Strengthening national HIV/AIDS coordinating structures.
- Strengthening capacity for decentralized planning, management and implementation of

65 UNAIDS, UNDP, World Bank, "Mainstreaming AIDS in Development Instruments and Processes at the National Level: A Review of Experiences," September 2005.

HIV/AIDS responses, at provincial, regional, district and local authority levels.

- Developing capacity of CSOs and community-level capacity development and empowerment to address HIV/AIDS.
- Empowering PLWHA and other people vulnerable to the effects of the epidemic.
- Generating, managing and disseminating HIV/AIDS-related knowledge.

Progress was recorded in each of these areas. The nature and extent of results varied greatly. Overall,

BOX 3.10 KEY CONTRIBUTIONS AND OUTCOMES OF UNDP ON HIV/AIDS CAPACITY DEVELOPMENT

While results differed among countries, UNDP has contributed to enhanced individual and institutional capacity in:

- NAC and national government capacity to respond to HIV/AIDS.
- Capacity for decentralized planning, management and implementation, in relation to HIV/AIDS.
- Capacity of HIV/AIDS-related CSOs and community-level capacity to address HIV/AIDS.
- Empowerment of PLWHA and other people vulnerable to effects of the epidemic.
- Greater knowledge relating to HIV/AIDS to guide responses.

Innovative achievements in community and decentralized level capacity development were particularly notable, and should be considered for further support in CO and overall strategies. UNDP missed opportunities to deal with larger scale capacity problems related to human resource planning, development and management.

UNDP needs to improve exit strategies to ensure that initiatives are consolidated and sustainable, and to take successful innovations to scale. Important issues related to these concerns include fostering strategic partnerships with other donors, more efficient and reliable systems to support implementing partners, and strengthened knowledge generation, management and communication.

The scale and range of capacity challenges in the case-study countries is huge. It will be important to prioritize and consolidate capacity development agendas to ensure that impact is not compromised by overextension. In an increased role, the UNDP Regional Centre for Southern Africa could possibly harmonize experiences in capacity development and deploy dedicated support to cross-country experience sharing.

there was a widely held opinion at the country level that capacity had been strengthened significantly by UNDP. Certain limitations of outcomes and missed opportunities were, however, apparent. Capacity development, particularly for strategic planning and management, was frequently cited as a particular strength or comparative advantage of UNDP in Southern Africa and Ethiopia.

3.4.1 INCREASING NATIONAL GOVERNMENT MINISTERIAL CAPACITY TO RESPOND TO HIV/AIDS

At the national government ministerial level in Botswana, Ethiopia, Lesotho, Malawi, and Swaziland, UNDP has been instrumental in building skills and structures, such as ministry AIDS coordinating units, that have enhanced the capacity of government to respond to HIV/AIDS. In these countries, UNDP often took the lead when other donor support in these areas was quite limited.

In Botswana, capacity enhancement through UNDP-supported training, planning exercises and technical assistance to various ministries improved HIV/AIDS planning and led to the formation of AIDS coordinating units. In Malawi, the public sector HIV/AIDS impact assessment and ongoing UNDP advocacy and policy development support gave important momentum to the formation of key capacity to address the epidemic. A number of ministries had appointed focal persons and started workplace programmes as a result of UNDP interventions.⁶⁶

In Ethiopia, Lesotho, and Swaziland, LDP was specifically mentioned as having developed leadership skills, attitudes and institutional change within national ministries that enhanced HIV/AIDS responses. In Lesotho, LDP contributed to the recognition by the government of the need to improve capacity utilization of senior policy officials by placing HIV/AIDS at the centre of policies and plans. In Ethiopia, LDP was a catalyst for the formation of national level bodies such as Ethiopian Media Volunteers against AIDS and the Women's National Coalition on AIDS, which has strong

⁶⁶ A Permanent Secretaries' task force has been formed to ensure that ministries responded to the epidemic more effectively. The army and most line ministries have implemented workplace programmes and HIV/AIDS have been incorporated in nearly half of the public institutions in the country.

involvement of senior politicians. In Swaziland, L4R helped to increase the momentum of national private sector HIV/AIDS bodies.

UNDP also missed opportunities to strengthen capacity to plan and implement HIV/AIDS-related policies, plans and programmes. As illustrated by the limited degree of effective sectoral mainstreaming, more sustained support is needed to build adequate capacity and skills for action. In Namibia, for example, missed opportunities appeared to be due, at least in part, to lack of resources to fund needs for technical assistance or deployment of UNVs. Additional missed opportunities also seemed to be due to limited impact of policy dialogue aimed at creating demand for better multisectoral planning on HIV/AIDS.

3.4.2 STRENGTHENING NATIONAL HIV/AIDS COORDINATING STRUCTURES

UNDP support has enhanced the capacity of national AIDS coordinating bodies in Botswana, Malawi, Swaziland, Zambia, Zimbabwe, and—with less clear results—in Lesotho. Many NACs have been weak during the period under review, and more still needs to be done to overcome their weaknesses. However, this does not negate the significance of UNDP's support. Much of this has been achieved through direct support, such as training, deployment of UNVs, technical assistance and the provision of funds for projects and operations. Institutional capacity has also been developed simply by enabling NACs and key stakeholders to 'learn by doing,' as well as through support in resolving dilemmas and conflicts that have arisen around where to locate the authority to coordinate inter-sectoral responses.

UNDP often supported NAC capacity development at a stage when the institutions were new, and support from other donors was limited.

- In Zambia, UNDP contributed a major proportion of NAC finances at a time when support from alternative sources was minimal. UNDP also provided flexible support in the form of technical assistance and funding of basic operational requirements such as computers and transport. This was essential to the ability of the NAC to maintain a basic level of function and to refine and understand its role (Box 3.11).
- In Botswana, UNDP supported the National AIDS Coordination Authority and the Ministry of Health's HIV/AIDS STD Unit through

BOX 3.11 ZAMBIA: UNDP CONTRIBUTIONS TO NATIONAL AIDS COUNCIL INSTITUTIONAL DEVELOPMENT

In Zambia, UNDP has made important contributions to institutional development in the NAC.

UNDP provided Programme Acceleration Fund (PAF) support to the NAC in 2000-2002. The resources were meant to help initiate or strengthen a broad range of catalytic projects. The funds were disbursed to different institutions in different provinces and districts—11 districts were supported on a pilot basis. Funds were also meant to support the NAC directly, especially in developing its monitoring and evaluation system. Other support went to ZNP+, Girl Guides, faith based organizations, Youth Alive, special populations (such as CSW, military and refugees), Zambia Business Coalition, World Aids Day and home based care.

A senior NAC official commented: "The PAF funds were the lifeline of the National AIDS Council. UNDP came in at a time when we had nothing and nowhere to go. However, most importantly PAF made it possible for NAC to learn what to do and what not to do.... NAC, having little experience and not being able to distinguish between implementation and coordination, learnt some valuable lessons when we attempted to do both and burnt our fingers. We got bogged down in details and discovered we had neither the time nor expertise to monitor, evaluate and ensure accountability if we were being an implementer and a coordinator. Not only that, but there were issues of alienating stakeholders who did not understand the criteria for programme selection and it was difficult to justify to the satisfaction of everyone. Accountability of funds due to the constrained human resource situation was problematic... It was from the experiences of the PAF initiative that we learnt how to focus on coordination and ensure that we support implementing agencies from that context... At the same time however, we were able to commence initiatives such as galvanizing the private sector response through the formation of ZBCA....build a relationship with the FBOs...."

At the time of the evaluation, the effectiveness of Zambia's NAC continued to be undermined by a number of obstacles. However, by maintaining a basic level of function and allowing lessons to be learned, the NAC was better positioned to receive support from other donors and to play its role in the 'Three Ones' approach to national HIV/AIDS responses.

Source: Chitah B, "Evaluation of the UNDP HIV/AIDS Programme in Zambia," National consultant study for the present evaluation, 2005.

training, deploying UNVs and other technical assistance. This has had a substantial role in organizational development and capacity

enhancement for executing coordination and other roles, including support to the antiretroviral rollout.

- In Malawi, UNDP has had a substantial role in the emergence of the NAC under the Office of the President, including the mobilization of resources and facilitation of appointments to key positions.
- In Lesotho, UNDP was a major influence behind revamping Lesotho AIDS Programme Coordinating Authority and contributed to the government's decision to create the newly established NAC, with an enhanced mandate sanctioned by Parliament to coordinate the national response.
- In Swaziland, UNDP is considered to have had a role in strengthening the National Emergency Response Council on HIV/AIDS's organizational development and staff capacity for its roles in coordination, mobilization of resources, and policy development.

By assuming the *PR responsibility in GFATM-financed projects* in Angola and Zimbabwe UNDP assumed a major HIV/AIDS capacity development role. However, concerns were raised about UNDP's role as PR and the implications of PR activity for UNDP's broader role, including whether the role creates a conflict of interest with other UNDP activities. This could not be assessed in this study, but the implications of UNDP's PR role clearly need careful examination by UNDP management.

3.4.3 STRENGTHENING CAPACITY FOR DECENTRALIZED PLANNING, MANAGEMENT AND IMPLEMENTATION

The most recognizable capacity development contributions and outcomes in several countries were within HIV/AIDS structures at the regional, district and local levels. These results of UNDP support are particularly notable because capacity at these levels is a major gap in many countries, as well as in the HIV/AIDS responses of other development partners.

The most marked results have been achieved in Botswana and Zambia. In Botswana, UNDP played a groundbreaking and critical role in the development of DMSACs early in the period under review. A number of DMSACs have proved to be sustainable, effective players in the HIV/AIDS response. The clearest recent outcomes at the time of the evaluation

were in Zambia, where the success of UNDP support has been reflected in increased action at decentralized levels, increased funding flows to districts, collaboration with other donors, and government requests for rollout to all districts. UNDP's role was central to these successes, through contributing UNVs, training, assistance in planning, and resources for Information and Communication Technology and transport.

In Zimbabwe, UNDP had a significant role in the decentralization of NAC functions, including the development of an apparently successful system of 'bottom-up' budgeting and planning. As part of the UNDP project with the Ministry of Education in Angola, some decentralized capacity for project management was created. In South Africa, training of local authorities raised awareness for mainstreaming. However, capacity development to translate this into effective planning and action through the local authority Integrated Development Plans was limited. This is a missed or emerging opportunity.

In several other countries, capacity development at decentralized level has also occurred, though generally on a smaller scale. In Lesotho, UNDP training with the Ministry of Local Government led to improved capacity to plan and manage local AIDS programmes by DATFs. However, it appears that opportunities were missed to involve DATFs more systematically in other UNDP initiatives; some perceived that UNDP was unwilling to use its programmes to empower some local structures. In Swaziland, L4R has led to substantial involvement of local chiefs in initiating local action, with some noticeable changes at organizational and community levels.

In Ethiopia, LDP has improved capacity, particularly in Southern Nations, Nationalities and Peoples Region, but also in other regional HIV/AIDS Prevention and Control Offices. However, several donors felt that UNDP had missed an important opportunity to more systematically strengthen lower level government capacity for HIV/AIDS responses. UNDP's decentralization programme to strengthen local government planning systems in Malawi has also contributed to enhancing citizen engagement in planning at the lowest levels. However, this work has not been linked with the ability to address HIV/AIDS issues, nor have the newly-established District AIDS Councils been connected with the experiences in other countries in participatory planning so successfully supported by UNDP.

3.4.4 DEVELOPING CAPACITY OF CIVIL SOCIETY ORGANIZATIONS, AND COMMUNITY-LEVEL CAPACITY DEVELOPMENT AND EMPOWERMENT

The importance of civil society for effective national HIV/AIDS responses was widely noted. UNDP initiatives stimulated NGO, faith based organization and other CSO activity on HIV/AIDS through direct financial and technical support. In six of the study countries, UNDP achieved results in building the capacity of CSOs. The exceptions were Angola, Lesotho, South Africa, and Zimbabwe, where civil society strengthening was not a major feature of the UNDP HIV/AIDS programme. CSO capacity development for the HIV/AIDS response was a particularly notable achievement in countries where civil society was previously very weak.

In Botswana, Malawi, and Swaziland UNDP contributed to establishing and strengthening strategically placed civil society *umbrella* or *coordinating*

bodies. In these countries and others, such as Ethiopia and Zambia, it also stimulated formation and strengthening of significant *individual organizations* in areas such as media, PLWHA AIDS services, labour, and women's coalitions on AIDS. In Ethiopia and Swaziland, organizational leadership was strengthened, specifically through LDP, and the capacity of CSOs was enhanced through involvement as implementers of CC and for delivering specific services. Assessment of the effectiveness and sustainability of this capacity development could only be made on a limited basis as part of the present evaluation. However, some clear, immediate and strategic benefits for the HIV/AIDS response were identified.

In Botswana, Ethiopia, Malawi, Swaziland and Zambia, a notable feature of UNDP involvement has been *strengthening organizations and the involvement of PLWHA* either at national level or at the local level through participation and support groups linked to interventions such as CC. In general, this produced progress in representation, involvement, visibility,

BOX 3.12 SOUTH AFRICA: STRENGTHENING CAPACITY FOR LOCAL AND COMMUNITY-DRIVEN RESPONSES FOR EMPOWERING THE POOR AND VULNERABLE

In South Africa, UNDP has strengthened capacity for community-driven responses to HIV/AIDS and empowering the poor and vulnerable.

UNDP support to the AIDS response in South Africa has focused on sub-national levels, particularly at provincial, district and community levels, targeting the poor and especially vulnerable. The main thrust of UNDP's actions in these areas has been in the employment of UNDP corporate tools—the LDR and CC Programme. At the national level, the government assumed the coordination role and did not require upstream policy support.

UNDP's interventions at the district and local council levels recognized the critical role councils need to play to ensure adequate service delivery to their constituents to address the impact of HIV/AIDS. The LDR and CC processes were used to sensitize leadership at the national, district and local council

levels. This contributed to a greater understanding of the multidimensional nature of the epidemic and the need for a concerted and multi-sectoral response. CC reinforced the need for community-driven responses and solutions. Emerging responses by municipalities indicated UNDP's success in this area. Local CC brought the government closer to the people and started to yield results as communities began to use conversations on HIV/AIDS as entry points for critical reflections on the broader issues of what can be done to fight poverty.

CC demonstrated that communities have capacity to analyze their own problems, find solutions and assume responsibility for addressing problems associated with poverty and HIV/AIDS, provided there is a supportive social, political and economic environment. UNDP established the tone for the dialogue between government and communities, and among community members. The result was a renewed confidence

at the local level to hold those responsible accountable for the local action needed to address the impact of HIV/AIDS.

UNDP's success with LDR and CC in mobilizing action at the sub-national level has been hampered by the unique circumstances surrounding UNDP's collaborative arrangements with the Government of South Africa. UNDP has not been able to expand this success into its support to civil society to advocate for the rights of the poor and vulnerable. UNDP has supported capacity development initiatives through GIPA and employment for HIV-positive youth. But, UNDP has not been able to lend a voice to the advocacy and agitation of CSOs for increased access to treatment and care for the poor. This was a missed opportunity, especially in a political environment where the government was described to be in denial of the treatment needs and requirements of the poor.

de-stigmatization and enhanced support, despite reports of organizational and other limitations inhibiting the integration of these achievements into government planning and implementation processes.

UNDP involvement included initiatives to enhance *arts and media involvement* on HIV/AIDS issues through engagement with journalists' associations and the promotion of positive role models. In Ethiopia and Swaziland, this improved the quantity and quality of media involvement and reporting on HIV/AIDS. However, there was little clear indication of the extent of improvement and the need to reinforce results should be addressed.

While significant capacity development occurred, some important limitations and missed opportunities were identified in UNDP's support for civil society capacity development. In three countries—Angola, Lesotho, and Zimbabwe—UNDP concentrated on engaging with the government but had limited engagement with civil society, even where there was a clear need for CSO and PLWHA involvement in the national response and for capacity development.

In countries such as Ethiopia and Swaziland, a number of the CSO initiatives stimulated by UNDP were still at an early stage and results were still evolving. There were frequent comments across countries that many of the CSO activities did not have the ability to become sustainable and effective without further support. UNDP's mode of providing support to CSOs was also described as laborious, requiring enormous time and effort, and posing challenges for sustained CSO access to these resources. In brief, UNDP implementation processes and procedures represented an obstacle to effective UNDP support for CSOs. Furthermore, UNDP often had inadequately developed or communicated exit strategies for organizations that it supported. This put their effectiveness and sustainability at risk.

Community level capacity development and empowerment, including the development of community level capacity to address HIV/AIDS, were a prominent result of UNDP programmes in Ethiopia, South Africa, Swaziland, and Zambia. The most dramatic and widely acknowledged effects at community level were achieved through CC. UNDP has been the driving force behind developing CC, which represents an interesting example of adaptation of previous community development method-

ologies and applying them to HIV/AIDS. In Ethiopia, CC strengthened community skills, motivation and mechanisms for action in relation to HIV/AIDS (Box 3.13). This led to marked changes in community norms and behaviours related to HIV risk and PLWHA, as well as increased assertiveness in relation to local and other authorities to tackle HIV/AIDS issues. In addition, CC has had positive spillover effects in addressing gender and broader poverty and development issues.

In South Africa, CC has changed knowledge, attitudes and practices among communities and their leaders. In addition, CC has led to actions that address the link between poverty and HIV/AIDS, including establishing 'self-help' initiatives, forming committees to channel demands to municipalities, and engaging in dialogue with service providers to improve service provision. However, although CC

BOX 3.13 ETHIOPIA: IMPROVING COMMUNITY CAPACITY TO RESPOND TO HIV/AIDS THROUGH COMMUNITY CONVERSATIONS

UNDP has improved community capacity to respond to HIV/AIDS in Ethiopia through its pilot CC programme.

The UNDP CC programme was launched, on a pilot basis, in Alaba in late 2002 and Yabello in mid 2003. The participatory CC process has led to significant changes in the pilot sites. Changes included improving knowledge, breaking the silence about HIV/AIDS, reduction in stigma and greater support for PLWHA, increased voluntary counseling and testing, and evidence of changes related to harmful traditional practices including norms around having multiple sexual partners and female genital mutilation. Risk factors such as market hours meaning women have to travel home after dark were also addressed. Spin off benefits of empowering communities to address other local developmental challenges, and of changing gender relations were also reported.

External observers and communities agreed that the CC process has started dramatic changes. Outcomes in pilot areas led several other donors and the government to start adopting CC methodologies as part of their strategies and programmes. However, final outcomes of UNDP's initiative will become clearer only after initiatives begun at the time of the evaluation around exit strategies, sustainability, and scale-up have been implemented. The need to manage risks of conflict with stakeholders who feel themselves threatened by the methodology was also raised.

has direct relevance to strategic gaps in the national response, little attention was given to ensuring that the government is aware of and acts on the methodologies that have been developed.

Other UNDP initiatives, such as enhancing district-level and NGO capacity to support community initiatives, L4R, and specific youth or other projects, have also improved community capacity to respond to HIV/AIDS. In Swaziland, L4R initiatives brought about observable changes in capacity, competencies and actions in organizations and communities targeted by the programme, although the scale of outcomes is not completely clear. Mobilization of youth stimulated youth involvement markedly in targeted communities and led to the formation of youth groups, increased uptake of voluntary counseling and testing and sexually transmitted disease treatment, condom use, and greater openness. Other components of L4R enhanced capacity of chiefs and other local players to act more effectively at community level. In Botswana, enhanced community capacity to prevent and mitigate HIV/AIDS resulted from UNDP support for development of District and Village multisectoral HIV/AIDS committees. Increasing involvement of local leadership in community-based initiatives, and more recent implementation of CC in five districts, reinforced this. In Lesotho, UNDP support for capacity development, community meetings, workshops, and social mobilization had noticeable effects on community level progress towards AIDS competence.

3.4.5 GENERATING, MANAGING, AND DISSEMINATING KNOWLEDGE

A number of UNDP country-level initiatives have contributed to the generation and dissemination of information, knowledge, methodologies and tools to support HIV/AIDS responses. These included impact studies, other publications and research, and the development of innovative projects and interventions.

Impact studies have made significant contributions to mobilizing awareness and support for HIV/AIDS responses in Angola, Botswana, Malawi, and Swaziland, particularly at early stages in national or sectoral responses. Some of these studies have also contributed to subsequent specific actions, including policy on rollout of antiretroviral therapy in Botswana and mainstreaming in public service and sectoral ministry programmes. A notable example of

effective use of UN/UNDP-led publications and information to achieve results was the Lesotho study 'Turning a Crisis into an Opportunity.' The government adopted the study as a working and advocacy tool for scaling up the national response.

In nearly half of the case-study countries (Botswana, Swaziland, Zambia, and Zimbabwe), impact studies, MDG progress reports, and National Human Development Reports (NHDRs) have provided information that has had ongoing value in advocacy and planning, and have helped focus attention on key issues, such as the HIV/AIDS-poverty link. However, in some countries, the impact studies, NHDRs and other UNDP publications had limited outcomes at the country level. Factors contributing to these limitations include conflicting advocacy and planning agendas, and limitations of local commitment to study results. The unreliability of data and, in particular, the capacity limitations in developing responses to new information limited the utility of the NHDRs. In Malawi and South Africa, country partners challenged the appropriateness of methods and findings of the HDRs. One UN country official, reflecting sentiments heard in several countries, remarked that the development of NHDRs needed to be more participatory to enhance use and credibility, as currently, "It remains a UNDP report, and it is used at the international level, but not really by government and others."

UNDP's contribution to knowledge through *innovation and pilot projects* has had substantial secondary effects. Prominent examples include CC and initiatives to strengthen district HIV/AIDS structures. Earlier projects in areas such as home-based care and trucker prevention programmes were also noted to have informed UNDP strategies. Other donors, governments and CSOs have also adopted methodologies, tools and manuals developed out of UNDP HIV/AIDS capacity development projects. For example, CC is now being used by UNICEF and other partners in Ethiopia and Swaziland. In Ethiopia, LDP is being integrated into general civil service training. UNDP's ability to use broader development experience and methodologies, such as CC and LDP, to enhance HIV/AIDS responses was an important feature.

In Botswana, UNDP initiatives were specifically noted to have resulted in better *information sharing*, for example through leadership programme networks and publications. However, there were also missed

opportunities to transfer knowledge and communication between and within countries, as well as within the donor community. For example, learning from Botswana's DMSAC initiative did not explicitly feed into other district and regional initiatives in countries such as Zambia and Ethiopia. The effectiveness of many conventional UNDP projects and best practices and how they contributed to buy-in, follow-up support for piloted initiatives, and results was also questioned.

3.4.6 STRATEGIC ISSUES AND ONGOING CHALLENGES

UNDP has achieved substantial results in various areas of capacity development in the case-study countries. Data deficiencies and the limited period of certain interventions, however, made it difficult for the evaluation team to develop a clear assessment of the scale and depth of capacity development and, therefore, overall HIV/AIDS capacity development outcomes in each country. From the evidence gathered, UNDP appears to have been influential in helping to catalyze a “re-thinking” of the needs, context and direction of capacity development with regard to HIV/AIDS. However there are areas where UNDP's capacity development role can be strengthened. These include missed opportunities and limitations on efficiency, sustainability, scale-up and—ultimately—achievement of impact.

UNDP has made particularly notable achievements at the *community level* through CC and at *decentralized levels of government*. This suggests that UNDP may have a strategic role in consolidating the use of these methodologies in more places. Possible interventions include further development of tools, information dissemination, technical support for implementation in diverse contexts, and quality assurance. Limited ability to promote activity at these levels is often a major gap in national responses. Other donors are increasingly supporting central NACs, making UNDP's role there less pivotal.

These considerations point to the need for a more strategic approach to UNDP HIV/AIDS capacity development innovations, to ensure appropriate choice, sustainability and impact:

- In the case of CC, limited attention was paid to issues relevant to scaling-up and sustainability, such as costs, recruitment of other funding agencies, capacity requirements, exit strategies from UNDP support by transferring responsibility to

others, differing requirements for skills and management in large programmes, and management of quality and possible conflicts with key stakeholders.

- Decentralization interventions highlighted the pivotal role of UNVs, particularly local UNVs in countries where there is substantial local underutilized capacity outside government. The UNV role was highly desirable to achieve urgent results, even if it represented a temporary ‘capacity substitution’ rather than skills development and transfer. However, the need to develop a more strategic approach going forward is needed. In some cases, UNVs are making a difference but are hamstrung by limited clarity on mandate, and inadequate skills development, support, and basic resources, such as transport. There are also concerns about sustainability and exit strategies. These issues will be important for SACI to systematically address, to avoid risks of creating inefficient precedents.
- Similar issues were raised in relation to UNDP training in several countries. In Botswana, Ethiopia, Namibia, Swaziland, and Zambia it was noted that, when training had not been situated within a well-considered process of follow-up and support, outcomes were often limited. This applied both to short courses and longer ones such as LDP.

As mentioned in the discussion of governance, some *outcomes related to gender issues* have been achieved through developing capacity and involvement of women. However, results in this area have not featured prominently in many countries. This suggests an opportunity to increase focus on capacity development for HIV/AIDS-related gender issues, or at least more specific monitoring of gender-specific and gender-disaggregated outputs and outcomes.

The CC and district interventions also suggest that UNDP can have a valid role as a lead agency in developing methodologies that can be taken to scale or leveraged by other partners. The reorganization of the Regional Centre for Southern Africa to provide a unified service in methodological refinements, testing new tools, and professional support to COs increases the potential for these tools to be refined with a common vision and disseminated throughout the region. The Zambia district interventions and Ethiopia CC were examples of helping to leverage World Bank and other partner support to enhance

responses and coverage at these levels. Recent initiatives to address the issues of sustainability and scaling up in Ethiopia may provide some important lessons for wider application.

Other notable outcomes have been achieved through *support for civil society* capacity development. A more strategic approach is important to ensure effectiveness, sustainability and impact, if similar interventions are used in future. Key issues to address include reliability, efficiency and coherence of support and exit strategies.

An area of capacity development that is increasingly prominent is building *country capacity to mobilize and manage external HIV/AIDS resources*. Particular emphasis is needed on moving such resources beyond the national level to decentralized and community levels. UNDP has begun to grapple with this issue, particularly through its GFATM PR roles. However, definition of desirable and feasible roles for UNDP in this area is likely to need further attention in strategic planning. Work on financial management and procurement under ARMADA represents only a beginning. More concrete modalities for external resource management and the strengthening of capacities at the level of District AIDS Committees or Task Forces are needed to complement the complex procedures for management established by NACs at the national level.

A further strategic issue is the missed opportunity for UNDP to play a more focused role in *human resource (HR) planning, management and development*, which may be taken up under SACI. In several countries (Botswana, Malawi, Swaziland), UNDP has used impact studies and other means to raise awareness about the human resource challenges presented by HIV/AIDS for the health and other sectors. Governments and other donors have begun to act on this awareness and data. However, prior to the recent SACI initiative, UNDP has done little to capitalize on this awareness in order to more systematically address capacity constraints arising from deficient HR planning, development and management strategies. Where UNDP lacks the staff capacity, it could at least actively monitor developments.

Country and CO experience indicates that *transfer of knowledge and learning* within and between countries around innovative ideas and other projects has been weak and should be enhanced. This suggests an important role for the Regional Centre, and possible

limitations of centrally driven initiatives where the staff concerned may not be sufficiently familiar with precedents and country contexts.

3.5 PARTNERSHIP COORDINATION FOR COUNTRY RESULTS

For purposes of the evaluation, partnership coordination for country results was defined to cover UNDP contributions relating to:

- Mobilization of financial resources for HIV/AIDS at the country level.
- Strengthening of interagency synergy among UN agencies and with official development partners.
- CO staffing and coordination, and resources for HIV/AIDS in the CO.

The evaluation examined UNDP roles and contributions in the UN Country Team, Thematic Working Groups on HIV/AIDS, and in relation to other donors.

UNDP has achieved positive outcomes in donor partnership coordination for country results in nine of the case-study countries. The exception is South Africa. The outcomes vary greatly from country to country, and it was not easy for the international team to assess these aspects. In some countries, the evaluation team's work also led to the identification of missed opportunities.

BOX 3.14 KEY CONTRIBUTIONS AND OUTCOMES IN PARTNERSHIP COORDINATION FOR COUNTRY RESULTS

UNDP played important roles and made important contributions at the country level in partnership coordination for the achievement of country results. This was most evident in financial resource mobilization from the GFATM in Angola and Zimbabwe. UNDP also made important contributions in strengthening interagency synergy among UN agencies and with official development partners in Ethiopia and Lesotho, among other countries.

Many stakeholders would like UNDP to play more assertive roles in this area of HIV/AIDS responses. Strategies to strengthen partnership development roles will require consideration of several factors. These include: specific circumstances and opportunities in each country; capacity of COs and the characteristics of specific Resident Representatives, Resident Coordinators and staff; clarification of roles between UNAIDS and UNDP at country level; and improved design and communication of UNDP CO AIDS strategy.

UNDP has a key position in relation to partnerships in most countries, in large part due to its role as Resident Representative and in the Resident Coordinator system. An official's remark that "UNDP is the agency we all look to for leadership" was representative of many others.

3.5.1 FINANCIAL RESOURCE MOBILIZATION AT THE COUNTRY LEVEL

The most important identifiable partnership contribution from UNDP in the case-study countries lies in the mobilization of resources from other external partners. In five of the case-study countries, successful resource mobilization has occurred where UNDP has been associated. In Angola, the active engagement of the UNDP CO is widely thought, particularly in the donor community, to have been central to the country's first success in obtaining a grant from the GFATM under Round Four. The UNDP focal point for HIV/AIDS played a central role in bringing CSOs into the GFATM proposal preparation process and in continuous follow-up. UNDP now serves as PR of the grant.

- In Botswana, the UN Theme Group worked with the government on the development of the GFATM grant proposal, and it assisted with advocacy to attract more donors to HIV/AIDS work in the country.
- In Malawi, UNDP's support and coordination were viewed as important in the development of an AIDS SWAp arrangement with the country's development partners (although the evaluation was unable to document details).
- In Zambia, UNDP leveraged resources from multiple partners to support district and community-based initiatives and responses to HIV/AIDS. These results were attributed to UNDP, and particularly to UNVs.
- In Zimbabwe, UNDP manages the GFATM grant under Round One, a grant that might not have been awarded without UNDP's role as PR. UNDP was also instrumental in mobilizing resources for HIV/AIDS in Zimbabwe from the United Nations Foundation.

While the overwhelming outcome in resource mobilization was positive, this result was not universal. In Ethiopia, UNDP was seen as being weak in financial resource mobilization for HIV/AIDS, despite the well-regarded donor coordination

arrangements in the country and strong signs of increasing adoption of the CC methodology by other donors. In Lesotho, while UNDP's active leadership may have contributed to resource mobilization, policy guidance, such as was provided by UNDP, was not enough to ensure effective operational use of a UNDP guidance manual. Similarly, in Malawi, UNDP was, at the time of the evaluation, on the sidelines in the creation and operation of a pooled fund of donor resources to support AIDS programmes, after substantially coordinating the earlier phases of awareness-raising concerning the need for increased donor resource commitments to HIV/AIDS.⁶⁷

3.5.2 STRENGTHENING SYNERGY AMONG DEVELOPMENT PARTNERS

UNDP played an important role in strengthening inter-agency synergy for partnership results in six of the case-study countries, but also missed some opportunities. In Botswana, UNDP was instrumental in the formation of a Partnership Forum that includes donors, the private sector and the CSO sector. The Forum had improved information sharing and collaboration on interventions, though the level of interaction with the large US PEPFAR programme could not be ascertained. In Ethiopia, the UNDP Resident Representative played a key role in the UN Theme Group, strengthened harmonization and efficient inter-agency coordination within the UNDAF and the joint government-donor Development Assistance Group (DAG), and improved donor-government relationships. However, UNDP's role was perceived to have diminished, and informants felt that resurgence of a more assertive and strategic role was desirable. In Lesotho, the UNDP Resident Representative gave an entirely new dynamic to inter-agency cooperation (Box 3.15). As a result, UN agencies agreed that AIDS would represent a key strategic area for all agencies in Lesotho.

In Malawi, UNDP's work created greater synergy in support of the NAC. In Swaziland, UNDP leadership through the Round Table, the UN Country Team, and the HIV/AIDS Theme Group made a difference, especially with bilateral donors. In Zambia, UNDP

⁶⁷ Between 2000 and 2001, UNDP was the prime mover in convening national conferences in Malawi to raise awareness among donors for coordinated resource mobilization. It later played limited roles in the new pooled funding arrangement, in part because UNDP funds were not in the pool. UNDP guidance permitting UNDP participation in pooled funding was issued at the beginning of 2006.

BOX 3.15 LESOTHO: A UNDP RESIDENT REPRESENTATIVE CREATES NEW PARTNERSHIPS, WITH RESULTS

In Lesotho, the forceful leadership of a new UNDP Resident Representative strengthened and developed new partnerships with government and other donors.

The Resident Representative established credibility by brokering among actors in domestic political disputes, and drew upon UNDP's consequentially increased standing to launch many new HIV/AIDS initiatives. At the time of her arrival, despite a declaration by the King that HIV/AIDS was a national disaster, the national HIV/AIDS response was weak. Between 2002 and 2004, the Resident Representative engaged in a flurry of activity. At her initiative, UNDP supported the Ministry of Local Government with decentralized planning, including voluntary counseling and testing. The Prime Minister and Resident Representative flew together to a small town, Qacha's Nek, in the eastern mountains of the country, to launch and later to close the kick-off events. In 2003, the Resident Representative had a five-hour meeting with the

Prime Minister, his entire cabinet and all Principal Secretaries. By the end of the meeting, the government had accepted the urgent need for scaling up. UNDP produced a 300 page reference manual, 'Turning a Crisis into an Opportunity: Strategies for Scaling Up the National Response to the HIV/AIDS Pandemic in Lesotho,' widely referred to as 'The Bible.' The Prime Minister publicly launched it. 'Know Your Status' was the slogan for a nationwide campaign for voluntary counseling and testing. It culminated in a major session led by the UNDP Resident Representative, with the Minister of Health in attendance. With UNDP support, Lesotho's Principal Chiefs launched a programme to make themselves HIV/AIDS competent, in order to educate local people about the pandemic.

The Resident Representative systematically used her position to promote partnerships for country results. HIV/AIDS were mainstreamed into all aspects of UNDP's Country Programme, and UNDP promoted

transformational leadership workshops wherever there was an opportunity. An Expanded Theme Group was established including CSOs and bilateral donors, co-chaired by one of the main bilateral donors. According to CO data, HIV/AIDS rose dramatically as a share of UNDP's total programme spending in Lesotho, from 5 percent in 2002 to 42 percent in 2004. The staff re-profiling exercise is reported to have been taken as an occasion to align staff skills and aptitudes with the needs of the country programme, giving increasing attention to HIV/AIDS.

Despite these successes, partnerships continued to pose challenges in Lesotho at the time of the evaluation. Implementation weaknesses hampered the effectiveness of UNDP's programme, and staffing changes diluted the UNDP partnership coordination role. Finally, tensions created by the very process of aggressive UNDP leadership needed to be resolved.

Sources: Caplan G, "Towards a UNDP CO of the Future—Lessons from Lesotho," November 10, 2004 (processed, report for the UNDP CO); country programme spending data provided by CO.

mobilized partnerships to help in rolling out HIV/AIDS initiatives at the provincial and district levels, following the successes of the UNDP pilots. UNDP also increased the effectiveness of the smaller UN agencies, such as the International Labour Organization. In Ethiopia and Zambia, the internal technical capacity of the UNDP CO HIV/AIDS team was an important strategic resource to the government and some other agencies. Unfortunately, tensions between UNDP and UNAIDS somewhat undermined synergy in two countries.⁶⁸

Certain other UNDP initiatives have assisted in creating awareness and attitudes that enhance partnerships. In Ethiopia, UNDP facilitated increasingly participatory processes for HIV/AIDS policy and strategic planning, although limitations on stakeholder inputs remained.

68 The evaluation team found it inappropriate to name the countries concerned in an evaluation intended to be strategic in character and not to have the character of a performance audit.

3.5.3 COUNTRY OFFICE STAFFING, COORDINATION, AND RESOURCES FOR HIV/AIDS

The *capacity of the UNDP CO*—financial resources, leadership, staffing, skills, incentives, and attitudes—was a critical variable in the creation of effective partnerships for results in the case-study countries. There were wide variations in the technical and organizational capacity of the COs to support national HIV/AIDS responses, as well as in the will and determination of CO managers and staff to take action on the matter.

In Angola, the staff re-profiling exercise of 2001 seriously restricted CO HIV/AIDS capacity, through budget reductions, but in Lesotho the Resident Representative seized the opportunity of the staff re-profiling to alter the CO skills profile (see Box 3.15). In Ethiopia, the UNDP CO increased its

HIV/AIDS capacity in recent years, but limited HIV/AIDS programme capacity still constrained partnerships and the rollout of pilots. In Malawi, it was uncertain whether the CO was sufficiently equipped to support scaling up the HIV/AIDS response, and in Namibia, there were important gaps in staffing the CO to support HIV/AIDS activities.

In several countries, including Angola and Namibia, the individual responsible for both poverty and AIDS in the CO was described as over-burdened and could not effectively cope with both responsibilities. In Zambia, the limited capacity of the highly capable HIV/AIDS programme staff to perform both project functions and communication and coordination roles was an obstacle to UNDP effectiveness.

The substantial variations in UNDP CO capacity and effectiveness were not only the consequence of the differences between countries' perception of the significance of HIV/AIDS as a health and development problem. They were also heavily dependent on the *personality and disposition of the UNDP Resident Representative*. Changes in Resident Representative and staff assignment discontinuities were frequent sources of weakness in the UNDP CO HIV/AIDS response. At the same time, the *Lesotho* experience suggests that changes in the assignment of the UNDP Resident Representative can also be a powerful stimulus for action, depending on the personality, commitment and vision of the Resident Representative.

3.5.4 STRATEGIC ISSUES AND ONGOING CHALLENGES

UNDP has the ability to be a key role player in strengthening partnerships for country results on HIV/AIDS, particularly in resource mobilization and management and in inter-agency cooperation. Effective functioning of Expanded HIV/AIDS Theme Groups in some countries is a case in point. A key strength of UNDP is its good relationships with host governments, which adds to its credibility and potential effectiveness as a coordinator of partnerships.

The positive contributions documented above were thought to have been accomplished with less-than-adequate CO staff and coordination with Headquarters and the Regional Centre. This view was shared not only among CO staff but also among

many development partners. At the same time, questions were raised about the apparently large UNDP staff presence in individual case-study countries, and their roles, competence and credibility. Thus, the 'adequacy' of UNDP CO HIV/AIDS staffing, sometimes captured as a complaint about having only a part-time HIV/AIDS focal person, turned out to be a more complex issue of CO HIV/AIDS strategy, administrative budget, staff skills, staff numbers and allocations, incentives, leadership, and attitudes.

The roles and relative responsibilities and relationships of Headquarters, Regional Centre and CO staff were also sometimes unclear. There were also concerns about repeated requests from Headquarters for action on what were perceived as unfunded international mandates. There were wide variations among COs in this respect, and the evaluation team was unable and not mandated to examine the issue in detail. The Regional Centre was seen as an important complement to the COs, but its roles, activities, coordination with CO initiatives, were not well understood by COs and partner staff. CO capacity might be strengthened by 'projectizing' support and thereby removing it from the constraints of the UNDP CO administrative budget.⁶⁹

Wide differences among UNDP Headquarters staff in their personal commitment to the corporate HIV/AIDS agenda are an important part of the explanation of the inter-country differences in the HIV/AIDS response of UNDP. One observer suggested a gap in New York between the high level of commitment of the UNDP top management and working level officials, on the one hand, and the apparently half-hearted responses of some UNDP officials in middle and senior management who have the ability to ensure follow-through on the corporate agenda.

Several other obstacles to effective partnerships were identified:

- *Inadequate communication.* In Angola, opportunities for synergy were missed due to UNDP's inadequate definition and communication of the UNDP CO's role and HIV/AIDS strategy to other development partners. While a strong partnership exists between UNDP and Development Cooperation Ireland in building a

69 USAID has done this very successfully at its headquarters.

formidable programme for UNVs at the Provincial and District levels across Zambia, other donors suggested that better communication about this strategy would have increased synergies with the roll out of the UNV work at district level.

- *Agency role definition and tensions.* In two countries tensions between UNDP and UNAIDS were a serious obstacle.⁷⁰ In others, there were indications of lack of clarity of roles. Fortunately, there are recent, focused attempts to articulate clear policy on UNAIDS and UNDP roles at country level. Associated processes for resolution of problems in practice may still be needed.⁷¹
- *Limited UNDP assertiveness.* In Ethiopia and Zambia, UNDP was described as too ‘diplomatic’ in its approach, and could have taken a firmer position on some issues with the public authorities and certain donors, for more coherent and effective HIV/AIDS responses.
- *Project focus.* Obstacles could arise when UNDP country HIV/AIDS activities are largely ‘projectized.’ This could lead to missed opportunities for UNDP to provide overall strategic perspectives and guidance in its coordination role, as the limited CO resources end up being devoted to project support and resolution of urgent crises rather than longer-term important issues of policy, strategy and coordination.

3.6 CONCLUSIONS ON COUNTRY-LEVEL CONTRIBUTIONS AND OUTCOMES

UNDP roles and activities have contributed in many ways to HIV/AIDS being a development rather than solely a health issue. While the issue might be perceived solely as mainstreaming, the theme of HIV/AIDS as a development issue ran through the entirety of the UNDP HIV/AIDS work reviewed by the study team. UNDP interventions led to substantive changes in government and grass-roots mobilization within specific targeted areas and groups. Some important precedents have been established. Many interventions have been innovative and have contributed to important paradigm shifts and knowledge generation. Overall, UNDP has achieved important outcomes in all the main outcome theme

70 Naming these countries would be inappropriate in the evaluation, since its role is not to single out individuals but to raise strategic issues.

71 UNAIDS, “UNAIDS Technical Support Division of Labour—Summary and Rationale,” UNAIDS, August 2005.

areas related to the HIV/AIDS response in case-study countries.

In addition to identifying positive contributions, the evaluation team’s *analysis identified missed opportunities*. Given the prominent associations between poverty and HIV/AIDS, integration of HIV/AIDS into poverty reduction strategies is particularly relevant to UNDP. The potential for UNDP to mainstream HIV/AIDS in poverty alleviation and other sectors was one of UNDP’s key comparative advantages. UNDP can offer particular technical capabilities and broader development perspectives, as well as the advantages of linkages with political leadership in key ministries, such as finance and development planning. Despite the finding that HIV/AIDS is included in poverty reduction strategy statements, this work is just beginning.

There has been *substantial variation in outcomes among countries*. In general, country level outcomes and even outputs of UNDP activities up until the end of 2004 are probably more moderate and smaller in scale than some previous ROARs and other reports have suggested.⁷² In addition, the depth and sustainability of change and resulting action tended to be difficult to substantiate with available M&E data. The evaluation team therefore considers the ROAR statements to be at risk of hyperbole that could undermine the credibility of the good work done.⁷³

Despite the relatively broad understanding of UNDP contributions and outcomes used in this chapter, this viewpoint might not do full justice to the work of UNDP during the period under review. Implementation of key programme components has only started recently in many countries. This meant limited time for changes to manifest themselves, even if a number of potentially significant processes and outputs could be reported by country teams.

72 ROAR 2001 refers to “growing evidence of the impact of UNDP work on HIV/AIDS in SSA as a major achievement,” and also refers to “clear indications” in many countries of SSA that “comprehensive UNDP interventions are contributing to significant country-level progress in government and grass-roots mobilization to respond to HIV/AIDS.” ROAR 2001 refers to capacity building results in 2001, without detail, in all of the case-study countries except Angola. It mentions mainstreaming results in Botswana, Malawi, and South Africa, and promotion of human rights in response to HIV/AIDS in Botswana, Malawi, and RBA’s regional programme. It also mentions results of information dissemination and awareness-raising on HIV/AIDS in Botswana and Swaziland. The UNDP Annual Reports for 2002, 2003, and 2004 do not take the form of the ROARs.

73 The evaluation of the Second Global Cooperation Framework of UNDP also mentions, in reference to HIV/AIDS work, that “The use of hyperbole and inflated language do not add much to the development debate nor the UNDP role in it.”

Limited scale or even absence of clear, significant outcomes should not be interpreted as meaning that interventions have failed or should not receive further support. In fact, it may indicate a need for greater and more sustained support for certain interventions. Similarly, the strategic issues identified for attention are intended to enhance potential for substantial outcomes and impact arising from good work and dedication of many CO, regional and headquarters staff.

There were *wide discrepancies between UNDP statements of policy and its performance at the country level*. Specifically, the evaluation team is concerned about problems in the implementation of UNDP's own interventions and the adequacy of its COs for the interventions of UNDP. In country after country, concerns were repeatedly expressed about delays in approval and subsequent implementation of UNDP HIV/AIDS projects and activities. These problems were attributed to bureaucracy; unclear roles and relationships among Headquarters, the Regional Centre, and COs; and within the Headquarters and the Regional Centre itself.

Substantially sound UNDP initiatives sometimes had the appearance of being UNDP-driven, rather than partner-driven. Where the client was unambiguously in charge, as in the case of nationally executed projects, UNDP staff were concerned about the implications for further implementation delays. CO adequacy concerns relate to staff, budgets, leadership, knowledge management, and strategy. They suggest significant gaps between the strong statements of UNDP corporate strategy and senior management statements, and the capacity of COs to respond adequately to them. The balance sheet on CO staffing and coordination that results from this evaluation should not, however, be seen as entirely negative. There are cases, as cited in this chapter, where UNDP COs played critical roles in important UNDP accomplishments.

The central importance to UNDP effectiveness of the Resident Representative and Resident Coordinator system was underscored repeatedly. However, there were wide variations in the roles and activities of Resident Representatives and Resident Coordinators.

In examining next steps, experience of the case-study countries indicates that UNDP will need to address a number of general limitations on its ability to achieve

more substantial outcomes in the case-study countries. These include the following:

- Programmes and activities gave limited attention to identification and exploitation of UNDP's strategic focus and areas of comparative advantage in the country. Since these vary from country to country, they merit identification at the country level.
- Mainstreaming of HIV/AIDS within UNDP itself was not well developed at country, regional and headquarters levels, and made it difficult to bring overall comparative advantages to bear.
- Many programmes and projects had yet to consider fully issues related to exit strategies, consolidation and sustainability for particular interventions, as well as strategies for scaling up of successful interventions.
- Communication and coordination with other development partners and COs was often too limited in creating awareness of lessons learned from UNDP programmes and other initiatives to leverage their resources to achieve greater depth and scale of outcomes.
- Tendencies to become too project-focused could dilute strategic thrust, distract from areas where UNDP has clearer comparative advantages, and limit synergy among programmes, development partners and countries.⁷⁴
- Under-developed monitoring and evaluation systems created risks that effective interventions would not receive appropriate ongoing support, and that limitations would not quickly be recognized and addressed. Dramatic claims of success with little clear substantiation might hinder the understanding of how to intervene more effectively to resolve problems, and discourage other partners from supporting sustainable initiatives and roll out of UNDP-initiated innovations.

These conclusions have implications for the directions that UNDP might assume in deepening its support to the HIV/AIDS response at the country level in Southern Africa and Ethiopia.

⁷⁴ A number of smaller projects in various case-study countries, in areas such as home based care, prevention programmes for key target groups, and voluntary counseling and testing have not featured prominently in the above discussion of UNDP contributions and outcomes. In the early years of national responses, such initiatives may have led to important learning by UNDP and its partners. However, it is difficult to argue that in more recent years they have built on UNDP areas of comparative advantage or represent effective strategy.

SUMMARY OF FINDINGS AND RECOMMENDATIONS



This chapter summarizes major findings of the evaluation, reviews UNDP comparative advantages in addressing HIV/AIDS in the case-study countries, and sets out recommendations for action by UNDP.

Overall, the evaluation finds that UNDP has been instrumental in increasing awareness about HIV/AIDS and has facilitated, along with other UN agencies and donors, increased commitment to HIV/AIDS as a development issue in Southern Africa and Ethiopia. UNDP also followed through on its commitment to support the HIV/AIDS programmes and activities that it said it would support. While it was too soon to assess the effectiveness of the UNDP initiatives in a number of areas, certain important contributions and outcomes were identified in all the main outcome theme areas related to the HIV/AIDS response in case-study countries.

This is not intended to suggest that UNDP did enough or achieved enough. There were a number of missed opportunities, as cited in the chapters earlier. In addition, UNDP's ability to monitor and evaluate its activities needs to be addressed and strengthened, especially as HIV/AIDS activities and programming continue to expand and mature.

In the face of the magnitude of this pandemic and its devastating impacts on development, UNDP must find a renewed energy and impetus in its HIV/AIDS actions and responses. Implementation of UNDP policies, strategies and projects are not keeping abreast with the growing toll that HIV/AIDS is taking on countries, especially those that are already facing numerous other developmental challenges. If UNDP is to assist countries in halting the spread of this epidemic and meeting the MDG deadline of 2015 for reversing and rolling back HIV/AIDS, it must invest itself more wholly in its commitment to the response, and it must also make the transition from discussion to implementation, from talk to action.

This evaluation calls for new urgency and recommends actions to adjust UNDP HIV/AIDS programming and strategies, strengthen HIV/AIDS institutional capacity within UNDP, and learn from and build upon its experience.

4.1 SUMMARY OF FINDINGS

On the basis of the detailed country and international evidence gathered, the evaluation summarizes four major findings concerning UNDP's roles

and contributions in the HIV/AIDS response in the case-study countries in:

Finding 1. UNDP has made signal contributions to the increasing recognition in Southern Africa and Ethiopia of HIV/AIDS as a development issue and has supported important changes to this end at the country level.

The theme of HIV/AIDS as a development issue ran throughout the AIDS-related work of UNDP in the case-study countries, beyond the specific issue of mainstreaming HIV/AIDS into other sectors. UNDP Resident Representatives, UN Resident Coordinators, and UNDP CO personnel have made important contributions to the progress in Africa in recognition of HIV/AIDS as a development crisis. UNDP was at the forefront on mainstreaming, and initiated change through its support to National AIDS Commissions and Councils, gender issues, and many levels of government and society. When other development partners were reluctant or unable to provide support, UNDP continued supporting the case-study countries in working on HIV/AIDS, both as a current crisis and as a long-term development issue.

The evaluation demonstrated that UNDP has the ability to engage effectively with country partners at four main levels in its support for national responses. These are: political institutions and leaders; the main sector ministries related to UNDP's development mandate; sub-national levels of government including regions, districts and local government; and communities. At the *national* level, UNDP has engaged in *upstream* work with central government agencies to strengthen macro-level responses. In this work, it had to compete for attention with better-funded partners, particularly in major sectors such as health, education, and agriculture. Evidence from the field indicates that UNDP engagement with higher levels of governance (including Parliament, Cabinet, President's office, and powerful ministries such as Finance and Planning) has more often resulted in the greatest influence in shaping policy and strategy. This was seen in Botswana, Lesotho and Zimbabwe. Unfortunately, the attention paid to these levels, especially parliaments, was more limited in most case-study countries than would have been desirable.

Mid-stream interventions at *decentralized, sub-national* levels of government and civil society are an area where UNDP has achieved some of its most

prominent successes in the case-study countries. Support for decentralized, participatory planning, and capacity development for district and local government, as well as for strategically placed and umbrella HIV/AIDS CSOs, were among the areas where UNDP's support has been highly valued across the 10 case-study countries. UNDP has also piloted innovative projects downstream at community levels.

The evaluation team found substantial inter-country variations in contributions and outcomes and some *missed opportunities* for UNDP to address HIV/AIDS as a development issue through projects and dialogue with political and opinion leaders at the country level. The achievements and roles played by UNDP in contributing to the recognition of HIV/AIDS as a profound development issue in Africa are at risk. The very success of the international community in mobilizing significant new financial resources for HIV/AIDS programmes, and especially treatment, could revive the dominance of the previously prevailing medical paradigm.

Finding 2. Despite UNDP's achievements in making HIV/AIDS a development issue, important gaps exist between UNDP's statements and its performance.

Strong stances on HIV/AIDS in senior management statements and UNDP publications⁷⁵ were not often matched at the country level by comparable performance in the design, execution and measurable outcomes of UNDP activities at the country level. This does not deny the dedication and effectiveness of many staff and programmes in many countries. Rather, it points to the limited scale and depth of outcomes thus far, and to *gaps in strategy and institutional capacity*.

In particular, the evaluation identified limited consideration of how to scale up important outcomes and ensure sustainability, limited sense of urgency and importance for HIV/AIDS in UNDP programmes, and limited information and communication—UNDP's work on HIV/AIDS at the country level was often unknown by key stakeholders and some informants tended to confuse UNDP and UNAIDS.

75 See, for example, the UNDP Results-Oriented Annual Report for 2001. It refers to "growing evidence of the impact of UNDP work on HIV/AIDS in Sub-Saharan Africa as a major achievement," and also refers to "clear indications" in many countries of SSA that "comprehensive UNDP interventions are contributing to significant country-level progress in government and grass-roots mobilization to respond to HIV/AIDS."

In the view of the evaluation team, this lack of knowledge of UNDP's HIV/AIDS work was due not only to inadequate communication but also, once again, to inadequate strategy at the country level, especially with respect to how to maximize outcomes.

A second major *gap is between policy and plan, and actual implementation* in most areas of HIV/AIDS responses—from NAC functioning to mainstreaming. Focus on upstream policy advocacy and analysis is not giving room to a new priority for implementation of UNDP, client country, and external partner programs. In addition, UNDP projects and programmes are not receiving enough support from COs and other sources to reduce delays in execution. This challenge is also influenced by the growing external financial resources being promised by donors.

Finding 3. In refining its roles and making future contributions to the HIV/AIDS response in the case-study countries, UNDP faces significant external challenges and needs for internal change.

The growing flow of external financial resources for HIV/AIDS programmes coming from outside the UN system implies a need for UN agencies to rethink their roles and activities. In financial terms, UNDP is almost certain to become a much less important actor on the HIV/AIDS scene in the case-study countries. In contrast, the UNAIDS Secretariat is becoming an increasing presence at the country level, with rapidly rising financial resources and personnel in the field.

The rapid changes in the environment for the HIV/AIDS response of UNDP are affecting the case-study countries. The most significant manifestation of this lies in programmed external financial resources. The work of the Global Task Team, the understanding among key partners on the Three Ones principles, and other global policy initiatives must be expected to have direct impact on UNDP's work at the country level. Additional global initiatives, currently unknown, must also be expected.

Finding 4. The central position of UNDP Resident Representatives, UN Resident Coordinators and COs in the international system of development support to the case-study countries was a key theme in interlocutors' comments.

UNDP's role very frequently extended beyond UN agencies. This was reflected, for example, in country-

level Expanded Theme Groups on HIV/AIDS that were thought more effective than Theme Groups limited to UN agencies. However, sometimes it was not clear whether UNDP's comparative advantage in coordinating development at the country level was viewed as actual or only potential. The team identified cases, as in Lesotho, where the UNDP Resident Representative seized opportunities to provide forward-looking leadership. Too often, both internally and externally, UNDP country level leadership was seen as bureaucratic and diplomatic, rather than substantial and development-oriented. Skills, aptitudes, and budgets were all part of the problem.

4.2 UNDP COMPARATIVE ADVANTAGES IN ADDRESSING HIV/AIDS

The evaluation team offers several conclusions on UNDP's comparative advantages in addressing HIV/AIDS at the country level.

The issue of comparative advantage must be seen in relative rather than absolute terms, that is, UNDP must be viewed in relation to other external development partners in the case-study countries. This suggests the importance of inter-country differences and the uniqueness of each country case. Country differences in epidemiology and social, political and economic conditions lead to different external presences in the country. Furthermore, in any given country there may be important differences between UNDP's potential comparative advantages and its actual advantages. For this reason, the evaluation is cautious on categorical statements about UNDP's comparative advantages, and urges that UNDP's country-specific comparative advantages be discussed among stakeholders at the country level.

Despite this cautionary note, the team identified several areas of comparative advantage. First, one key UNDP comparative advantage is UNDP's position as coordinator and voice for the UN system and UN Country Team. This was widely remarked upon by sources. It is a central theme throughout the work of the evaluation team in the case-study countries as well as in its global policy interviews.⁷⁶ One observer from outside the UN system commented that UNDP

⁷⁶ See Annex 7 for a synthesis of the evaluation team's global policy interviews.

can and should bring other donors to the dialogue at the country level, even when those donors may be inclined not to participate and to operate outside it. UNDP comparative advantage as voice of the international aid system, even beyond the UN family, includes its closeness to country situations, its presence on the ground, its contacts with political, parliamentary, and government leaders, and its capacity to reach out to opinion leaders throughout the country.

Second, UNDP's generally, but not universally strong, trusting relationship with government is another key comparative advantage. This strengthens UNDP's role as coordinator and facilitator in the dynamic of government-donor collaboration. It also enables UNDP to work with government to achieve better results. The experience of the evaluation suggests that this comparative advantage has been under-used.

Third, ability to facilitate and promote mainstreaming and integration of HIV/AIDS issues into development strategy, including poverty reduction, *should* be a comparative advantage of UNDP. This includes mainstreaming HIV/AIDS issues into other sectors, and helping partners in host countries as well as among bilateral donors to move in their thinking and action on HIV/AIDS beyond narrow, vertical or—as one key informant expressed the problem so vividly—'stovepipe' approaches. UNDP demonstrated this capacity in several case-study countries. However, given the importance of other external actors, especially the international financial institutions, in a number of countries, as well as the challenges of supporting actual implementation of mainstreaming in sectors, the evaluation team concluded that UNDP would need actively to prove this comparative advantage in mainstreaming case-by-case. Mainstreaming must be disaggregated to specific sub-issues at the level of individual countries.

Fourth, the team found a UNDP comparative advantage in addressing certain aspects of AIDS-related governance issues, especially decentralized support to HIV/AIDS programmes and policies. This was seen in several of the case-study countries, including Botswana and Zambia. Whether UNDP would have a comparative advantage in bringing decentralized support to HIV/AIDS programmes to a national scale was, however, not clear to the study team because of the enormous demands this would bring for human, financial and organizational resources.

Fifth, UNDP has a comparative advantage in facilitating the effective involvement of other donors, particularly the smaller UN agencies and donors with some financial resources but little field presence or knowledge of country situations. Because of UNDP's universal field presence, this was thought to be especially important in smaller countries, where some external partners would wish to engage but be unable to provide sufficient locally based staff support. Several global policy commentators saw the UNDP role in facilitating the engagement of other donors as particularly important in the future, with the growth in GFATM, PEPFAR, and World Bank MAP resources, saying that UNDP should be able to assist countries to mobilize, disburse, and effectively utilize funds from these sources.

Sixth, UNDP *should* have a comparative advantage in capacity development, including particularly, as one interviewee put it, the "architecture of AIDS institutions" at the country level. AIDS impact on the workforce and AIDS linkages to civil service issues were also mentioned in the team's global policy interviews, but the team observed little work in these areas in the case-study countries. Beyond generic reference to capacity development, one informant said that UNDP needs to address the question of "capacity for what?" There is a particular need to strengthen UNDP training, especially planning and follow-up.

4.3 RECOMMENDATIONS

This evaluation has one overarching recommendation: In Southern Africa—where the HIV/AIDS epidemic is the most severe in the world—the COs in the case-study countries must demonstrate a much higher level of urgency in their work on HIV/AIDS.

Urgency should be measured, *inter alia*, by use of resources, leadership, people, time and money. Total UNDP spending on HIV/AIDS overall is not large enough to have a significant impact on the epidemic at the country level. It is therefore particularly important that it use HIV/AIDS resources, both human and financial, in a strategic manner. It is critical to develop coherent approaches to leveraging partner resources in order to achieve the scale of outcomes required in countries with very severe epidemics.

With support of an agile team drawn from all concerned headquarters units and the Regional Centre, each

UNDP CO and each of the other units concerned should develop, by September 2006, a monitorable action plan through which to implement the specific recommendations detailed in the evaluation report. These specific recommendations are:

4.3.1 COUNTRY OFFICES

Clarify strategic direction

COs should formulate or update UNDP country HIV/AIDS strategies and integrate them into national HIV/AIDS strategies and programmes. Strategies should:

- Include UNDP inputs from the Regional Centre and headquarters units, and promote mainstreaming, especially the full integration of HIV/AIDS into poverty reduction strategies.
- Draw upon initiatives from the headquarters Bureau for Development Policy (BDP) and the Regional Centre, where those initiatives are relevant to the country's situation.
- Be based on country demand and need rather than UNDP supply; take into account implementation of the 'Three Ones' principles; support donor harmonization; support integration of HIV/AIDS into poverty reduction strategies; and associated actions should feature prominently in UNDP country HIV/AIDS strategies and programmes.
- Integrate all UNDP financial resources for HIV/AIDS, whether managed at country, regional or headquarters level, and whether core resources or trust funds.

Shift programme focus

- Give central attention to supporting implementation of country HIV/AIDS programmes, especially at decentralized levels.
- With support from the Regional Centre, assist partner countries in designing, financing, and executing programmes that take actions successfully piloted by UNDP and other external partners to scale on a country-wide basis.
- Assist partner countries with mobilization, disbursement and effective utilization of external financial resources for HIV/AIDS, with support from the Regional Centre.

Strengthen HIV/AIDS capacity

COs should strengthen their HIV/AIDS capacity, with support from the Regional Centre for Southern Africa and headquarters. CO HIV/AIDS capacity should include budgets; staff skills, attitudes, and

deployment; staff incentives; organization for HIV/AIDS work; and internal and external leadership. Leadership by example rather than by mandate should characterize UNDP cooperation with UN organizations and other partners. In their HIV/AIDS work, COs should go beyond UNDP projects and should plan, draw upon and facilitate deployment of the entirety of the institutional resources available to UNDP through UNAIDS and the UN system.

Foster a culture of monitoring and evaluation

Such a culture should be fostered by strengthening monitoring, evaluation, exit strategies, and especially learning from experience, with an expectation of measurable results from each UNDP HIV/AIDS project or intervention. Specific recommendations include:

- Review each ongoing UNDP HIV/AIDS project or activity for adequacy of its monitoring, evaluation and exit strategy. Projects should not simply end, but should have a planned exit strategy involving evaluation and transfer of responsibility.
- Establish successful work on monitoring and evaluation as a criterion for positive evaluation of staff performance.
- Draw upon the monitoring and evaluation work of the Regional Centre for methodology to synthesize monitoring and evaluation analysis in forms usable by others, and to establish and disseminate good practices and lessons learned.

4.3.2 REGIONAL BUREAU FOR AFRICA

Assume new HIV/AIDS leadership roles

- Support stronger HIV/AIDS leadership on the part of Resident Coordinators and Resident Representatives. The Regional Bureau for Africa (RBA) should support and promote proactive leadership on HIV/AIDS through job design, staff selection and performance appraisal, and through support with other UNDP units and external partners.
- Review and revise SACI and ARMADA strategies and mandates in close cooperation with the Regional Centre, to prioritize supporting country HIV/AIDS programmes with particular reference to monitoring and evaluation, and disseminating good practices; support expansion of pilots evaluated as successful; design and support public management actions necessary for scaled-up HIV/AIDS programmes; and contribute to formulating and executing CO HIV/AIDS strategies and programmes.

- Lead a task force for the independent assessment of HIV/AIDS capacity in COs, the Regional Centre and RBA, with participation of BDP, the Bureau of Management, the Regional Centre, and COs.

4.3.3 BUREAU FOR DEVELOPMENT POLICY

Review corporate HIV/AIDS strategy

Review the corporate HIV/AIDS strategy of UNDP in the light of the evaluation report to support implementation of country HIV/AIDS programmes and poverty reduction strategies.

- Focus on the two themes of: support to implementation of country HIV/AIDS projects and programmes, and support to integration of HIV/AIDS into poverty reduction strategies. UNDP/BDP HIV/AIDS programmes outside the two central themes should gradually be consolidated and transferred to other partners, except to the extent that they are directly responsive to country demand and have been evaluated as being successful. The revised corporate strategy should encompass a review of UNDP approaches to mainstreaming.
- Assist the Regional Centre, and especially COs, with HIV/AIDS country strategy formulation and implementation.
- Weigh the HIV/AIDS capacity of BDP, including budgets, staff skills, attitudes, incentives, and links with other UNDP units and partners, against the changing needs. BDP should give particular attention to capacity for monitoring and evaluation.

4.3.4 BUREAU OF MANAGEMENT

Accelerate implementation of a financial management improvement programme. The financial management strengthening programme should make it possible for users in BDP, regional bureaux and COs to access and effectively use real-time, consistent,

comparable financial data on the full range of UNDP HIV/AIDS activities.

4.3.5 OFFICE OF THE ASSOCIATE ADMINISTRATOR

Clarify working relationships

Examine and, where necessary, revise internal HIV/AIDS working and reporting relationships and external partnerships. The Office of the Associate Administrator should position UNDP for increasingly effective engagement on HIV/AIDS.

- Take the lead in defining CO standards and procedures for resolving problems that arise in implementing the division of HIV/AIDS-related labour among UN organizations that was recently agreed upon in follow-up to the work of the Global Task Team on Improving AIDS Coordination. Particular attention is needed to ensure effective cooperation between UNDP and the UNAIDS Secretariat.
- Review collaboration and reporting relationships among the concerned headquarters offices and bureaux, the Regional Centre and the COs. Establish the principle that the COs are supported by the other units within the framework of agreed strategies.
- Review UNDP's role as principal recipient for the GFATM for conflict of interest. If that role is retained, guidelines should be established to ensure its separation from UNDP advisory functions, and there should be a concentrated focus on capacity development for early phase-out at the country level.

4.3.6 EXECUTIVE BOARD

Request a report on the implementation of the recommendations for the annual session in 2007. Monitor implementation of the recommendations and commission a further evaluation at a convenient mid-point between 2006 and 2015.

ANNEXES

ANNEX 1. TERMS OF REFERENCE (SUMMARY)

Evaluation of UNDP's Role and Contributions in the HIV/AIDS Response in Southern Africa and Ethiopia

JUSTIFICATION FOR THE EVALUATION

Southern Africa is the most devastated sub-region in the world by the HIV/AIDS pandemic, and has the greatest danger to sustaining development achievements. Although rich in natural resources, it is a sub-region suffering from the triple effects of poverty, drought and famine, and the consequent severe erosion of human capacities. In addition, movements of people and soldiers across borders have had serious implications for the spread of HIV/AIDS. The impact of HIV/AIDS is also manifested in other ways. Due to shared economic interests, especially through the mining industry, and reliance on one dominant economy in the sub-region, there is much cross-border migration for work. This greatly increases the exposure of the general population to HIV/AIDS from high transmission areas. Further, HIV/AIDS disproportionately affects women and adolescent girls. Gender differences are at the root of a number of social, economic and political factors that drive the HIV/AIDS epidemic. Without an understanding of the complex relationship between gender and HIV/AIDS, strategies devised to tackle the epidemic are not likely to succeed.

The Evaluation Office is undertaking a strategic evaluation of UNDP's role and support in addressing HIV/AIDS in Southern Africa, in particular in the following 10 countries: Angola, Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. Ethiopia, in the Horn of Africa, is also included in this evaluation since it is estimated to have the second highest number of AIDS-infected people in Africa after South Africa. It also suffers from chronic food shortage and famine, which has sharply increased its vulnerability to the HIV/AIDS epidemic, and like Angola, has recently emerged from conflict.

PURPOSE OF THE EVALUATION

The purpose of the evaluation is to assess, within the context of the Millennium Development Goals (MDGs) and the Declaration of

Commitment, UNDP's role in achieving key outcomes at the country level. More specifically, the evaluation will assess UNDP's role in the context of the challenges described above and the extent to which it used its resources to respond to the HIV/AIDS challenge at the country level. Identification of countries for team visits will be made in consultation with the concerned bureaus, based on a mix of criteria including the severity of the pandemic and its impact on capacities, size and complexity, implementation of a Poverty Reduction Strategy (Paper) [PRS(P)], post-conflict situation, existence of good practice programmes, and successful and not-so-successful coordination mechanism in place.

In order to know if UNDP is doing the right thing and doing things right, policy and planning choices being made by countries to address HIV/AIDS and UNDP's role in advocacy, promoting a multi-sectoral response, and capacity development, will be assessed, including the extent to which UNDP's support has helped make progress towards the MDG on HIV/AIDS. Further, UNDP's potential role to increase synergies between activities to scale-up HIV/AIDS responses for society-wide impact will be identified and assessed.

The evaluation will also assess the outcomes of UNDP's strategy, programmes and projects in addressing HIV/AIDS at country level, including policy advice, knowledge management, and coordination issues. It will also assess UNDP's partnership and funding strategies and role as a cosponsor of UNAIDS. The evaluation will identify gaps if any, lessons learned and propose future directions.

UNDP's role as the Resident Coordinator and success in coordinating actions to address HIV/AIDS issues needs to be assessed, as does the role of the UN Expanded Theme Group on HIV/AIDS within the country. The extent to which UNDP, with other partners, is assisting countries emerging from conflict, in developing realistic and achievable targets in national development plans, PRSs and PRSPs, to address the impact of the AIDS crisis will also be assessed.

The findings of this evaluation are expected to assist the selected UNDP country offices in positioning themselves for a more effective role in the future in response to the crisis, with appropriate contributions and meaningful and coordinated support from corporate units and the newly established regional service centre. The findings will also contribute to the formulation of future UNDP strategies at the country level in combating HIV/AIDS.

SCOPE OF THE EVALUATION

The evaluation will be strategic in nature and forward looking. It will cover the period beginning from 1999 with the introduction of Strategic Results Frameworks (SRFs) and will include an outlook into budgeted activities that are either ongoing or have not yet begun. It will review evaluative evidence provided through available outcome evaluations at country/regional/sub-regional levels conducted by UNDP, including the Assessments of Development Results (ADRs) for Ethiopia.

PROCESS AND METHODOLOGY

The methodology for this evaluation requires the evaluators to obtain and analyze data to reach conclusions and build up empirical evidence to back up their conclusions. The empirical evidence on which the evaluation will be based will be gathered through three major sources of information (according to the concept of "triangulation"): perception, validation and documentation.

The evaluation exercise will include country visits to selected countries, the preparation of country case studies on UNDP's experience, good practices and lessons learned in each of the 10 countries, and forward looking recommendations. Team visits by independent consultants to the countries will validate issues and hold discussions with all key stakeholders. National consultants will prepare Country Assessment Reports and will be part of the evaluation team in-country.

ANNEX 2. BASIC DATA ON CASE-STUDY COUNTRIES

SOCIO-ECONOMIC INDICATORS													
Country	Adult HIV Prevalence (% of population 15-49 years of age)		Population (2002, millions)	Life Expectancy at Birth (2002, years)	Infant Mortality Rate (2002, per 1,000 live births)	Female Literacy (2002, %)	GDP per capita (2002, USD)	Human Development Index (HDI)				Health Expenditure per capita (2001, USD)	Composite ICRG Risk Rating (2003)
	2001	2003						HDI Rank (1998)	HDI Value (1998)	HDI Rank (2002)	HDI Value (2002)		
Angola	3.9	5.5	13.1	40.1	154	N/A	857	160	0.405	166	0.381	31	53.3
Botswana	37.3	38.8	1.7	41.4	80	81.5	3,080	122	0.593	128	0.589	190	79.8
Ethiopia	4.4	6.4	67.2	45.5	114	33.8	90	171	0.309	170	0.359	3	59.3
Lesotho	28.9	31.0	1.8	36.3	91	90.3	402	127	0.569	145	0.493	23	N/A
Malawi	14.2	15.0	10.7	37.8	114	48.7	177	163	0.385	165	0.388	13	54.0
Namibia	21.3	22.5	2.0	45.3	55	82.8	1,463	115	0.632	126	0.607	110	76.5
South Africa	21.5	20.1	45.3	48.8	52	85.3	2,299	103	0.697	119	0.666	222	68.8
Swaziland	38.8	33.4	1.1	35.7	106	80.0	1,091	112	0.655	137	0.519	41	N/A
Zambia	16.5	21.5	10.2	32.7	102	73.8	361	153	0.42	164	0.389	19	53.0
Zimbabwe	24.6	33.7	13.0	33.9	76	86.3	639	130	0.555	147	0.491	45	34.3
Sub-Saharan Africa	7.5	9.0	641.0	46.3	108	55.9	469	N/A	0.464	N/A	0.465	29	N/A

Notes: ICRG indicates Composite International Country Risk Guide risk rating (2003), which is an overall index, ranging from 0-100 (highest to lowest), based on 22 components of risk grouped into three main categories: political, financial and economic ratings less than 50 indicate very high risk and those greater than 80 indicate very low risk. N/A indicates not available.

Sources:

- UNAIDS Global Report 2004: HIV Prevalence (2003) - Adults (15-49 years) living with HIV at the end of 2003 divided by the adult population of 2003
- UNAIDS Global Report 2002: HIV Prevalence (2001) - Adults (15-49 years) living with HIV at the end of 2001 divided by the adult population of 2001
- World Bank 2004 Development Indicators: Health Expenditure per capita 2001, USD; Sub-Saharan Africa value for 1997-2000; ICRG Risk Rating - 2003
- UNDP HDR 2002 and 2004: Population 2002, millions; Life Expectancy 2002, years; Infant Mortality Rate 2002, per 1,000 live births; Female Literacy 2002, percentage ages 15 and above; GDP per capita - 2002, USD; HDI rank and value for 1998 and 2002

ANNEX 3. UNDP COUNTRY COOPERATION FRAMEWORKS (CCFs) AND HIV/AIDS IN CASE-STUDY COUNTRIES

Country	Strategic Focus Areas (HIV/AIDS and Others)	Objectives/Planned Outcomes
Angola	<p>CCF 1997-2000</p> <ul style="list-style-type: none"> ■ Assistance to post-conflict activities such as mine action and the integration of demobilized combatants ■ Poverty reduction through the strengthening of poverty monitoring systems and community rehabilitation and empowerment ■ Promotion of good governance through improved economic management, state modernization and institutional reforms <p>CCF 2001-2003</p> <ul style="list-style-type: none"> ■ Poverty reduction and elimination of extreme poverty ■ Promotion and strengthening of effective participatory governance ■ Improved human security for post-conflict recovery ■ Promotion of gender equality through mainstreaming 	<p>CCF 1997-2000</p> <ul style="list-style-type: none"> ■ Support the reintegration and vocational training of demobilized soldiers ■ Development of a national mine action capacity ■ Community rehabilitation ■ Administrative reform and capacity for macroeconomic management <p>CCF 2001-2003</p> <ul style="list-style-type: none"> ■ Poverty reduction strategy formulated and being effectively implemented ■ Comprehensive strategies to prevent spread and mitigate the impact of HIV/AIDS ■ National decentralization strategy formulated and being implemented ■ Improved public-sector efficiency, accountability and transparency ■ Improved institutional capacity for planning and for supporting community empowerment ■ Improved national capacity for aid coordination ■ Increased public debate on sustainable human development ■ Electoral process implemented
Botswana	<p>CCF 1997-2002</p> <ul style="list-style-type: none"> ■ Poverty alleviation and job creation ■ Gender equity ■ HIV/AIDS ■ Environment <p>Country Programme (CP) 2003-2007</p> <ul style="list-style-type: none"> ■ Poverty ■ HIV/AIDS ■ Environment 	<p>CCF 1997-2002</p> <ul style="list-style-type: none"> ■ Develop comprehensive approaches to gender issues ■ Prevent the spread of HIV and mitigate the impact of HIV/AIDS at all levels of society <p>CP 2003-2007</p> <ul style="list-style-type: none"> ■ Improve national capacity for leadership, coordination, implementation, and monitoring and evaluation of the multisectoral response ■ Build institutional capacity to plan and implement multisectoral strategies to limit the spread of HIV/AIDS and mitigate its social and economic impact
Ethiopia	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Agricultural development programme ■ Health sector development programme ■ Water resources development and utilization ■ Education sector development programme ■ Capacity development for public policy and management <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Good governance ■ Special pro-poor initiatives ■ Sustainable environmental management and water resources development 	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Improve the quality of life of the rural population through generation of higher incomes and reduction of poverty ■ Provide comprehensive and integrated primary healthcare in health institutions at the community level, with emphasis on disease prevention and health promotion <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Strengthened capacity of key governance institutions ■ An efficient and accountable public sector ■ Human and income poverty addressed in national policy frameworks ■ Expand and protect the asset base of the poor (human, physical and financial) ■ Sustainable environment management to improve livelihoods and security of the poor, and regional and global instruments for environmentally sustainable developments that benefit the poor

Country	Strategic Focus Areas (HIV/AIDS and Others)	Objectives/Planned Outcomes
Lesotho	<p>CCF 1997-2000</p> <ul style="list-style-type: none"> ■ Enhanced governance and capacity development for economic management and civil service reform ■ Human resources development and employment creation ■ Rural development and environmental management <p>CCF 2002-2004</p> <ul style="list-style-type: none"> ■ Poverty reduction ■ Good governance ■ Environment 	<p>CCF 1997-2000</p> <ul style="list-style-type: none"> ■ Provide neutral mediation in a complex and unstable political environment ■ Strengthen the technical and institutional capacity of the Ministries of Employment and Labour, Trade and Industry ■ Institutional strengthening of the National Environment Secretariat to oversee and coordinate environmental activities at local, regional and national level, within the framework of a revised National Environment Action Plan <p>CCF 2002-2004</p> <ul style="list-style-type: none"> ■ Mainstream gender concerns ■ Transparent and accountable governance ■ Strengthen national capacities for peaceful management and resolution of conflict, and national culture of tolerance and accommodation of other people's views ■ Improve capacity of local authorities, communities and private sector in environmental management, conservation and sustainable utilization of natural resources
Malawi	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Governance and democracy ■ HIV/AIDS ■ Sustainable livelihoods ■ Gender ■ Environment and natural resources management <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Poverty Reduction Strategy Support Programme ■ Poverty reduction through good governance ■ HIV/AIDS management 	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Formulation of multisectoral and results-oriented national HIV/AIDS strategic framework ■ Preparation of guide on participatory assessment, planning and implementation for sustainable livelihoods ■ Develop systems for environmental and natural resources utilization <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Build capacity for the poverty reduction policy and programming and promote interventions to empower vulnerable groups to enhance their livelihood base in a sustainable manner ■ Capacity development for implementation and monitoring of the decentralization policy and the Local Government Act ■ Strengthen capacities related to development management in the public sector ■ Strengthen institutional structures related to democratic governance ■ Strengthen the capacity of national coordinating, implementation and monitoring institutions to effectively carry out their roles and functions in the national response to HIV/AIDS
Namibia	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Capacity building for human development ■ Integrated community-based rural and urban poverty reduction ■ Small and medium-scale enterprise and entrepreneurship development ■ Water management <p>CCF 2002-2005</p> <ul style="list-style-type: none"> ■ Poverty reduction ■ HIV/AIDS prevention and mitigation ■ Sustainable development through environmental initiatives 	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Provide shelter and training to street children and to empower women in economic activities and decision making ■ Provide better information about existing possibilities for potential entrepreneurs through development of markets, improvement of access to credit <p>CCF 2002-2005</p> <ul style="list-style-type: none"> ■ Support advocacy and upstream policy development for strategic thinking and planning and to play a catalytic role for resource mobilization in the national priorities issues of poverty reduction, HIV/AIDS and sustainable development

Country	Strategic Focus Areas (HIV/AIDS and Others)	Objectives/Planned Outcomes
South Africa	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Poverty reduction ■ Sustainable livelihoods ■ Sound governance ■ Cross-cutting themes ■ South-south cooperation <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Transformation for human development ■ Integrated sustainable rural development ■ Holistic response to HIV/AIDS and poverty ■ Environment and development 	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Job creation ■ Promotion of women in role of development ■ Implementation of national gender planning framework ■ Development of small to medium-sized enterprises with emphasis on women and rural communities ■ Creation of capacity for provision of housing, safe water, sanitation, health, education, sustainable energy and social services ■ Enhanced transparency and accountability to encourage, individuals, groups and institutions to take initiative, save, invest, manage, and participate in the development of their communities and country ■ Enhanced status of women and men to ensure equal access to opportunities and resources as outlined in the Reconstruction and Development Programme ■ Strengthened capacity of government and other partners to monitor the impact of HIV/AIDS on reconstruction and development <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Help the country translate some of its political, social, and economic transformation policies and strategies into reality to benefit the majority of South Africans, particularly women who live in poverty-stricken conditions without benefits of public services or basic governance systems ■ Achieve upstream results through advocacy, policy dialogue, capacity enhancement at all levels, and development of systems, guidelines and best practices
Swaziland	<p>CCF 1997-2000</p> <ul style="list-style-type: none"> ■ Capacity building for good governance ■ Promotion of sustainable livelihoods ■ Poverty reduction ■ Gender <p>CCF 2001-2005</p> <ul style="list-style-type: none"> ■ Poverty reduction through establishment of a policy environment and planning framework for sound economic development and management targeting human and income poverty and addressing HIV/AIDS epidemic ■ Strengthening national capacity for policy analysis, decentralized planning and good leadership, in order to increase social cohesion based on participatory governance 	<p>CCF 1997-2000</p> <ul style="list-style-type: none"> ■ Support codification of Swazi Law and Custom for harmonization of the two systems towards a more efficient and effective governance system ■ Empower participants from the government and civil society with information, knowledge, new skills, and exposure to the critical role and responsibilities of leadership in advancing the country's political, economic and social development agenda ■ Assist small and micro-enterprise development, looking particularly at the policy environment and improving access by the poor to productive assets of the formal economy ■ Strengthen capacity of the Gender Unit and have gender focal points in every ministry <p>CCF 2001-2005</p> <ul style="list-style-type: none"> ■ Improve living conditions of the poor and reduction of poverty levels from 66% to 50% by 2005 ■ Reduce spread of HIV/AIDS as a result of an integrated and coordinated response at national level, reaching out to communities, and resources mobilized and effectively used ■ Mainstream environmental concerns in development planning and operational capacity to respond more effectively to environmental issues and disasters ■ Synchronize relationships between traditional and Westminster systems of governance

Country	Strategic Focus Areas (HIV/AIDS and Others)	Objectives/Planned Outcomes
Zambia	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Good governance ■ Sound environment management ■ Agriculture, rural development and food security ■ Gender and HIV/AIDS <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Multisectoral responses to HIV/AIDS ■ Governance ■ Environment and natural resources management ■ Information and communications technology and advocacy 	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Preparation of national policies, plans, strategies and programmes <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Create an enabling environment for achievement of Millennium Development Goal commitments, in particular, halving poverty by 2015
Zimbabwe	<p>CCF 1997-1999</p> <ul style="list-style-type: none"> ■ Development management ■ Poverty reduction ■ Environment management and regeneration <p>CCF 2000-2003</p> <ul style="list-style-type: none"> ■ Poverty reduction ■ Development management ■ HIV/AIDS ■ Cross-cutting themes 	<p>CCF 1997-1999</p> <ul style="list-style-type: none"> ■ Support national efforts to integrate poverty reduction strategies into the macro-policy framework through pro-poor advocacy ■ Build capacity of communities to respond better and more effectively to the challenge of alleviating poverty <p>CCF 2000-2003</p> <ul style="list-style-type: none"> ■ Sustain the high level of consciousness of poverty issues in Parliament, the government and nationally ■ Support leveraged delivery of resources to at least 12 districts through provision of staff to assist communities and rural district councils ■ National allocation of financial resources to poverty programmes, HIV/AIDS programmes and other social programmes ■ Establish mechanisms for greater participation of private sector and civil society in macro-policy formulation through the work of the National Economic Consultative Forum ■ Enhance the capability of Parliamentary Committees to influence and comment on draft bills

ANNEX 4. UNDP HIV/AIDS PROGRAMMES IN CASE-STUDY COUNTRIES

Note – Programmes and projects are not necessarily mentioned in Country Cooperation Frameworks (CCFs). For example, the Southern Africa Capacity Initiative (SACI) was launched in 2004 and provides additional resources for support (as in Zambia) to all case-study countries except Angola and Ethiopia. In addition, the Leadership Development Programme (LDP) is being implemented in only a few countries, and is not reflected in CCFs, as in Ethiopia, Lesotho and Swaziland.

Country	HIV/AIDS Programme Components	Planned Outcomes/Results	Comments
Angola	<p>CCF 2001-2003</p> <ul style="list-style-type: none"> ■ Joint United Nations Programme on HIV/AIDS ■ Incorporation of HIV/AIDS concerns in school curricula in collaboration with the United Nations Educational, Scientific and Cultural Organization (UNESCO) 	<p>CCF 2001-2003</p> <ul style="list-style-type: none"> ■ Comprehensive strategies to prevent the spread and mitigate the impact of HIV/AIDS ■ Incorporation of HIV/AIDS concerns into school curricula 	<p>In the 1997 CCF, HIV/AIDS was not an area of focus for Angola. However, one of the lessons learned from this CCF was the need to move away from implementing stand-alone projects with no upstream linkages to broader development policies and strategies. HIV/AIDS was then included as a cross-cutting theme in the CCF 2001-2003.</p>
Botswana	<p>CCF 1997-2002</p> <ul style="list-style-type: none"> ■ Strengthen central and district level government institutional capacity and non governmental organizations (NGOs), together reviewing the needs and preparedness of key institutions to respond to the likely impact of HIV/AIDS ■ Strengthen applied research capacity ■ Support efforts to combat HIV within organized target groups <p>Country Programme (CP) 2003-2007</p> <ul style="list-style-type: none"> ■ Support the development and implementation of an effective national HIV/AIDS monitoring and evaluation system ■ Support capacity development at the National AIDS Coordinating Agency (NACA), key ministries and District Multi-Sectoral HIV/AIDS Committees ■ Improve water, waste and sanitation management by supporting public-private partnerships for the urban environment and supporting the development of integrated water resources management 	<p>CCF 1997-2002</p> <ul style="list-style-type: none"> ■ Arrest the spread of HIV/AIDS epidemic and mitigate its consequences <p>CP 2003-2007</p> <ul style="list-style-type: none"> ■ Strengthen national coordination capacity within government, the private sector and civil society organizations, including networks of people living with HIV/AIDS; support leadership and institutional arrangements to respond to the pandemic at all levels ■ Reduce both the prevalence and incidence of HIV/AIDS and mitigate its impact 	

Country	HIV/AIDS Programme Components	Planned Outcomes/Results	Comments
Ethiopia	<p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Support to parliament and justice sector reform ■ Civil service reform and decentralization ■ Public/private sector programme ■ National capacity development ■ PRSP and sector programmes ■ HIV/AIDS ■ Food security and agriculture ■ Promotion of information and communications technology 	<p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Formulation of comprehensive justice sector reform programme ■ Improved service delivery, efficiency, effectiveness and transparency in civil service ■ Building of strategic alliance for private sector development. ■ Strengthened national capacity focal points to establish and coordinate the development of a national capacity framework ■ Development of a multisectoral response to limit the spread of HIV/AIDS and mitigate its social and economic impact 	HIV/AIDS was not a programme area or area of focus in the CCF 1997-2001. It is a cross-cutting theme in the second CCF (2002-2006) and is to be mainstreamed into all programmes.
Lesotho	<p>CCF 2002-2004</p> <ul style="list-style-type: none"> ■ United Nations Partnership Programme to Combat the Transmission of HIV/AIDS 	<p>CCF 2002-2004</p> <ul style="list-style-type: none"> ■ Raising awareness, improving access to health services and counseling, and generating employment opportunities ■ Pilot country for the We Care Programme ■ Unplanned inclusion in the Leadership Development Initiative ■ SACI 	HIV/AIDS was not a programme area in the first CCF. It was included in the second CCF (2002-2004) under the thematic area of Poverty Reduction through the United Nations Fund for International Partnerships (UNFIP) Programme. After the 2002 general election, which provided an opportunity to focus on development, and the UN Special Envoy Report on the Triple Threat, UNDP undertook a mid-year review of its CCF refocusing its efforts on using HIV/AIDS as a strategic entry point. This resulted in adoption of the scaling up book as a policy manual and a new country programme CPD 2005-2007 with four thematic areas: HIV/AIDS; democratic governance; poverty reduction and food security; and energy and environment.
Malawi	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Support to formulation of a multi-sectoral and results oriented national strategic framework <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Development of a national HIV/AIDS policy and legal framework that is sensitive to gender and human rights to guide HIV/AIDS management ■ HIV/AIDS mainstreaming in public and private sector policies programmes and projects, especially military ■ Capacity building for coordinating and advocacy institutions for people living with AIDS (PLWA) ■ Access to services and technologies to overcome the HIV/AIDS pandemic 	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Building broad ownership and consensus around policy concerns on the national response to HIV/AIDS <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Improved capacity of the National AIDS Commission to plan, coordinate and monitor the national response as enshrined in the Malawi National HIV/AIDS Strategic Framework by 2003 ■ Strengthened capacity at district level to implement district HIV/AIDS plans by 2004 ■ Strengthened capacity of civil society, especially PLWAs, and community-based organizations to carry out advocacy work aimed at improving management and control of HIV/AIDS by 2003 ■ Formulation of HIV/AIDS policy and legal framework and adoption of HIV/AIDS work place strategy by 2003 ■ SACI 	

Country	HIV/AIDS Programme Components	Planned Outcomes/Results	Comments
Namibia	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Integrated community-based rural and urban poverty-reduction development programme <p>CCF 2002-2005</p> <ul style="list-style-type: none"> ■ Ohangwena Poverty Reduction Programme ■ UNV Support Programme ■ Capacity Building for Economic Management Programme ■ Public-Private Partnership for Urban Environment Programme 	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Extend basic social services to the poor especially those with HIV/AIDS <p>CCF 2002-2005</p> <ul style="list-style-type: none"> ■ Provision of adequate human resources needed for effective implementation of the National Development Plan 2 ■ Strengthened capacity for national and regional governments and private sector to address increasing problems of urbanization ■ SACI 	
South Africa	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Reconstruction and development <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Support to developing poverty reduction models for 4 poorest provinces 	<p>CCF 1997-2001</p> <ul style="list-style-type: none"> ■ Strengthened capacity of government and other national partners to monitor the impact of HIV/AIDS on reconstruction and development <p>CCF 2002-2006</p> <ul style="list-style-type: none"> ■ Poverty reduction models developed with HIV/AIDS fully mainstreamed ■ SACI 	HIV/AIDS was a cross-cutting theme in the reconstruction and development programme.
Swaziland	<p>CCF 1997-2000</p> <ul style="list-style-type: none"> ■ Mobilization of local authorities, churches, legal firms and youth clubs to focus on different aspects of the response to HIV/AIDS to offer counseling and testing, legal aid, education, care and support <p>CCF 2001-2005</p> <ul style="list-style-type: none"> ■ Implementation of the National Strategic Plan for a multisectoral response ■ Promote research and studies on traditional medicines and policy action as well as a comprehensive communications strategy in support of the national response ■ Capacity-building for pro-poor and gender sensitive policy development and sound macro-economic management 	<p>CCF 1997-2000</p> <ul style="list-style-type: none"> ■ Create awareness of the need for comprehensive action to fight against the pandemic at all levels <p>CCF 2001-2005</p> <ul style="list-style-type: none"> ■ Reduced spread of HIV/AIDS as a result of an integrated and coordinated response at national level, reaching out to communities, and resources mobilized and effectively used ■ Documentation of findings on traditional medicines including formal recognition of the potential of local medicines and other affordable options for positive living ■ Availability of anti-poverty and gender sensitive policies and strategies, the existence of enhanced business skills development structures, improved microfinance facilities and a gender policy ■ SACI 	

Country	HIV/AIDS Programme Components	Planned Outcomes/Results	Comments
Zambia	CCF 2002-2006 <ul style="list-style-type: none"> ■ Formulation of the HIV/AIDS decentralized multi-sectoral policy and legal framework ■ Strengthened capacity for assessing and monitoring the sectoral impact of HIV/AIDS ■ Support to NGOs and civil society organizations to replicate successful district-level HIV/AIDS interventions on a national scale 	CCF 2002-2006 <ul style="list-style-type: none"> ■ Enhance the capacity of district-level structures to implement the national HIV/AIDS strategy, to monitor the incidence and the impact of HIV/AIDS, and to replicate in rural areas the strategies that have reduced urban HIV/AIDS infection rates ■ SACI 	In the first CCF, HIV/AIDS was a cross-cutting theme in Zambia and a National HIV/AIDS strategy was formulated.
Zimbabwe	CCF 2000-2003 <ul style="list-style-type: none"> ■ Adoption of a strategy to combat HIV/AIDS and coordinate the local-level efforts into a comprehensive programme 	CCF 2000-2003 <ul style="list-style-type: none"> ■ A comprehensive economic impact assessment of HIV/AIDS to facilitate national policy formulation ■ Information dissemination and education, provision of condoms, support for home based care, and income projects for care of orphans ■ SACI 	In the first CCF, HIV/AIDS was a cross-cutting theme but the Country Review Report suggested that it should become a thematic area in the CCF 2000-2003.

ANNEX 5. HIV/AIDS FINANCIAL DATA ON CASE-STUDY COUNTRIES

ANNEX 5A. INDICATIVE LIST OF UNDP HIV/AIDS PROJECTS IN CASE-STUDY COUNTRIES, 1999-2004¹					
Country	Project	Project Number	Planned Spending (USD)		
			UNDP Resources	Cost Sharing Resources	Total
Year					
Angola					
1999-2003	No Projects				
1999-2003	Subtotal		0	0	0
2004	Strengthening the Education System in Angola	11109	702,437	72,616	775,053
2004	Subtotal		702,437	72,616	775,053
	Angola Total		702,437	72,616	775,053
Botswana					
1999-2003	HIV/AIDS Support to the National AIDS Programme	BOT96B01	0	635,976	635,976
1999-2003	HIV/AIDS Support to the National AIDS Programme	BOT96001	1,559,604	5,148,896	6,708,500
1999-2003	NKAIKELA Youth Support Group	BOT0004	37,864	0	37,864
1999-2003	NKAIKELA Youth Support Group	BOT00H04	0	37,864	37,864
1999-2003	Subtotal		1,597,468	5,822,736	7,420,204
2004	HIV/AIDS	11625	0	394,000	394,000
2004	Reproductive Health & Promotion of Safer Sex	11630	0	262,609	262,609
2004	HIV and AIDS	11633	400,000	785,663	1,185,663
2004	Subtotal		400,000	1,442,272	1,842,272
	Botswana Total		1,997,468	7,265,008	9,262,476
Ethiopia					
1999-2003	HIV/AIDS Diagnostic & Screening Services	ETH94316	201,251	0	201,251
1999-2003	Subtotal		201,251	0	201,251
2004	HIV/AIDS & Gender & Development	12473	0	236,051	236,051
2004	HIV/AIDS and Development	12479	2,044,350	0	2,044,350
2004	Subtotal		2,044,350	236,051	2,280,401
	Ethiopia Total		2,245,601	236,051	2,481,652
Lesotho					
1999-2003	No Projects				
1999-2003	Subtotal		0	0	0
2004	Joint UN Partnership on HIV/AIDS	13404	0	181,920	181,920
2004	Subtotal		0	181,920	181,920
	Lesotho Total		0	181,920	181,920

¹ This list was prepared by a researcher employed by the UNDP Evaluation Office, under supervision of a member of the international consultant team. Prior efforts by the Evaluation Office to assemble background data for the international consultant team were not successful. During report preparation, the team was aware of the discrepancies between Table 5A and Table 5B. These discrepancies are more substantial than can be explained by the differences between planned spending (Table 5A) and actual spending (Table 5B). During review of the draft evaluation study, UNDP financial staff recommended deletion of the table, and construction of a detailed table along the lines of Table 5B by each case-study Country Office. This was not feasible in the time remaining. The team decided to leave the table in its final report as a purely indicative expression of UN HIV/AIDS Projects in the case-study countries. The financial data in Table 5A should be read as lower bound figures, as indicated by the differences between the Lesotho data in Table 5A versus Table 5B.

Country	Project	Project Number	Planned Spending (USD)		
			UNDP Resources	Cost Sharing Resources	Total
Year					
Malawi					
1999-2003	Support to HIV/AIDS: UNV Support to People Living With HIV/AIDS	MLW99V01	300,000	0	300,000
1999-2003	HIV and Development	MLW97007	1,763,769	169,515	1,933,284
1999-2003	Subtotal		2,063,769	169,515	2,233,284
2004	HIV/AIDS Management	13618	937,479	162,504	1,099,983
2004	Subtotal		937,479	162,504	1,099,983
	Malawi Total		3,001,248	332,019	3,333,267
Namibia					
1999-2003	No Projects				
1999-2003	Subtotal		0	0	0
2004	Support to National HIV/AIDS Strategic Plan	13957	340,000	0	340,000
2004	Acceleration of the Multi-sectoral Implementation of MTPII: National Strategic Plan on HIV/AIDS in Namibia	25778	0	27,192	27,192
2004	Support to National Strategic Plan on HIV/AIDS	25779	0	5,711	5,711
2004	Study on HIV/AIDS in Farming Communities	25781	0	172,609	172,609
2004	Subtotal		340,000	205,512	545,512
	Namibia Total		340,000	205,512	545,512
South Africa					
1999-2003	GIPA: UN Support for the Greater Involvement of People Living with HIV/AIDS	SAF97016	298,597	43,363	341,960
1999-2003	HIV/AIDS in the Workplace: Guidelines for the Code of Good Practice: HIV/AIDS in the Workplace	SAF00015	49,482	0	49,482
1999-2003	SIRF: UN Support to Integrated Response Framework to HIV/AIDS	SAF00013	60,000	0	60,000
1999-2003	Subtotal		408,079	43,363	451,442
2004	Involving Youth in HIV/AIDS Programmes in South Africa	14668	0	945,525	945,525
2004	Prevention of HIV/AIDS	14676	0	877,635	877,635
2004	National Database	14679	0	186,958	186,958
2004	Integrated Response to HIV/AIDS	14680	711,570	4,805,645	5,517,215
2004	Subtotal		711,570	6,815,763	7,527,333
	South Africa Total		1,119,649	6,859,126	7,978,775
Swaziland					
1999	Development of a Comprehensive HIV/AIDS Community/Home Based Care and Prevention Programme in Swaziland	SWA95003	100,357	63,280	163,637
1999	Joint UN Support to Combat HIV/AIDS: Joint UN Support to Develop Regional Capacity in Swaziland to Combat HIV/AIDS Among Adolescents	SWA01H01	52,500	0	52,500
1999	Programme Acceleration Funds HIV/AIDS: Support to accelerate the Implementation of the HIV/AIDS Strategic Plan	SWA00003	0	110,000	110,000
1999	Multi-sectoral Response to HIV/AIDS: Capacity Building for a Multi-sectoral Response to HIV/AIDS	SWA00001	0	225,000	225,000
1999	Subtotal		152,857	398,280	551,137
2004	Sustainable Livelihoods	14884	0	0	0
2004	Joint UN Support to Combat HIV	14886	0	127,919	127,919
2004	Scaling Up VCT in all Four Regions	14887	0	2,524	2,524
2004	Joint UN Support to Combat HIV	14888	0	100	100

Country	Project	Project Number	Planned Spending (USD)		
			UNDP Resources	Cost Sharing Resources	Total
Year					
Swaziland	(cont-d)				
2004	Poverty Reduction and HIV/AIDS	14890	244,949	201,320	446,269
2004	Programme Acceleration Funds- HIV/AIDS	25906	0	5,983	5,983
2004	Development of a Comprehensive HIV/AIDS Community Home-Based Care and Prevention Programme	25907	0	461,400	461,400
2004	Subtotal		244,949	799,246	1,044,195
	Swaziland Total		397,806	1,197,526	1,595,332
Zambia					
1999-2003	Community Oriented HIV/AIDS Care Prevention and Support Project	ZAM98002	563,304	0	563,304
1999-2003	UNAIDS Support to AIDS Institution: Institutional Support to National Programme, Professional Associations and Vulnerable Groups	ZAM00005	10,000	860,000	870,000
1999-2003	Subtotal		573,304	860,000	1,433,304
2004	UNAIDS Support to AIDS Institution	15678	0	5,113	5,113
2004	Local Community to Mitigate Impact of HIV	15691	0	0	0
2004	HIV/AIDS District Response in Zambia	15682	1,030,625	0	1,030,625
2004	HIV/AIDS District Response in Zambia	33500	150,000	0	150,000
2004	HIV/AIDS District Response Output 3	34253	38,515	0	38,515
2004	Subtotal		1,219,140	5,113	1,224,253
	Zambia Total		1,792,444	865,113	2,657,557
Zimbabwe					
1999-2003	HIV/AIDS District Response Initiatives: HIV/AIDS District Response Initiatives United Nations Country Team In Zimbabwe	ZIM00H07	3,499,650	0	3,499,650
1999-2003	HIV/AIDS Youth Project: HIV/AIDS Adolescent Reproductive Health Project	ZIM00H06	1,202,826	0	1,202,826
1999-2003	Support To the National AIDS Council: Support for the National AIDS Council National AIDS HIV/AIDS Programme Coordination	ZIM00010	1,256,000	0	1,256,000
1999-2003	Supporting Sentinel Surveillance System: Supporting Sentinel Surveillance System for HIV/AIDS in Zimbabwe	ZIM0009	0	96,857	96,857
1999-2003	HIV/AIDS District Response Initiative: HIV/AIDS District Response Initiative in Selected Districts in Zimbabwe	ZIM00002	0	571,429	571,429
1999-2003	Subtotal		5,958,476	668,286	6,626,762
2004	HIV/AIDS District Response Initiative	15697	0	424,881	424,881
2004	Support to the National AIDS Council	15699	-452,727	0	-452,727
2004	HIV/AIDS District Response Initiative	15700	0	2,118,386	2,118,386
2004	HIV/AIDS Youth Project	15701	0	493,258	493,258
2004	District Response Monitoring and Evaluation	15707	0	235,050	235,050
2004	Management & Coordination Support	15708	0	266,070	266,070
2004	HIV/AIDS Mainstreaming and Integration	15716	117,000	0	117,000
2004	Advocacy and Mass Media Campaign for HIV/AIDS	25966	0	23,363	23,363
2004	Supporting Sentinel Surveillance System	25967	0	2,037	2,037
2004	Subtotal		-335,727	3,563,045	3,227,318
	Zimbabwe Total		5,622,749	4,231,331	9,854,080
Grand Total			17,219,402	21,446,222	38,665,624

Notes: All figures are in U.S. dollars. Figures for 1999-2003 are from the UNDP Gateway financial system. Figures from 2004 are from the UNDP Atlas financial system. In late 2003, UNDP transferred its financial accounting from Gateway to Atlas. Cost sharing is the amount of money provided by other donors or recipient governments. The list consists of all UNDP projects in the ten case-study countries that have HIV or AIDS in their title or description in the UNDP Headquarters financial databases.

ANNEX 5B. DISAGGREGATION OF UNDP COUNTRY PROGRAMME SPENDING ON HIV/AIDS IN LESOTHO

Programme	2002 (actual, USD)	2003 (actual, USD)	2004 (actual, USD)	2005 (planned, USD)
Combating the Spread of HIV/AIDS Among Adolescent Girls (UNF)	18,676	262,546	177,628	17,000
Environmental Management for Poverty Reduction	40 000			
Workplace HIV/AIDS Programme 'We Care'	10,000	20,000		
Core-streaming of HIV/AIDS in Trade Sector			32,000	
HIV/AIDS Leadership Development Programme (LDP)			168,000	50,000
Core Streaming HIV/AIDS (Regional Project)	10,000		70,000	
Core Streaming HIV/AIDS (SACI)			75,000	
Core Streaming HIV/AIDS in Education Sector			10,000	
Empowering Communities in Development Planning	12,000	101,860	101,860	
Capacity Enhancement (Irish-funded)		137,000	137,000	
Fighting HIV/AIDS with Traditional Leaders (Canada-funded)			35,000	
Fighting HIV/AIDS with Traditional Leaders (British-funded)			45,000	
Scaling up the National Response to HIV/AIDS			70,250	
Scaling up the National Response to HIV/AIDS (Dfid-funded)				766,283
Total HIV/AIDS programme spending	88,676	521,406	921,738	833,283
Total programme spending*	1,917,917	3,075,815	2,181,195	1,746,283
Total HIV/AIDS programme spending as percentage of total programme spending (%)	4.6	17.0	42.3	47.7

*This reflects the total allocation of programme funds for the years 2002–2005 and is inclusive of HIV/AIDS programmes.

Source: UNDP Lesotho Country Office, March 2005

Note: The Lesotho Country Office (CO) staff are concerned that in a difficult environment for resource mobilization, the above amounts do not reflect the extensive involvement of the CO in scaling up the national response to HIV/AIDS. For UNDP Lesotho, HIV/AIDS was used as a strategic entry point to work with government on more effectively using its capacity and resources as a governance issue. It is therefore difficult to separate funding from programmes since the CO, in re-positioning itself, put HIV/AIDS at the core of its business, whether be it governance, environment or poverty reduction. To this extent, the CO undertook a revision of the second CCF to better reflect HIV/AIDS as a governance issue, addressing policies, stakeholder involvement, delivery of services, systems, and transformational leadership. As the Chair of the Expanded Theme Group, the Resident Representative spearheaded the preparation of an integrated strategy for all stakeholders, titled 'Turning a Crisis into an Opportunity: Strategies for Scaling Up the National Response to HIV/AIDS in Lesotho.' This strategy has been adopted as a policy document by the government. Consultations in this process involved the core part of the work of the CO over two years, and yet the allocation for funding of the document is valued at USD 120,000, in the CO administration budget. This does not reflect the total CO commitment in time and personnel. Through advocacy work and collaboration with WHO, the CO has spearheaded a complete change in the roll out of the 3x5 Initiative and the understanding of HIV/AIDS as more than a health issue and representing a major development challenge. The CO work led further to the launch of the national 'Know Your Status' campaign spearheaded by the Prime Minister, UNDP support to restructuring the public service to more effectively deliver in light of the triple threat, and UNDP support to generate social mobilization in one of the remote districts affected by the triple threat to generate social mobilization. The CO work in 2005 and beyond will build on this, as it endeavors to support the change agenda within the public service and elsewhere, especially at district level.

ANNEX 5C. GLOBAL FUND GRANTS FOR HIV/AIDS IN CASE-STUDY COUNTRIES

APPROVED PROPOSALS							GRANT AGREEMENTS & DISBURSEMENTS			
Country	Round	Disease Component	Source	Approved Grant Amount (USD)	Total Lifetime Budgets (USD)	Principal Recipient	Grant Number	Grant Signature Date	Grant Amount (USD)	Amount Disbursed to Date (USD)
Angola	4	HIV/AIDS	CCM	27,670,810	91,966,080			Not signed yet		
Botswana	2	HIV/AIDS	CCM	18,580,414	18,580,414	The Ministry of Finance and Development Planning of the Government of Botswana	BOT-202-G01-H-00	04-Dec-03	18,580,414	9,019,119
Ethiopia	2	HIV/AIDS	CCM	55,383,811	139,403,241	The HIV/AIDS Prevention and Control Office	ETH-202-G03-H-00	09-Oct-03	55,383,811	40,444,917
	4	HIV/AIDS	CCM	41,895,884	401,905,883	The HIV/AIDS Prevention and Control Office	ETH-405-G04-H	11-Feb-05	41,895,884	19,390,093
Lesotho	2	HIV/AIDS	CCM	10,557,000	29,312,000	The Ministry of Finance and Development Planning of the Government of the Kingdom of Lesotho	LSO-202-G01-H-00	10-Oct-03	10,557,000	4,419,252
Malawi	1	HIV/AIDS	CCM	41,751,500	267,176,782	The Registered Trustees of the National AIDS Commission Trust of the Republic of Malawi	MLW-102-G01-H-00	10-Feb-03	41,751,500	36,253,844
Namibia	2	HIV/AIDS	CCM	26,082,802	105,319,841	The Ministry of Health and Social Services of the Government of Namibia	NMB-202-G01-H-00	23-Nov-04	26,082,802	809,947
South Africa	1	HIV/TB	CCM	14,354,000	70,354,000	The National Treasury of the Republic of South Africa	SAF-102-G01-C-00	08-Aug-03	2,354,000	2,354,000
						The National Treasury of the Republic of South Africa	SAF-102-G02-C-00	08-Aug-03	12,000,000	12,000,000
	1	HIV/TB	Sub CCM	26,741,529	71,968,018	The National Treasury of the Republic of South Africa	SAF-102-G03-C-00	08-Aug-03	26,741,529	12,873,456
	2	HIV/TB	CCM	8,414,000	25,110,000			Not signed yet		
	3	HIV/AIDS	CCM	15,521,457	66,509,557	The Provincial Health Department of the Western Cape, South Africa	SAF-304-G04-H	25-Aug-04	15,521,457	8,282,075
Swaziland	2	HIV/AIDS	CCM	29,633,300	54,872,400	The National Emergency Response Council on HIV/AIDS (NERCHA) of the Government of the Kingdom of Swaziland	SWZ-202-G01-H-00	18-Jun-03	29,633,300	15,991,853
	4	HIV/AIDS	CCM	16,396,800	48,283,310			Not signed yet		
Zambia	1	HIV/AIDS	CCM	42,298,000	92,847,000	The Central Board of Health of the Government of Zambia	ZAM-102-G01-H-00	30-Mar-03	21,214,271	16,936,307
	4	HIV/AIDS	CCM	26,770,776	253,608,070			Not signed yet		
Zimbabwe	1	HIV/AIDS	CCM	10,300,000	14,100,000	The United Nations Development Programme	ZIM-102-G01-H-00	14-Apr-05	10,300,000	
Total for Case-Study Countries				412,352,083	1,751,316,596				312,015,968	178,774,863
Total for Sub-Saharan Africa				1,849,781,705	4,859,050,959				1,441,942,501	611,673,956
Grand Total for Global Fund				3,274,421,318	8,062,745,795				2,423,643,364	1,121,170,573

Source: Global Fund website, data as of April 23, 2005

ANNEX 5D. COMMITMENTS OF OFFICIAL DEVELOPMENT ASSISTANCE FOR HIV/AIDS IN CASE-STUDY COUNTRIES, 2000-2003 (USD, MILLION)

Country	2001	2002	2003	2004
Angola	1.8	1.8	9.5	N/A
Botswana	3.9	11.6	10.0	29.6
Ethiopia	73	24	30.0	86.8
Lesotho	2.6	1.5	2.2	11.6
Malawi	13.1	24.7	23.6	134.8
Namibia	4.1	5.4	10.3	17.3
South Africa	19.5	24.9	43.8	140.1
Swaziland	<0.5	1.0	2.0	N/A
Zambia	20.3	25.4	82.6	134.3
Zimbabwe	31.4	17.9	31.8	24.6
Total	169	138	246	579

N/A indicates not available.

Source: OECD/DAC data base and World Bank Global HIV/AIDS Programme, May 2005

ANNEX 6. COUNTRY CASE-STUDY SUMMARIES

6.1 ANGOLA

6.1.1 Methodology

Due to delays in completion of work by the national consultant and his subsequent withdrawal from the task, the Angola country report did not follow the methodology of the other country case-study assessments. Because of the importance attached by UNDP to inclusion of Angola among the country case studies, a member of the international consultant team visited the country in February 2005 without prior preparation by a national consultant. A national consultant without specialized health expertise joined him for a week in the field. The two collected documents, interviewed actors and stakeholders, and held a validation meeting on tentative findings at the end of the week. On the basis of this fieldwork, the national consultant prepared a draft report under the guidance of the international consultant, who completed the study.

6.1.2 Context

During the past three decades, Angola's ongoing civil war has destroyed much of the country's physical and social infrastructure. Angola's HDI rank in 2004 was 164--the weakest HDI ranking of the 10 case-study countries, despite a per capita income of more than USD 850. With a settlement of the civil conflict in 2002, Angola finds itself in transition. Development issues are only beginning to gain greater attention from policy makers. At the time of the field work, a Poverty Reduction Strategy Paper (PRSP) was near completion and discussions were under way with the Bretton Woods Institutions about the possibility of organizing a Consultative Group meeting of the country's development partners.

Estimates of adult HIV prevalence in Angola have fallen in recent years, from 5.5 percent in 2001 to 2.8 percent in 2004. The civil war and the low seropositivity in Angola have resulted in little attention and few resources being allocated to HIV/AIDS. However, the increasing awareness of the situation elsewhere presents an opportunity for early intervention. In 2002, the National AIDS Commission was created with a mandate to coordinate and oversee the fight against AIDS and other epidemics at national level. In 2003, a new National Strategic Plan was adopted, and an AIDS law was adopted in 2004. In 2005, the National Programme to Fight AIDS became

Strategic Issues and Key Implications of Main Report for UNDP Action in Angola

UNDP experience in Angola points to several strategic issues.

- The importance of defining and communicating UNDP's country strategy and roles on HIV/AIDS to all stakeholders.
- The successful identification of a new niche for UNDP as facilitator of access to external resources for HIV/AIDS from external partners.
- The importance of moving beyond small-scale UNDP pilot projects and assisting in designing, establishing, and facilitating the financing of expanded programmes when the pilots are successful.
- The critical importance of Country Office capacity for supporting HIV/AIDS projects and programmes.
- Making outcome-oriented monitoring and evaluation a central part of UNDP activity.

In the future, UNDP should:

- Build on opportunities to prevent HIV transmission while HIV seroprevalence is still low through formation and communication of an updated country HIV/AIDS strategy integrating all UNDP HIV/AIDS-related activities carried out in Angola regardless of their sources of financing.
- Make capacity development of AIDS institutions and effective use of new donor financial resources central to its HIV/AIDS work in Angola.
- Expand its work on mainstreaming in the education sector and with CSOs – they are key to future success.
- Strengthen the HIV/AIDS capacity of the UNDP Country Office, including its capacity for outcome-oriented evaluation of projects and programmes – also a condition for UNDP success.

the National AIDS Institute, giving HIV/AIDS a more prominent place in the Ministry of Health. An HIV-in-the-workplace law has also been approved. HIV/AIDS NGOs have evolved but have limited capacity and few financial resources. In addition, there was a generally strained relationship between NGOs and the government at the time of the field work.

The financial situation of Angola concerning HIV/AIDS changed dramatically in 2004. A grant of USD 90 million was awarded from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) under Round 4, after rejection of previous proposals. In addition, the World Bank committed USD 21 million for HIV/AIDS, TB and malaria (HAMSET) in 2004.

During the evaluation period, four main changes were observed: (a) Increased awareness of HIV among Angolan leaders; (b) Limited increase in country capacity for addressing HIV/AIDS, in the public, private and NGO sectors; (c) Creation of a framework of policies and institutions for action on HIV/AIDS, which at the time of the evaluation still had not been given sufficient Angola-specific content and operational character; and (d) Commitment of significant new external financial resources for HIV/AIDS from the Global Fund and the World Bank.

6.1.3 UNDP response

During the civil war, the main United Nations family actors in Angola were the UN Office of the Coordinator for Humanitarian Affairs (OCHA) and the World Food Programme (WFP). UNDP was relatively inactive, and the Resident Coordinator and Theme Group leader was from WFP. There were discontinuities in staffing of the Resident Representative position, and the 2001 UNDP staff re-profiling exercise was perceived to have weakened Country Office HIV/AIDS capacity. At the time of the evaluation, the Representative expressed a wish to deepen UNDP's engagement on HIV/AIDS.

In 1999, UNDP supported the first socioeconomic impact study of HIV/AIDS in Angola, and in 2001 it sponsored a survey of the perceptions and knowledge of Angolans regarding HIV/AIDS. This led to a 2002 UNDP project, Strengthening the Education System in Angola to Combat HIV/AIDS. Its aim is to reduce the impact of HIV on the Angolan education system, but the project has reached out beyond the education sector. In 2002, UNDP facilitated an AIDS study tour of an Angolan senior political delegation to Uganda. UNDP provided technical support in the formulation of the National Strategic Plan and in the preparation of the Angola proposal to the Global Fund. UNDP was also involved in drafting the AIDS law and facilitated the integration of HIV into the Interim PRSP. The UNDP Country Office has also made efforts to tackle HIV in the workplace within UNDP itself. In January 2004, UNDP was selected as principal recipient (PR) for the Global Fund grant. As PR, UNDP will be responsible for funds management, monitoring and evaluation, and building government capacity to take on the PR role within two to three years. At the time of the evaluation, the UNDO CO was working to implement a larger programme of HIV/AIDS activities with several other development partners.

6.1.3.1 Outcomes associated with UNDP response

Governance: The UNDP Country Office focal person is widely thought to have contributed greatly in the work of the technical group preparing the National Strategic Plan (NSP). Much of the background information contained in the NSP on projections, impact, and attitudes came from UNDP studies. The NSP has been translated into provincial plans in a process that also benefited from UNDP input. At the time of the evaluation, there was still a need to operationalize these provincial plans. UNDP assisted in the establishment of the National AIDS Commission (NAC). The NAC is led by the President of Angola and composed of ministers and vice-ministers from several ministries, as well as representatives from the medical faculty of the public university and the armed forces. However, it was not operational at the time of the field work for the evaluation and does not include NGOs, especially people living with HIV/AIDS (PLWHA). Several stakeholders saw an opportunity for UNDP to intervene in clarifying the relative roles and responsibilities of the NAC and other AIDS institutions, especially the Country Coordination Mechanism.

Leadership: While there were still reports of tension between NGOs and public officials, there is a growing space for NGOs and CSOs in the political and social fabric of Angola. UNDP's Resident Representative and Country Office staff have contributed to this result through parliamentary contacts, Country Office staff facilitation, and a programme to support national NGOs. UNDP has assisted the embryonic AIDS umbrella organization ANASO. Discontinuities in leadership and staffing of the UNDP Country Office reduced the effectiveness of UNDP's support in this area. The HIV/AIDS study tour of Angolan personnel to Uganda, while having considerable potential, involved a lower level delegation than anticipated and had little follow-up and no apparent impact.

Capacity development: Public officials and other stakeholders have increased their knowledge of HIV/AIDS and associated issues. UNDP's support for AIDS studies, and its associated advocacy activities, contributed to this result. There is also growing awareness of HIV among UNDP Country Office staff, and the "We Care" UNDP workplace programme and the work of the human resources staff in the Country Office have contributed to this. The Country Office has not drawn on other UNDP instruments

for capacity development support, such as L4R and UNV.

Mainstreaming: The UNDP-supported project with the Ministry of Education has initiated the integration of AIDS into school curricula, with training of social actors in two provinces. The project has facilitated participation of local NGOs by integrating them into provincial units, expanding delivery capacity, promoting community involvement, and engaging PLWHA. The project has established a small, well-regarded pilot but not a practical, financable investment proposal for scaling-up the response.

Partnership coordination for country results: Relations among AIDS Theme Group partners were sound at the time of the evaluation. However, opportunities for synergy and outspoken leadership with the government and within the donor community seemed to have been missed—in part due to a failure adequately to define the UNDP Country Office strategy and role in HIV/AIDS and to communicate that information to UN agency partners and beyond. As a result, UNDP was perceived to have a dispersed, un-conceptualized, and often unknown programme and strategy on AIDS in Angola. One strategy might be that of opportunity and of filling gaps left by others, however, this did not seem to be the case at the time of the evaluation. The advent of large GFATM and WB funding commitments provides UNDP an opportunity to position itself as facilitator of access to those and possibly other financial resources, but this would mean a willingness to take a less visible role. It would also require equipping the Country Office, either directly or through regional projects, with capacity to assist in transitioning pilot projects to large-scale programmes.

Monitoring and evaluation of the outcomes of UNDP's HIV/AIDS-related work in Angola has received no attention. This has weakened UNDP's ability to recognize successes, disseminate information, learn from failures, and facilitate sustainable UNDP projects.

6.2. BOTSWANA

6.2.1 Methodology

The Botswana country assessment was conducted by a national consultant with support from a designated international consultant, although the international team did not visit Botswana. The assessment

involved documentation review, interviews of key informants, and group discussions using standard interview guides. Three districts were visited and focus group sessions were held with communities. A stakeholders' validation workshop was held to discuss findings and to provide feedback to persons and institutions who were engaged in the data collection.

Strategic Issues and Key Implications of Main Report for UNDP Action in Botswana

UNDP experience in Botswana points to several strategic issues.

- UNDP has a comparative advantage as a strong partner in catalyzing actions for district level responses to the epidemic, and related governance and capacity development. This has earned the agency credibility. It has leveraged domestic resources in some districts, and the opportunity to scale up this experience is high.
- Support to civil society as a parallel track for a comprehensive national response has been initiated, but these efforts have apparently not been systematic enough to create the momentum required for civil society to enter into partnership with government for managing the national response. UNDP's credibility among civil society organizations could be further exploited to boost synergy between government and civil society.
- Interventions such as assisting ministries with mainstreaming HIV/AIDS into operational plans have not been harnessed to sufficiently meet programme requirements. A more rigorous plan for priority setting and increased support for capacity development would appear to be a critical next step in support of national level institutions in their efforts to mainstream and implement HIV/AIDS initiatives.
- Leveraging other funding resources from government and other donors can enhance the scale and outcomes of UNDP support considerably.

In Botswana, UNDP should:

- Continue, strengthen, and expand existing interventions, especially on capacity development, particularly, at the "mid-stream" decentralized level.
- Identify roles that build on comparative advantages and complement the initiatives of other external partners, especially PEPFAR and GFATM, and external partners with less in-country presence.
- Updated its HIV/AIDS country strategy, to give greater emphasis to priority-setting, CSO collaboration, mainstreaming HIV/AIDS into other UNDP programmes and activities, and initiating a UNDP-UN "We Care" workplace programme.
- Strengthen monitoring and evaluation and knowledge-sharing.

6.2.2 Context

Botswana is a large country, mostly desert, with a population of 1.7 million. The country is classified as middle income due to strong economic growth, based mainly on diamond mining. However, 37 percent of the population still live below the poverty line. Botswana was ranked 126 in the Human Development Index of 2003.

The HIV/AIDS epidemic in Botswana is one of the world's most severe. Sentinel Surveillance results showed a rise in the rate of HIV/AIDS infection from 18.1 percent in 1992 to 35.7 percent in 1998. By 2003, 37.3 percent of people aged between 15-49 years were believed to be infected with HIV. An estimated 43,000 children have lost their parents to HIV/AIDS.

Botswana's Short Term Plan of Action (1987-1989) focused on preventing infection through blood transfusion. The Medium Term Plan I (1989-1997) prioritized public awareness and prevention through ABC (Abstain, Be Faithful, and use Condoms) strategies. The Medium Term Plan II (1997-2002) and the National Strategic Framework (2003-2009) adopted a multi-sectoral and multi-level participatory approach, and strengthened systematic and strategic coordination of interventions. In 1993, the National HIV/AIDS Policy was launched. At the time of this evaluation, this document was being revised to address current developments, including antiretroviral therapy (ART).

Strong political leadership on HIV/AIDS has been prominent since the late 1990s. The institutional base of the response has evolved from the HIV/AIDS/STD Unit in the Ministry of Health, to the National AIDS Council (NAC) and the National AIDS Coordinating Agency (NACA). Provincial and district level structures have been created and they are receiving support through the national budget system.

The focus of national strategy includes prevention, care and support, and impact mitigation. The Botswana national ART programme that was started in 2001 was the first in Southern Africa. Approximately 23,000 people were receiving ART by August 2004, but an estimated 110,000 people were still in need of ART.

6.2.3 UNDP response

UNDP Botswana was the first of the Country Offices in the 10 case-study countries to develop

HIV/AIDS interventions. Between 1997 and 2003, UNDP focused on capacity development in policy, institutional strengthening and improving service delivery systems. Capacity development targeted central and district level institutions, disciplined forces, civil society organizations (CSOs) and applied research. In the late 1990s, UNDP began supporting the HIV/AIDS/STD Unit in the Ministry of Health, which was responsible for coordinating the national response to HIV/AIDS. It has subsequently supported NACA in its coordination of the implementation of a multi-sectoral approach to HIV/AIDS. UN Volunteers (UNVs), technical support, and training have been provided to the HIV/AIDS/STD Unit, NACA, NGOs, line ministries and District Multi-Sectoral AIDS Committees (DMSACs) in support of the national response. UNDP has also had innovative approaches to use of Information Communication Technology, particularly an interactive Talkback programme facilitating teacher-participant communication on HIV/AIDS.

Since October 2003, a new UNDP programme has been implemented. It aims to strengthen capacity for a gender-sensitive multi-sectoral response to HIV/AIDS, focusing on four areas: community conversation dialogues, leadership training, mainstreaming HIV/AIDS, and gender and teacher capacity development.

6.2.3.1 Outcomes associated with UNDP response

Governance: UNDP has had a key role in helping to redefine structures and develop a more participatory, decentralized approach to managing and implementing the national response to HIV/AIDS. These efforts have created stronger structures within local government that are coordinating community-level awareness and programmes for impact mitigation. In particular, UNDP's support at the district level was critical in the emergence of DMSACs and Village AIDS Committees to facilitate, coordinate and implement HIV/AIDS interventions. UNDP advocacy also facilitated the appointment of District Commissioners or Council Secretaries as the Co-Chairs of DMSAC. UNDP has provided UNVs, finance, training and other technical assistance for each of the districts. Several districts have elaborated situation and response analyses, and developed strategic plans with UNDP and SIDA support. District AIDS Coordinators have assumed previous UNVs' roles in some districts.

At the national level, UNDP has influenced development of governance institutions since it began supporting the HIV/AIDS/STD Unit. UNDP advocacy and support are considered to have been an important contribution to the formation of the NAC, NACA and Department Committees. Advocacy has also boosted the authority of HIV/AIDS structures by situating NACA in the Office of the President and elevating the NACA Coordinator's post to the Permanent Secretary level. UNDP has also been integral to producing national HIV/AIDS strategic planning frameworks by supporting processes that developed and refined the National Policy on HIV/AIDS and the National Strategic Framework and its Operational Plan. These have helped to clarify the roles of HIV/AIDS structures.

Effective functioning of many components of the governance system has been an ongoing challenge. However, overall, UNDP support is considered to have improved coordination and community mobilization, resulting in greater involvement of CSOs, local authorities and private sector institutions in decisions and policy making at all levels. UNDP assisted in clarifying the roles of CSOs and other key stakeholders in the national response. Ownership of interventions was reported to be moving to communities, and PLWHAs are increasingly assuming leadership roles in programmes at national and local levels.

Another key role that UNDP played was to emphasize the notion of HIV/AIDS as a development issue. This has been reinforced by support for improved information generation and dissemination. The Botswana UN Human Development Report 2002 was the first to focus on HIV/AIDS. This report, impact studies and other publications have provided information that made significant contributions to mobilizing awareness and support for the HIV/AIDS response, particularly at the early stages of the response. They have influenced subsequent policy, planning and actions, including policy on roll out of ART and mainstreaming by the public service and other line ministries. However, it was difficult to assess how new forms of information are being utilized, especially, the lessons learned in managing new information and the knowledge generated through UNDP support.

Botswana is a country where UNDP has promoted gender mainstreaming in conjunction with HIV/AIDS programmes. UNDP advocacy, research,

Human Development Reports, and training were specifically noted to have contributed to bringing gender issues and involvement of women into the national response. However, UNDP still missed opportunities to build on its gender-specific interventions. Strengthening the Women's Affairs Department and development of national gender frameworks had little follow-up support for implementation, and were not linked with HIV/AIDS programmes to enhance mainstreaming in both directions.

Leadership: UNDP has facilitated stronger leadership in the HIV/AIDS response at the national, district, and community levels through advocacy, training, study tours and exposure to best practices. UNDP advocacy also seems to have contributed to strong political leadership by the President, who chairs the NAC, other political leaders and officials, and PLWHAs. At the operational level, programme managers have increasingly provided sound leadership to improve collaboration among key stakeholders.

The scale of outcomes of leadership development in Botswana was reported to have been greatly increased by supplementary funding from the government—an important indication of growing national ownership for the coordinated response to HIV/AIDS. One of the challenges, however, was the limited scale-up of leadership development instruments and techniques introduced by UNDP. While increased resources were found to be available for programming at the district level, they were not necessarily being deployed to fund the issues, such as leadership for development, which have a high potential for impact on HIV/AIDS planning and management.

Capacity development: UNDP played a critical role in developing the capacity of the HIV/AIDS and STD Unit in the Ministry of Health, and subsequently NACA, through training, deployment of UNVs, and other technical assistance. This has contributed substantially towards the ability of these institutions to carry out their responsibilities, including the support to ART roll-out. In addition, capacity enhancement through training, planning exercises and technical assistance to various ministries was widely considered to have improved planning related to HIV/AIDS.

UNDP played a groundbreaking role in developing DMSACs early in the period under review. A

number of DMSACs have proved to be sustainable and have played effective roles in the HIV/AIDS response. DMSACs and Village AIDS Committees have enhanced community capacity to prevent and mitigate the impact of HIV/AIDS.

UNDP support is also considered to have enhanced the capacity of CSOs. It supported the establishment of network organizations such as BONELO, BONEPWA and BONASO at a time when civil society's role in the response was minimal or absent. However, an overall weakness of UNDP's efforts to strengthen civil society was lack of appropriate exit strategies to ensure sustainability of organizations once UNDP withdrew support.

A feature of UNDP involvement has been the strengthened involvement of PLWHAs at the national and lower levels, through support to NGOs, promoting PLWHA involvement, and support for the formation of PLWHA support groups. This has been instrumental in achieving greater representation, involvement, destigmatization, care and support.

Mainstreaming: UNDP has had a substantial role in increasing acceptance of the multi-sectoral nature of HIV/AIDS and mainstreaming in Botswana, one of the earliest outcomes in this area in Southern Africa. Advocacy, planning, research and other processes supported by UNDP have facilitated mainstreaming of AIDS into the health sector, public service management, labour, education, agriculture and finance. UNDP was instrumental in advocating for the appointment of ministry HIV/AIDS focal persons, development of sector plans, and HIV/AIDS workplace programmes. Nearly all public sector institutions are now implementing HIV/AIDS workplace programmes. However, there has been no rigorous evaluation of these interventions to determine their impact. There are concerns that policies, plans and programmes may achieve limited impact.

UNDP has also enhanced mainstreaming and multi-sectoral involvement at district and local levels. DMSAC initiatives have been a catalyst for enhanced understanding, planning and action at the district level, although results vary and obstacles to effective multi-sectoral action still exist at this level.

It is important to note that UNDP Botswana—despite its focus on mainstreaming in government and other sectors—is not mainstreaming HIV/AIDS

into its own programmes, such as in the poverty reduction and environment programme. In fact, the evaluation found no UNDP-UN HIV/AIDS workplace programme.

Partnership coordination for country results: UNDP has played an important role in building inter-agency synergy. UNDP, to a large extent through the resident coordinator, has played a key role in the UN Theme Group and was instrumental in forming the Partnership Forum. This forum includes donors, the private sector, and CSOs and is reported to have improved information sharing and collaboration, including several joint projects. The important roles played by other partners in this connection must, however, be acknowledged. The environment for financing in Botswana, as in other countries, was found to be complex and sometimes competitive, even among UN agencies.

An important aspect of UNDP work in Botswana has been helping to mobilize resources from external partners. UNDP has been part of joint UN initiatives with the government to develop Global Fund proposals, access funds and implement projects from PEPFAR, and to mobilize funding from foundations and bilateral donors.

6.3 ETHIOPIA

6.3.1 Methodology

The country assessment was undertaken in late 2004 by a national consultant who was joined by an international consultant for a week to conclude data collection. It was based on documentary evidence, extensive interviews using interview guides, group discussions, a visit to Leadership Development Programme (LDP) training and Community Conversation (CC) sites, and a validation workshop to complete the triangulation.

6.3.2 Context

Ethiopia is a large country with more than 70 million people. Of these, 87 percent live in rural areas and are largely dependent on subsistence agriculture. Ethiopia's 2004 HDI rank was 170, the lowest among the study countries, despite gains since the mid 1980s. In addition to addressing chronic development challenges such as food insecurity, the country is still rebuilding from the civil war. The per capita GDP was USD 90 in 2002, and around 45 percent of the population lives below the absolute poverty line.

Strategic Issues and Key Implications of Main Report for UNDP Action in Ethiopia

At the time of the international consultant visit, many UNDP Ethiopia HIV/AIDS initiatives had only recently been implemented. There were indications of changes due to UNDP programmes in targeted communities, civil society and government, but the outcomes remain to be seen. However, UNDP experience in Ethiopia points to several strategic issues:

- UNDP's good relationship with the government was an important comparative advantage.
- The Resident Representative and other UNDP staff have a marked influence on UNDP's potential to achieve significant outcomes in HIV/AIDS.
- UNDP showed ability to develop innovative methods to tackle HIV/AIDS. Community conversation methods were particularly powerful at integrating HIV/AIDS and development issues.
- UNDP Ethiopia was developing ways to scale up and consolidate interventions at the time of the evaluation. However, the size of Ethiopia and its resource constraints highlight the need for focused consideration of exit

strategies, duration of funding, sustainability and scaling up with government and other partners.

- The future of some civil society and community initiatives stimulated by UNDP was uncertain at the time. Stronger monitoring and evaluation of interventions would help to substantiate their efficiency and outcomes, refine them, and create a firmer foundation for scaling up and sustainability.
- Enhancing capacity and resources for Country Offices, including their ability to access support, is an important determinant of their ability to achieve and ensure sustainability of results. Interventions such as the Leadership Development Programme and Community Conversations, which may be taken over by other donors or local actors, raise questions about potential UNDP roles (such as technical support and quality assurance) in the follow up and scale-up phase of piloted interventions.
- Overall, increased urgency needs to be given to HIV/AIDS throughout UNDP work in Ethiopia.

In the future, UNDP should:

- Learn from Ethiopia's experience in scaling up innovations, promoting sustainability, and facilitating effective use of partners' increased funding for HIV/AIDS.
- Increase emphasis on programme rather than project support, within the framework of an updated UNDP country HIV/AIDS strategy integrating all UNDP HIV/AIDS activities and funding.
- Prioritize support to provincial and local authority levels.
- Strengthen and expand capacity development, based on prior experience of country-level and piloted activities, and give greater attention to mainstreaming HIV/AIDS.
- Review the roles and capacities of the Resident Representative, Resident Coordinator, and Country Office for dealing with HIV/AIDS, and adopt a more assertive public policy posture with the host country authorities.
- Strengthen monitoring and evaluation of HIV/AIDS activities.

HIV prevalence among pregnant women reached 12.6 percent in urban areas in the 1990s and seems to have been level for the last seven years. In rural areas, it has risen slowly to approximately 2.6 percent and may be reaching a plateau. By 2003, there were an estimated 2.2 million Ethiopians living with HIV/AIDS and 1.2 million HIV/AIDS-related orphans.

In 1985, the Ethiopian government established a National Task Force on HIV/AIDS. The Ministry of Health (MOH) developed and implemented the first Medium Term Plan (1987-1990) and then the second Medium Term Plan (1992-1996). The government approved a comprehensive HIV/AIDS policy in 1998 that created an environment for a multi-sectoral response. In recent years, efforts have been made by the government, NGOs, the private sector and development partners to put in place policies, strategies, systems and institutions needed for the national response. A National AIDS Prevention and Control Council, chaired by the

President and involving civil society, was established in 2000. The HIV/AIDS Prevention and Control Office (HAPCO), which serves as its Secretariat, had moved from the Prime Minister's Office to the MOH at the time of the evaluation. Regional HAPCOs have also been formed. The HIV/AIDS Strategic Plan (2000-2004) was formulated with various stakeholders' input, and the National AIDS Priority Strategies (2001-2005) were also identified. Some 170 local and international NGOs are involved in HIV/AIDS.

During the past five years, awareness of HIV/AIDS has reached high levels. Capacity development for government and civil society has been progressing, as have efforts to increase access to care and support, including antiretroviral therapy (ART). Institutions, policy and strategic frameworks have been put in place to combat HIV/AIDS. Ability to coordinate and drive the national response has been limited, but establishment and recent clarification of mandates

around the HAPCO system should enhance ability to act.

A large number of development partners are involved in HIV/AIDS in Ethiopia, including virtually all UN agencies and a number of bilateral agencies. Substantial external resources have been available to support action on HIV/AIDS, with significant new financial support from the World Bank, GFTAM and PEPFAR. The major financial contributors through HAPCO (total in 2004 USD 50 million) were the Global Fund (43 percent) and the World Bank Ethiopian Multi-Sectoral AIDS Project (EMSAP) (42 percent). Other partners have not always funded through HAPCO but may use this channel more now that HAPCO's position is clearer.

6.3.3 UNDP response

Prior to 2002, UNDP had no specific HIV/AIDS programme in Ethiopia and focused on poverty reduction, reconstruction and institutional development. In 2001-2002, the Support Services for Policy and Programme Development on HIV/AIDS and Development assessed possible areas for HIV/AIDS support and informed the follow-up programme. Since UNDP's commitments to HIV/AIDS were recent at the time of the evaluation, it was difficult for the team to discern outcomes. More results could be expected in the future.

UNDP's HIV/AIDS and Development Project focused on governance issues and developing leadership in the government and civil society for responses to HIV/AIDS. The project has several components:

- 1) *Strengthening development planning.* Capacity development, research and information gathering have been used to enhance planning and mainstreaming HIV/AIDS into the draft Poverty Reduction Strategy Papers (PRSP) and other initiatives, including the Ethiopian Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response (2004-2008).
- 2) *Leadership and capacity development for social mobilization.* The LDP has cultivated new skills among leaders in government, AIDS councils, civil society and the private sector. The Community Capacity Enhancement Approach has used CCs to stimulate open discussion and empower communities to address stigma, prevention and support, initially in two woredas (districts) where HIV risk was assessed as being high.
- 3) *Human rights.* This includes support for legislative

and policy change, along with empowering PLWHA and organizations promoting human rights, women's rights and PLWHA issues.

- 4) *Communication and advocacy.* This aims to build an enabling environment through the action and example of new leaders. Training and workshops, including an Arts and Media Workshop have been held. Future 500, an innovative media campaign using role models, has been launched.
- 5) *Mainstreaming HIV/AIDS.* This has begun to integrate HIV/AIDS in UNDP-supported programmes under Country Cooperation Framework II including regional planning, decentralization and workplace interventions. The intention has been to develop capacity of the government, civil society, the private sector and UNDP programme managers to mainstream HIV/AIDS into their plans.

Other governance components (such as the Civil Service Reform Programme) and pro-poor components of the UNDP country programme have potential for direct or indirect contributions to combat HIV/AIDS.

6.3.3.1 Outcomes associated with UNDP response

Governance: UNDP involvement helped increase inclusiveness and thus broad-based national ownership of recent HIV/AIDS policy, strategy and programmes, although there is still room for improvement. There are strong indications that participatory approaches at the community level and some LDP breakthrough initiatives such as Mothers Against AIDS have helped to empower communities and vulnerable groups such as women and PLWHA.

UNDP has also contributed to recognizing the rights of PLWHA and reducing stigma. At the pilot community level, PLWHA reported that CCs had created a more supportive and less stigmatized environment. The Media and Arts initiative is thought to have led to more advocacy for an HIV/AIDS response, as well as more open and sensitive reporting on HIV/AIDS issues. UNDP involvement in revision of the penal code has helped to make it more sensitive to gender, sexual health and harmful traditional practices.

Empowerment of women appears to be a prominent feature of changes related to certain projects. This has manifested itself most notably in the recent formation of a National Coalition of Women Against AIDS (NCWA), as well as in empowerment

of women and reported changes in traditional practices such as female genital mutilation in communities involved in CCs.

There were also indications that involvement of regional HAPCOs and other leadership in LDP has helped to strengthen decentralized systems for HIV/AIDS responses, particularly in the Southern Nations Nationalities and Peoples Region (SNNPR).

Leadership: UNDP has enhanced leadership on HIV/AIDS in several spheres, particularly through the LDP. This has reached approximately 750 trainees from diverse levels and areas of work. A number of testimonies show that the programme has led to substantial changes in the attitudes and leadership approach of some trainees. Requests to incorporate LDP methodology into routine civil service training also suggest that it is seen as effective, and UNDP was working to institutionalize LDP in 2005. Several sources commented that LDP had contributed to clearer understanding among leaders of roles in the HIV/AIDS response.

At the national level, a number of parliamentarians and government officials have been reached by LDP. National and regional presidents were present at events such as launching of CCs. Initiatives such as the NCWA and Ethiopian Volunteer Media Professionals against AIDS (EVMPA) have not been established for long, but seemed to be providing leadership. Initiatives to engage influential religious leaders have won commitment of various denominations to new projects to mainstream HIV/AIDS in their development and spiritual work.

Limited regional and community level leadership on HIV/AIDS is a particular challenge. LDP appears to be important in building leaders' commitment and skills, and clarifying their roles, particularly in SNNPR. At the community level, CCs also enhanced leadership for HIV/AIDS responses in the pilot communities.

It was noted that the UNDP Resident Representative (RR) had previously provided strong leadership on HIV/AIDS issues within the donor community and in interactions with government.

Questions remained about whether UNDP has managed to establish a critical mass of effective leadership on HIV/AIDS. Steps have been taken to

form an LDP alumni group, but uncertainty remains about the longer term effectiveness and sustainability of key changes.

Capacity development: UNDP has had a role in developing more widely applicable knowledge, methodologies, tools and capacity for use in relation to LDP and CC. A cadre of LDP trainers has emerged with skills to take LDP forward, the NGO Kembata Women Self Help Organization has an emerging role in supporting implementation of CC by other projects, and other donors were starting to use CC methodologies, with potential support from a CC Implementation Guide that was being developed at the time of the evaluation.

The most widely cited outcomes were in relation to CC communities, where there was substantial qualitative evidence of changes in individual and collective knowledge, attitudes and, in some cases, practices. Beyond this level, UNDP initiatives have increased awareness and knowledge of HIV/AIDS among targeted leadership cadres at national, regional and civil society levels. There has been some progress in rolling out CCs, which were being adopted by other partners and government at the time of the evaluation, but achieving results on the required, less localized scale remained a challenge.

Other human and organizational capacity to respond to HIV/AIDS has been developed through initiatives such as Media and Arts, EVMPA and the Women's Coalition. However at the time of the evaluation, there was not much indication of how effective and sustainable these initiatives will be. Several CSOs and NGOs indicated that UNDP funding and support for initiatives were not always reliable, which can threaten their effectiveness and sustainability.

Informants reported that UNDP had reinforced HIV/AIDS responses by providing and leveraging capacity on HIV/AIDS issues that were in relatively short supply in Ethiopia at earlier points in the period under review. No clear outcomes from other UNDP knowledge generation, such as studies on HIV/AIDS impact on food security and gender issues, were reported.

Potential roles of UNDP in developing regional and lower level capacity and leadership were highlighted. Some positive impact on leadership and capacity at these levels was noted from the Country

Cooperation Framework and LDP, and Development Assistance Forum (DAF) members felt it was an important gap that UNDP could address.

Mainstreaming: Prior to 2003, mainstreaming rarely addressed in Ethiopia. UNDP's mainstreaming initiative has helped raise awareness of the need for HIV/AIDS mainstreaming and to place HIV on the agenda of donors, government and sectors. This has led to formation of a Mainstreaming Task Force, with multi-sectoral representation, that is developing a manual on gender and HIV/AIDS mainstreaming.

Nevertheless, there has been limited progress on mainstreaming in planning and implementation. This was described as being at "embryonic stage," especially at regional level, although the SNNP Region has started some initiatives. Some mainstreaming of HIV/AIDS into the PRSP and the Millennium Development Goal (MDG) review process has occurred. UNDP had a key position in chairing a donor task force and providing technical support to integrate HIV/AIDS in the PRSP. However some informants felt that UNDP could have provided stronger leadership for mainstreaming in the PRSP and MDG processes and achieved stronger results.

UNDP has developed a strong workplace response to HIV/AIDS, but has not assumed a leadership role among the UN agencies. Workplace responses were also reported by a number of government ministries, but the evaluation could ascertain how effective they were and to what extent this could be attributed to UNDP.

LDP and CC were notable for showing ways to use HIV/AIDS initiatives to address broader development challenges in areas such as civil service reform and community empowerment and development.

Partnership coordination for country results: UNDP Ethiopia made a substantial contribution to coordination among donors and the government, particularly under the previous RR. However, UNDP could have been more assertive in relations with the government, and at the time of the evaluation, UNDP had a low profile on HIV/AIDS issues outside the UN. Development partners indicated that they would be receptive to stronger UNDP leadership in partnership coordination and in defining strategic direction for partners. Strong RR leadership was seen as a critical success factor.

However, whether UNDP was the most appropriate partner to lead coordination depended on circumstances, such as the availability and ability of the RR or other appropriate UNDP staff, as well as availability of strong alternative leaders from other agencies.

UNDP was relatively weak in mobilizing resources for the HIV/AIDS response in Ethiopia. However, it should be noted that it had begun to have success in mobilizing government and other donors to adopt CC methodologies and extend interventions to more communities.

UNDP created a strong internal HIV/AIDS capacity that has benefited partners and its own programmes. However, UNDP capacity may be too low for it to play a significant role.

6.4 LESOTHO

6.4.1 Methodology

The Lesotho study follows the pattern of other case studies. A national consultant reviewed available literature and other documents, talked with UNDP Country Office staff, and interviewed of key informants. Research guides were used to obtain information, and focus group discussions were held with members of the District AIDS Task Force in four Lesotho Districts. The consultant worked closely with the UNDP Country Office focal person for HIV/AIDS and benefited from the visit of the international consultant assigned to support the Lesotho case study.

6.4.2 Context

Lesotho is a small, mountainous country of 2.2 million people, landlocked within South Africa and largely dependent on subsistence agriculture and remittances from South Africa. With a per capita income of USD 423 in 2001, Lesotho is one of the world's least developed countries. Nearly two thirds of the population lives below the poverty line. Following turmoil in the late 1990s, reasonable political stability has been re-established, with elections facilitated by UNDP in 2002.

The country works closely with its international partners. Since 2001, the government's economic programme has been supported by the International Monetary Fund and the World Bank. A Poverty Reduction Strategy Paper (PRSP) was prepared over a period of four years, with continuous UNDP involvement. HIV/AIDS is a central issue in the PRSP.

Strategic Issues and Key Implications of Main Report for UNDP Action in Lesotho

UNDP has had many sound initiatives, yet it has not successfully expanded its initiatives, or facilitated the expansion of others' activities, to a national scale.

- UNDP has succeeded in bringing a rights-based approach to HIV/AIDS issues and in integrating HIV/AIDS into its entire country programme.
- UNDP needs to ensure that the learning experience from initiatives is practical and applicable. For example, participants in leadership training workshops were unsure how to use their training and the District AIDS Task Forces supported by UNDP were unsure of their coordination role, including what to coordinate, their mandate, and what to implement.
- The capacity to design arrangements—including technical support, management, financing, and monitoring and evaluation—and to move from pilot projects to national programmes needs to be built into UNDP programmes. This could be a role for regional projects.
- UNDP engagement in HIV/AIDS in Lesotho was personally associated with one Resident Representative (RR). It is not clear to what extent the progress made under the outgoing RR has been fully institutionalized into the attitudes and work of the entire Country Office, and whether the same approach will continue under the new RR. This is an issue that should concern not only the Country Office but UNDP Headquarters as well.

In the future, UNDP should:

- Sustain the urgency given to HIV/AIDS in the UNDP programme in Lesotho.
- Within the Country Office, give greater attention to institutionalizing the attention given to HIV/AIDS issues by the former RR with a revised and updated UNDP country HIV/AIDS strategy.
- Strengthen Country Office follow-through and address implementation gaps, continuing the close cooperation with donor partners established under the the previous RR.
- Focus on expansion and scaling-up proven initiatives, to national programmes, and enhance monitoring and evaluation.

According to UNAIDS, Lesotho is Southern Africa's third worst affected country by HIV/AIDS. Adult prevalence of HIV was estimated at 31 percent in 2000. Life expectancy has declined to 48.7 years for men, and 56.3 for women. HIV/AIDS has drastically cut household income and constitutes a major impediment to the achievement of the country's MDGs.

In the year 2000, Lesotho adopted a National Strategic Plan and policy framework to address HIV/AIDS. The policy framework recognized the importance of partners such as NGOs and external donors. The Government of Lesotho (GOL) adopted a publication of the Expanded Theme Group, "Turning a Crisis into an Opportunity," as a working document for scaling up the national response. The National AIDS Programme Coordinating Authority (LAPCA) was established under the Prime Minister's office in 2001. Inter-ministerial task forces were created, but LAPCA was not effective in coordinating the response. Therefore the Cabinet decided to replace it with a broad-based autonomous National AIDS Commission (NAC), modeled after the Independent Electoral Commission that helped to reduce political conflict during the elections. The Ministry of Labor has prepared policy guidelines on AIDS in the workplace, but at the time of the evaluation had not yet published them, and employers have established a Business Coalition against HIV/AIDS.

6.4.3 UNDP response

UNDP engagement in HIV/AIDS in Lesotho came late. In July 2002, that the new Resident Representative (RR) initiated a consultative process with the GOL that led to a significant shift in UNDP strategy and to substantive growth in its engagement on HIV/AIDS. UNDP led a multi-disciplinary, multi-sectoral diagnostic mission that resulted in the UN Theme Group publication, "Turning a Crisis into an Opportunity."

The We Care Programme on HIV/AIDS in the UNDP workplace started as early as 2001, and the Country Office took advantage of the staff reprofiling exercise to realign its staff with the requirements for an expanded HIV/AIDS programme. UNDP used the approach of transformational leadership to pilot new initiatives with many key groups in the country. Parliamentary, church, public service and community leaders were all reached. The Lesotho 2003 MDG report prepared by the GOL and UNDP, "The War against HIV/AIDS," established HIV/AIDS as a priority area for achievement of all eight MDGs.

HIV/AIDS has grown remarkably as a share of total UNDP programme spending in Lesotho: In 2002, HIV was 5 percent; in 2003, 17 percent; in 2004, 42 percent; and in 2005 plans called for 47 percent of

total UNDP country programme spending to be devoted to HIV/AIDS.

6.4.3.1 Outcomes associated with UNDP response

Governance: UNDP successfully advocated for a rights-based approach to HIV, focusing on the disease as a governance issue. Its RR bears a high level of personal responsibility for shifting AIDS from a medical to a development paradigm in Lesotho. UNDP played a central role in facilitating dialogue for progress towards an AIDS-competent society, with decentralized HIV and health services and increasing the perception of HIV/AIDS as a cross-cutting issue with implications for all the MDGs. The Prime Minister declared AIDS to be the “biggest threat to humanity,” and stigma appears to have been reduced during the period of this evaluation. Nonetheless, superstition and denial remain critical issues.

UNDP played a central role in the decision to shift from LAPCA to the NAC, and at the time of the evaluation, the legislative process had started to enact the policy to establish the NAC. Some stakeholders remain concerned about the risks that the NAC would also be ineffective. A network of PLWHA acknowledged UNDP assistance in its formation, but the NGO response remained largely uncoordinated, unfocused and without vigor. Aside from its impact on the overall environment for AIDS-related decisions, UNDP advocacy might have influenced the GOL decision to allocate 2 percent of each ministry’s budget for HIV/AIDS. UNDP has not been engaged in budget monitoring for HIV/AIDS. In cooperation with WHO, UNDP played a key role in the GOL decision to adopt the 3 x 5 Initiative for the expansion of antiretroviral therapy (ART).

Leadership: The UNDP RR and the UNDP Country Office effectively exercised leadership on HIV/AIDS issues at many levels. HIV/AIDS is now widely seen as a development issue and this is the result of the RR activity and UNDP’s programme of transformational leadership. Leadership visits by many senior UN officials to the country have helped to boost local confidence and keep HIV/AIDS on local agendas. UNDP successfully promoted public commitment of political leaders to voluntary counselling and testing (VCT) through a public Know Your Status (KYS) campaign. Some stakeholders, however, felt inadequately included in the KYS launch. Questions have been raised about the extent to which participants

in UNDP-sponsored events have felt empowered to counsel others on VCT, and fear of testing is said to prevail widely. Interventions with parliamentarians helped to facilitate adoption of laws and to harness traditional leaders on HIV/AIDS. Nonetheless, there was some feeling that UNDP’s activity with many leaders consisted of meetings and organizing committees, with little follow-up action.

Capacity development: UNDP increased the capacity of many national stakeholders and a limited number of CSOs, particularly through the VCT-KYS campaign. However, UNDP has had little contact with the National Council of NGOs—the umbrella body of CSOs in the country. UNDP Lesotho publications and training helped to build confidence, particularly at the district level. While the Leadership Development Programme has helped, the government has identified a need to improve senior officials’ utilization of capacity for placing HIV/AIDS at the center of policies and plans.

Mainstreaming: UNDP contributed to the decision of the business community to launch policy guidelines on HIV/AIDS in the workplace. The extent of UNDP’s engagement in the PRSP process has not been documented, but it is clear that UNDP has integrated HIV/AIDS into its entire Country Office programme. The national consultant reported that UNDP has contributed significantly to a shift in the public service environment from burnout to openness and readiness to admit the need for assistance. Deepening and sustaining this shift will be a continuing challenge. For mainstreaming to succeed, UNDP must also overcome tensions between the Ministry of Finance and Economic Development and UNDP senior staff.

Partnership coordination for country results: The UNDP RR successfully mobilized the entire UNCT—indeed, the entire UN community in Lesotho—on HIV/AIDS. Resource mobilization was so successful that bilateral donor funding of UNDP Lesotho on HIV/AIDS exceeded UNDP core resources. A rotating scheme of Resident Coordinator leadership appears to have worked well. UNDP was perceived as a trusted and neutral partner. Yet, UNDP in Lesotho seems to have suffered from one widely perceived weakness in the country—the difficulty of moving from policies and plans to implementation. The national consultant, for example, observed that operational follow-through is

required to ensure utilization of a guidance manual prepared by UNDP. Another observer commented that UNDP needs to strengthen its relations with the donor community in Lesotho.

6.5 MALAWI

6.5.1 Methodology

The Malawi country assessment followed the model of other country assessments for this evaluation with the team leader participating in the evaluation in-country. A two-day workshop was held in Johannesburg, south Africa for training national consultants from participating countries to refine evaluation tools. Guidance questionnaires were used for interviews at the national and district levels, and topics for focus group discussions at the community level were predetermined. Available documents were also reviewed by the national consultant. An international consultant team member joined final discussions and selected interviews. Towards the end of the national consultant's work there was a validation workshop to review preliminary findings.

6.5.2 Context

AIDS was first diagnosed in Malawi in 1985. By 2003, 14.4 percent of the population was estimated to have HIV/AIDS. Life expectancy, which had been projected to rise from 48 years in 1992 to 57 years in 2000, actually declined to 40 years in the year 2000. The Human Development Index has fallen in recent years. Poverty, estimated at 65 percent of the population in 1998, has risen. GDP per capita was estimated to be less than USD 200 in 2002. Of the total country population of 11 million, more than 800,000 were orphans in 2003 – nearly 50 percent attributable to AIDS.

Following the implementation of two successive AIDS Medium Term Plans, in 2001 the government created the National AIDS Commission (NAC) to replace the National AIDS Control Programme. While the NAC has a broader mandate than the NACP, it remained under the Ministry of Health until 2002, when it was transferred to the Presidency. An HIV/AIDS policy was launched in 2004.

6.5.3 UNDP response

From 1998 to 2000, UNDP helped increase open discussion of HIV/AIDS through community mobilization and capacity development. This work culminated in the National Strategic Framework for

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UNDP experience in Malawi points to several important issues:

- UNDP had important accomplishments in areas such as the AIDS Round Table, supporting NGOs, and mainstreaming for uniformed personnel.
- However, there were missed opportunities in areas such as the central/district dichotomy, the capacity gaps of CSOs, the poverty reduction strategy, and the leadership and convening role among donors.
- Moving beyond upstream activities to follow-through by UNDP and its partners is critical, and it is important to address the risks of early exit from activities that have been successfully launched but not fully institutionalized.

In the future, UNDP should:

- Strengthen UNDP's HIV/AIDS engagement, with a growing urgency to the issue, under an updated UNDP country HIV/AIDS strategy moving from project to programme support for the country's HIV/AIDS SWAp.
- Review and strengthen CO HIV/AIDS capacity.
- Give greater attention to capacity building, particularly with the NAC and CSOs.
- Facilitate integration of UNDP and partner interventions into national processes, including the PRSP, the national budget, and for CSOs.
- Ensure greater attention to monitoring, evaluation, and institutionalization of initiatives.

2002-2004. UNDP provided financial and technical assistance to prepare and manage the HIV/AIDS Resource Mobilization Round Table. UNDP supported HIV/AIDS impact studies in the public service, assisted with the participation of Malawians in international AIDS conferences, and supported the NAC, district-level coordination, and civil society organizations. It also facilitated integration of HIV/AIDS issues into the military. The HIV/AIDS Theme Group supported by UNDP won a grant of USD 3.4 million from the UN Foundation.

6.5.3.1 Outcomes associated with UNDP response

Governance: HIV/AIDS is increasingly being recognized as a national concern and development challenge in Malawi. UNDP's support for impact studies and other advocacy work contributed to this result. UNDP contributed to the AIDS policy. In recent years, there has been important growth in community support groups and local non-governmental

organization (NGO) engagement; UNDP support was a key factor in this change. However, UNDP has not adequately supported the conversion of community groups to full NGOs. UNDP support for the NAC was critical to its effective establishment and operation, though there are concerns about its sustainability and future operation at the district level. UNDP has facilitated AIDS programme decentralization, although this remains to be adequately operationalized. UNDP is widely seen among Malawi's development partners to have taken the lead in mobilizing the national response to HIV/AIDS. UNDP's work is reported to have contributed to the reduction of stigma and discrimination against people living with HIV/AIDS.

Leadership: UNDP has contributed to the emergence of leaders and opinion makers who have strengthened the Malawi response to HIV/AIDS. Advocacy and commitment by UNDP Resident Representative and Resident Coordinator personnel at the highest levels of Malawian institutions are reported to have contributed significantly to the recognition of HIV/AIDS as a development challenge. The failure to support this at lower levels in the political arena represents a missed opportunity. Thanks to UNDP engagement, the public sector response has been converted to a multi-sectoral one, especially through UNDP support to the Department of Human Resources and Development in the Presidency. A task force sponsored by the Presidency with UNDP support has contributed greatly to engaging public institutions.

Capacity development: In recent years, thanks to UNDP support, Malawi has developed enhanced capacity among people living with HIV/AIDS and community support groups, such as the Malawi Network of AIDS Services Organizations. UNDP impact studies have contributed to enhanced knowledge on HIV/AIDS. In addition, capacity for HIV/AIDS-related planning has increased at the local level, thanks to UNDP's decentralization programme. UNDP support was essential for many aspects of the early development of the national strategic framework and the NAC, as a multi-sectoral body staffed with local nationals. Further progress is needed on integration of AIDS issues into Malawi's poverty reduction strategy and annual budgeting process.

Mainstreaming: UNDP support to NGOs has been critical to mainstreaming HIV/AIDS into their

work. However, NGOs expressed concern that they continue to need UNDP support in accessing other donor's resources. With the poverty reduction strategy of Malawi up for review, UNDP's past involvement in this work has positioned it well to facilitate integration of HIV/AIDS into the Poverty Reduction Strategy Paper, a missed opportunity in the past. UNDP advocacy for a multi-sectoral approach and its facilitation of the transfer of HIV/AIDS responsibilities from the Ministry of Health to the Presidency have contributed to the shift from a biomedical paradigm to a development orientation to HIV/AIDS issues. UNDP is also credited with the successful mainstreaming of HIV/AIDS into the Malawi Army and Police. UNDP support contributed to integration of HIV/AIDS issues into public sector workplaces, but this integration has not carried over to private sector workplaces. Even among public sector institutions, there still remains much to do—a survey of 40 institutions revealed that less than 40 percent had started preparing workplace HIV/AIDS plans as of January 2003. The survey shows the magnitude of the task ahead.

Partnership coordination for country results: UNDP's relatively early engagement and constant support were critical to the AIDS Round Table, which led to creation of donor basket funding for the AIDS Sector Wide Approach (SWAp), with pledges amounting to approximately USD 400 million. Since then, UNDP seems to have taken a back seat to Department for International Development and the World Bank in support of the NAC. Thanks to UNDP support, local level partnerships have been enhanced. Continuing support is needed to leverage additional resources to scale up efforts, especially at the local level. A forum is needed to bring all actors together to discuss partnership issues in the NGO sector. The UNDP Country Office has committed itself to invigorated HIV/AIDS programming through internal change, but little evidence of cultural change had emerged at the time of the evaluation.

6.6 NAMIBIA

6.6.1 Methodology

The country assessment for Namibia was conducted by a national consultant without a direct field visit by the international team. The approach followed the model of other country assessments for this evaluation, using data collection instruments prepared collectively

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Namibia demonstrates both the promise and the bottlenecks associated with UNDP's role in supporting the national response to HIV/AIDS. UNDP experience in Namibia points to two important issues:

- At the level of promise, Namibia appears to have an institutional framework that consistently produces national development strategies. These have been influenced to emphasize HIV/AIDS and to anticipate a more focused implementation.
- However, the absence of strategically-placed capacity development to move from policy to implementation continues to be a major issue for UNDP, especially in the context of increasing resources available to Namibia, through the Global Fund and other facilities.

In future, the UNDP should:

- Increase the urgency given to HIV/AIDS in the work of UNDP through an updated UNDP country HIV/AIDS strategy that integrates projects into a larger programme drawing upon the wide variety of instruments available, including UNVs for capacity development.
- Focus on the implementation gap, moving beyond policy and beyond generating a response to facilitating impact on the ground by UNDP and its partners.
- Move beyond the national level to mid-stream action.
- Give greater attention to monitoring and evaluation, and particularly to use of available information for increasing effectiveness.

to guide interviews at the policy, institutional and community levels. The country assessment for Namibia also benefited from an assessment of national development documents and those prepared by UNDP.

6.6.2 Context

Namibia is classified as a lower middle-income country, with an annual per capital income of approximately US\$1,800. In terms of income alone, Namibia performs quite well on the global scale, ranked 65 out of 175. However, when using the Human Development Index, combining income with other capability measures such as health and education, Namibia drops to a rank of 124. More than half of Namibia's population survives on approximately 10 percent of the average income, suggesting profound poverty levels. With a national unemployment rate of 35 percent, and particularly high unemployment among women and youth, diseases such as HIV/AIDS

have found fertile grounds for alarming escalation. As of 2004, Namibia was ranked among the top seven countries hardest hit by the HIV/AIDS epidemic in the world. From the first diagnosis in 1985, Namibia has recorded a cumulative total of more than 136,000 cases of HIV/AIDS, now standing at a national prevalence rate of 22 percent (based on the 2002 National HIV Sentinel Survey). With a population of 1.8 million people, HIV infection among women accounts for 50 percent of all reported cases. Current estimates put the number of orphans at 82,000, and this number is expected to rise to 120,000 by 2006.¹

Responding early to the HIV/AIDS challenge, Namibia established an AIDS Advisory Committee in 1987 and developed the National AIDS Control Programme (NACP), with a mandate to coordinate and manage HIV/AIDS patient care and prevention activities. Since 1992, Namibia has had three Medium Term Plans. The first was from 1992-1997, the second from 1999-2004, and the third covers 2004-2009. Under the second Medium Term Plan, the National AIDS Co-ordination Programme replaced NACP, with a comprehensive set of objectives that specifically related to a shifting emphasis from a bio-medical to a multi-sectoral effort. The third Medium Term Plan truncated the second plan to realign development priorities and institutional arrangements towards an HIV/AIDS-conscious national development planning approach.

6.6.3 UNDP response

UNDP's support for HIV/AIDS in Namibia did not begin until the 2002-2005 Country Cooperation Framework. This made it difficult for the evaluation to document specific results associated with UNDP support. UNDP support was entirely government executed; limited government execution capacity and limited UNDP Country Office HIV/AIDS staff hampered UNDP programme execution. However, the Regional Project provided support that was well-received. UNDP support targeted institutional reform to invigorate the NAC, support for decentralized management aligned with UNDP support for decentralization in Namibia, integration of HIV/AIDS responses into the Poverty Reduction Strategy Paper, and issues of human rights and gender equity. With the establishment of an HIV/AIDS Unit in

1 UNAIDS Country Report Summary, available online at <http://www.unaids.org> as of 5/15/2005.

the UNDP Country Office in 2002, UNDP was able to assist the government in reviewing the second Medium Term Plan and to truncate it by introducing the third Medium Term Plan. This third plan substantially restructured the institutions for managing HIV/AIDS, giving them a more multi-sectoral focus and aligning them better with overall policies and programmes elaborated in the Plan. UNDP has also been instrumental in assisting Namibia with resource mobilization. The government was successful in its proposal to the Global Fund and received approval in 2003 for a total of USD 113 million, of which more than USD 105 million is for HIV/AIDS.

6.6.3.1 Outcomes associated with UNDP response

Governance: Three key contributions are associated with UNDP's role as it relates to governance of the HIV/AIDS response: 1) supporting the integration of HIV/AIDS into the Poverty Reduction Strategy by assisting the National Planning Commission to focus on the connection between youth (un)employment and HIV/AIDS; 2) supporting the development of decentralized institutions for managing HIV/AIDS beyond the national level; 3) emphasizing gender issues, in the context of support for rights of marginalized populations and of people living with HIV/AIDS. However, while UNDP's contributions are appreciated at the policy level, there have been missed opportunities in transforming the policy-level supports to implementation arrangements on the ground. Since UNDP successfully assisted the government in reviewing and refining its Medium Term Plan, this led to a perception of UNDP as primarily a policy player. To date, the implementation gap looms large in Namibia.

Leadership: Advocacy and corresponding training for women leaders has been instrumental in ensuring that most Regional Coordinators of HIV/AIDS programmes are women. Business leaders have been supported to be advocates at the national level through grants and capacity development provided by UNDP to NABCOA—a national association with HIV/AIDS programmes that are often cited in the national media. While the efforts in leadership development have been described by UNDP as part of its transformation efforts, the emphasis appears to be at the national level, primarily with government officials and business leaders. UNDP has assisted in mobilizing faith-based organizations and other community organizations for active engagement in

HIV/AIDS, but other donors have been more instrumental to such community-level organizations by providing resources to fund projects and activities.

Capacity development: Capacity development has been one of UNDP's strongest contributions. Some significant outcomes and substantial missed opportunities were noted in this area. Starting with consistent efforts in building capacity with the National Planning Commission for the understanding of the human development dimensions of HIV/AIDS, Namibia has consistently produced Human Development Reports for 1997, 1998, 1999, 2000/1 and 2002/3. Increasingly, this capacity is being deployed to enrich planning processes at the national level, with the latest revision to the Medium Term Plan III reflecting a strong correlation between national targets and Millennium Development Goals, within the context of the Human Development Index. However, while these capacities are being developed at the policy level, their implementation is being constrained by the inability of staff at NPC to follow through and their limited capacity to use funds set aside by UNDP and other donors. One of the capacity development instruments that held promise for assisting Namibia to fill vital human resource gaps is the deployment of UN Volunteers (UNVs). More than 1,000 UNVs (both national and international) were expected to be deployed in Namibia. At the time of the evaluation only 18 had been mobilized. Inadequate funding has hampered this programme, which resulted in fewer opportunities for national and international UNV recruitment.

Mainstreaming: UNDP has contributed to mainstreaming in Namibia through strong advocacy for HIV/AIDS workplace coordinators in the public and private sector and the production of toolkits for use by promoters of workplace HIV/AIDS programmes, both among the private sector (through NABCOA) and municipalities (through AMICAL). This is a unique UNDP niche, which it has been sharing with UNAIDS. NABCOA claims that they would not be able to do the work they are currently doing without the support received from UNDP and UNAIDS, such as the AIDS BRIEF—a quarterly publication with a wide circulation among business leaders. However, concerns have been expressed about missed opportunities for assisting the NPC in operationalizing its plans for mainstreaming, which have been supported by UNDP. In particular, the Planning Commission has developed several good ideas about mainstreaming HIV/AIDS into policies, workplaces,

and national life, but there has been no monitoring or evaluation of how they are progressing. UNDP also experienced some setbacks in its effort to mainstream HIV/AIDS in the educational system. UNDP supported a pilot initiative to train university teachers on HIV/AIDS in the hope of launching a core course within the curriculum focusing on HIV/AIDS. After the one-off training, there was little substantive follow-up. The expectation of launching a course at university-level fizzled, until a much delayed renewal with the expected signature of a Memorandum of Understanding with the University of Namibia to co-sponsor a series of training sessions on HIV/AIDS.

Partnership coordination for country results: UNDP's role in coordination of HIV/AIDS activities at the country level has focused primarily on the UN Theme Group, which UNDP chairs. The UNDP Country Office has made effective use of PAF funds from UNAIDS. The Country Office also successfully negotiated for a two-year HIV/AIDS advisor from SIDA. However, UNDP has been characterized as rather insular--focusing on the specific HIV/AIDS projects that it is implementing, yet encouraging the government to broaden policies. Opportunities to leverage funding (which the government has been successful in mobilizing) and to use its convening capacity to generate consensus about improved capacity for implementation at the national and sub-national levels merit greater attention.

6.7 SOUTH AFRICA

6.7.1 Methodology

The country assessment for South Africa occurred at a time when the Country Office had commissioned one of its first evaluations of a major HIV/AIDS and Poverty Reduction Project, using a methodology for evaluation that focused on traditional project evaluation. This presented an opportunity to obtain information on project-level operations and to compare the project evaluation methodology with the outcome evaluation approach in order to assess changes in development conditions across a broader spectrum of programme interventions in support of HIV/AIDS action in South Africa. The national consultant applied the tools designed for data collection and, with the support of three members of the international team, complemented this data with selected strategic interviews with government, private sector, civil society and donor partners in

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Although UNDP currently has a limited role in South Africa, there are several areas of comparative advantage that UNDP should emphasize as it positions itself for future support of South Africa's national response to HIV/AIDS:

- UNDP is recognized by the government at the national, provincial and local levels as an impartial resource that does not feed into party political agendas, that is driven by international norms and conventions, and that is focused on the poor and marginalized, regardless of race, gender, creed or political orientation.
- Members of government and civil society also anticipate UNDP capacity to import global best practices through the UN system. One of the areas of knowledge and value-added development that the government appears anxious learn from UNDP is the focus on sub-national, community-driven processes for empowerment, targeting the poor and the vulnerable. With mounting pressures for solutions at the local, community levels, UNDP-supported pilot projects in Leadership for Development and Community Conversations are seen as potential contributions to national policy and strategy on HIV/AIDS.

In the future, UNDP should:

- Review and update UNDP country HIV/AIDS strategy to give increased urgency to the issue of HIV/AIDS as a development, and not just a medical, challenge; particular attention should be paid to actions at the provincial level and to adopting a more assertive posture with public authorities, even if that posture must be "behind the scenes."
- Give greater attention to UNDP's role as an AIDS innovator, including the expansion and scaling-up of pilot projects with support from other partners, and facilitating access by South Africans below the national level to knowledge and experience on HIV/AIDS issues around the world.
- Move beyond projects into an integrated country programme of HIV/AIDS support, drawing upon relevant UNDP instruments that are available at the national, regional and global levels.
- Facilitate the effective use of others' resources for HIV/AIDS, including the resources of public authorities.

South Africa. A validation session, although sparsely attended, provided an opportunity to refine the findings.

6.7.2 Context

South Africa has the unenviable record of having the largest number of people living with HIV/AIDS in a single country. Out of a population of 44.8 million,

an estimated 5.3 million people have HIV/AIDS. The national HIV infection rate among pregnant women attending antenatal clinics in 2003 was 27.9 percent, with variations among the country's nine provinces, from as high as 37.5 percent in Kwazulu-Natal to 13.11 percent in the Province of Western Cape.²

In contrast to other parts of Sub-Saharan Africa, however, South Africa experiences relatively high per capita income of approximately USD 2,300. There are wide variations in income distribution and a huge discrepancy in the standard of living between the races, reflecting a legacy of decades of apartheid policies. Development infrastructure, including education and health care delivery are relatively high in South Africa, making it one of the countries in Sub-Saharan Africa with higher capacity to manage the substantial quantity of care required for its large HIV/AIDS patients.

South Africa's national response to HIV/AIDS is shaped by the national strategic framework for 2000-2005, following the approval of a comprehensive national plan for HIV/AIDS care, management and treatment in 2003. The plan aims to provide treatment to more than 1.4 million South Africans by 2008. The government has a strong commitment to tackling the epidemic, backed by increased domestic financial resources. In 2003, the government allocated approximately USD 1.7 billion from the national treasury to fight the epidemic over a three-year period. Another measure of national commitment is the plurality and vigor with which organizations of civil society engage with the state in discussions (and sometimes strong disagreements) on strategy and priorities. This has promoted a great degree of accountability for public policy to various interest groups, including a large and vocal civil society of people living with HIV/AIDS.

6.7.3 UNDP response

UNDP support to the national response has been guided by the United Nations Development Assistance Framework (UNDAF) 2002-2006, the 1999 Common Country Assessment that informed the priorities of UNDAF 2002-2006, and the two Country Cooperation Frameworks (CDFs) of 1997-2001 and 2002-2006—all of which recognized the negative impacts of HIV/AIDS on development and

transformation in South Africa. UNDP has been part of the HIV/AIDS Theme Group and through the Resident Coordinator system participated in agency collaboration efforts in the fight against HIV/AIDS. The CCF 2002-2006 defined key programmatic interventions at the national, provincial and local levels that include Enhancing an Integrated Response to HIV, AIDS and Poverty, Involving Youth in HIV/AIDS Responses, Greater Involvement of People Living with HIV/AIDS (GIPA), and a National Database of philanthropic investments and activities aimed at prevention and mitigation of the impacts of HIV/AIDS in the country. UNDP's primary interventions target three provinces in the country, including KwaZulu Natal (with the highest infection rate—more than 35 percent), Limpopo and the Eastern Cape. The need for greater attention to monitoring and evaluation was recognized as a weakness in the UNDP programme.

6.7.3.1 Outcomes associated with UNDP response

Governance: Government leadership for policy and programming in HIV/AIDS is strong—it currently has a comprehensive plan funded substantially from government budget allocations. As a result, UNDP has had a less visible and discernable influence on government policies and programme priorities.³

At the time of the evaluation, the coordination of the shift to a multi-sectoral response to HIV/AIDS (versus a bio-medical response) remained a critical challenge to the government and represented a key missed opportunity for UNDP. While key institutions participating in programme formulation and implementation had internalized this paradigm shift, the coordination efforts were still in transition. UNDP was not at the forefront in the development and finalization of the HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 and the concomitant shifts that informed the plan such as the need for a multi-sectoral response have been largely driven by domestic considerations rather than external influence. Government departments that are more accustomed to dealing with HIV/AIDS as a developmental issue, such as the Department of Social Services, have not been the ones at the center of the partnership with UNDP.

While UNDP does not target civil society in its programme interventions (as its priority and prime

2 UNAIDS Country Update on HIV/AIDS available online at <http://www.unaids.org> as of 5/5/2005.

3 This poses frustrations for donors, such as UNDP, who have been accustomed to exerting considerable influence in public policy, elsewhere in the developing world.

partner is the government), it faces the danger of being perceived as uncritical of government inaction. A strong and vibrant civil society advocates for and engages the government in shaping and sometimes changing policy directions in the national response. However, UNDP has not played any noticeable role in the debates associated with government and civil society and has not been visible in supporting or helping to drive civil society responses to government inaction and delays.

UNDP has been successful in helping mainstream HIV/AIDS into the development plans of local councils in priority provinces, as indicated by the increased demand for the development of HIV/AIDS components for local and provincial plans. The emerging HIV/AIDS responses by municipalities are indicative of the efforts of the UNDP in laying the foundation for more concerted and formalized responses to the epidemic at the local levels. In addition, communities have been linking HIV/AIDS to wider issues of community governance, access to public services and accountability of government for service delivery, especially at the local government level. UNDP-facilitated conversations at the local community level galvanized energy and raised the confidence of communities to declare their needs and aspirations and to take responsibility for their own development challenges. UNDP community conversations brought government closer to the people and reinforced communities' involvement and leadership in handling their own development priorities.

Leadership: At the time of the evaluation, leaders in both the public and private sector were taking a more comprehensive view of addressing HIV/AIDS. The Leadership for Development process, which had champions from all sectors, sensitized leaders to HIV/AIDS--its dimensions, linkages with poverty, and personal impacts. However, missed opportunities in leadership development arose from UNDP's inability to demonstrate how the efforts at the provincial and district levels could be scaled-up to other equally vulnerable areas of the country.

UNDP has played an exemplary role in a number of pilot initiatives in that help people living with HIV/AIDS influence private firms' HIV/AIDS policies. The deployment of fieldworkers into corporate environments in private business, parastatal organizations and government departments has successfully reinforced the imperative that

PLWHA should lead their own endeavors in responding to the HIV/AIDS epidemic.

Capacity development: Because UNDP is limited in its input at the national level, there is little measure of capacity development at this stage. However, UNDP capacity development through community conversations at the local level showed evidence of changes in knowledge, attitudes and practices of community leaders in the fight against HIV/AIDS and poverty. By building grassroots capacity for social action, UNDP is helping put in place the building blocks of a more effective national response to HIV/AIDS.

Mainstreaming: Despite efforts by the UNDP (albeit limited at the national level) and other stakeholders in the country, the mainstreaming of HIV/AIDS in government had yet to be realized. While there has been a shift from a bio-medical approach to addressing HIV/AIDS to a multi-sectoral response, mainstreaming of HIV/AIDS was not pervasive at the national level as key institutions continued to undertake discrete yet profound programming and interventions.

At the sub-national levels, there was an increased understanding of the need to mainstream HIV/AIDS by key development planners at the provincial and local levels, with a few councils beginning to mainstream HIV/AIDS into their Integrated Development Plans. The development change was associated in part UNDP support at the sub-national levels, combining different programming instruments and thematic programmes with an effort in mainstreaming in the three priority provinces.

UNDP's programming has resulted in innovations, for example, workplace HIV/AIDS support of people living with HIV/AIDS. Yet, at the time of the evaluation these innovations, which seemed to work well in the HIV/AIDS programmes, were not being shared with other programmes within UNDP itself. Also, innovations and capacities in the other programmes were not embraced or shared by the HIV/AIDS interventions. This weakness in synergy among UNDP's programmes limited UNDP's impact on developmental conditions relating to HIV/AIDS in the provinces where UNDP provided support.

Partnership coordination for country results: The Government of South Africa's strong role in determining HIV/AIDS policy and programming, allocating substantial domestic resources, and directing

donors to areas commensurate with their comparative advantages has had the following impact on UNDP South Africa: limited convening role in coordinating donor activities to address HIV/AIDS in the country; and reduced leadership for providing intellectual content for HIV/AIDS programming and priority setting, compared to other case-study countries.

At the time of the evaluation, the Department of Health was central to the national response to HIV/AIDS, both as host of a nominal National AIDS Council and as the institution responsible for mobilizing and allocating resources for the national response. The UNDP Country Office worked closely with the department, but greater engagement of other departments was needed. The apparent diplomatic hiatus of UNDP vis-à-vis the Government of South Africa created a general paralysis at the Country Office and an inability to act in the role normally occupied by UNDP as convener, partnership broker and facilitator for development assistance. Mechanisms of interface between community demand and government resource allocation were still in their infancy, and resources earmarked for accelerated development, including some for HIV/AIDS were therefore not being disbursed fast enough to meet the huge needs. Greater potential seemed to exist for harmonization at the provincial, local government and community levels, but this needed an “honest and neutral broker” such as UNDP.

6.8 SWAZILAND

6.8.1 Methodology

The assessment was performed by a national consultant who reviewed available documentation and used semi-structured interview guides to conduct key informant interviews and group discussions. Informants included UNDP staff and other participants and stakeholders in UNDP activities at community and higher levels. An international consultant assigned to the study gave feedback on drafts and specific queries.

6.8.2 Context

Swaziland is a small country with a population of approximately 930,000 in the late 1990s. It is classified as a middle income country but has been challenged by slowing economic growth and large budget deficits that severely constrain the government’s ability to increase spending. Approximately two-thirds of the population live below the poverty line. The country’s 2004 Human Development Index

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UNDP can be particularly influential in achieving outcomes in countries such as Swaziland that are small and have limited capacity and limited development partner support. UNDP experience in Swaziland points to several important issues:

- UNDP has comparative advantages of strong relationships with the government and close involvement with national planning processes.
- There is a need to develop stronger strategies to ensure consolidation of various interventions, increase national ownership and deal with other requirements for sustainability and scaling up of interventions and outcomes.
- Support for high-level planning without follow-up at the implementation and operational level can limit potential for outcomes and impact.
- UNDP Swaziland may have been responsive to immediate priorities and country context, but the wide spread of UNDP activities raises questions of whether, in the longer term, all the interventions build on UNDP’s main comparative advantages and allow for strategic consolidation and optimal use of resources.
- Limited UNDP capacity and resources along with Country Office staff turnover were significant constraints on results, particularly in an environment where few other donor and government resources can be leveraged.

In the future, UNDP should:

- Formulate and communicate an updated UNDP country HIV/AIDS strategy giving greater urgency to the issue and drawing upon the relatively large UN presence in the country.
- Consolidate and integrate activities and interventions, and give greater attention to moving from ideas to action and consistent follow-through and implementation.
- Review and strengthen Country Office capacity to support HIV/AIDS actions.
- Give increasing attention to mobilizing and facilitating use of funds from other external partners.

rank was 137—a decrease from the early 1990s ranking due to HIV/AIDS and economic stagnation. Approximately 75 percent of the population lives in rural areas and recent droughts have necessitated large scale food aid. Controversial national governance and limited human resources in key sectors are other major challenges.

Swaziland has the highest rate of HIV/AIDS prevalence in the world. Levels among pregnant

women were higher than 42 percent in 2004, and more than 220,000 Swazis were living with HIV/AIDS. The number of orphans was approximately 60,000, and was projected to rise to about 120,000 by 2010. Effects of HIV/AIDS are being felt throughout society.

Government responses to HIV/AIDS started in the 1980s. Major changes have occurred since King Mswati III declared HIV/AIDS a national disaster in 1999. The National Emergency Response Committee on HIV/AIDS (NERCHA) was formed in 2000 to coordinate all HIV/AIDS activities and resource mobilization for a multi-sectoral response. The National Strategic Plan 2000-2005 covers a range of prevention, care and impact mitigation components. Swaziland has begun to roll out antiretroviral therapy (ART). About 6,000 people were on free ART in late 2004. Government expenditure on education and health has increased dramatically since 2004, in large part to cater to orphans and people living with HIV/AIDS (PLWHA). HIV/AIDS workplace programmes have been started in all government ministries, and sectors are required to mainstream HIV/AIDS in their programmes and budgets. The Poverty Reduction Strategy was expected to mainstream HIV/AIDS in various components. Non-governmental organizations (NGOs) have also been prominent in the national response.

Development partner support to Swaziland has been limited by the country's size, middle income status and concerns about its governance record. The limited number of bilateral agencies that are involved tend to have regional rather than country programmes. UN agencies therefore have a relatively large profile. The UNCT Theme Group on HIV/AIDS support aimed at capacity development and institutional strengthening of government, local authorities, NGOs, community based organizations, private sector and organizations for PLWHA. Current funding sources include the Global Fund, World Bank, UK Department for International Development, EU, Italy, USA, Germany and China.

6.8.3 UNDP response

UNDP assistance has transitioned from traditional development issues to focusing on HIV/AIDS since it was declared a national disaster. UNDP HIV/AIDS activities had a budget of USD 370,000 for the period 2003-2004.

UNDP has provided support in a range of areas during the period under review. A major focus has been synergistic initiatives under the Leadership for Results Programme since 2003. This has included leadership development programmes (LDPs) for national and lower levels of government and civil society partners, as well as community capacity enhancement through community conversations to develop participatory mechanisms to decentralize the response to HIV/AIDS.

Building on its relationship with government planners and policy makers, UNDP has promoted HIV/AIDS-responsive policy dialogue in relation to national development planning and in specific sectors. Other related initiatives have included three sectoral HIV/AIDS impact studies, and establishment of an inclusive Human Development Forum for policy dialogue around governance and poverty reduction. The government has also been assisted through technical and other support to strengthen institutional capacity to plan and implement multi-sectoral strategies on HIV/AIDS and strengthen skills at national and local level for mainstreaming HIV/AIDS.

UNDP has promoted sound perspectives on human rights, discrimination against PLWHA and gender in all aspects of the national response including legislation, policy, research and community initiatives. UNDP interventions have supported a range of NGOs and community based organizations including women's groups, churches, youth NGOs and organizations of PLWHA, as well as specific local and national government partners.

UNDP activities around HIV/AIDS have included: resource mobilization through organization of Thematic Round Tables; joint projects with other UN agencies including a joint UN/UNIFIP project targeting adolescents and strengthening voluntary counselling and testing; contributions to development of a national communication strategy on HIV/AIDS; piloting use of digital villages for access to information on HIV/AIDS; facilitating access to "e-pap" (fortified maize meal); and income generation through a mushroom growing project initiated with government in 2000.

More recent UNDP initiatives have included support to NERCHA to develop multi-sectoral policy and strategy on HIV/AIDS, and the 2004 Swaziland Capacity Initiative to assist the government and its

key partners to respond to human and institutional capacity erosion.

6.8.3.1 Outcomes associated with UNDP response

Governance: UNDP advocacy, policy and planning inputs, and policy dialogue were seen as important to a more receptive environment for multi-sectoral policy development and planning in response to the epidemic. In national planning processes, including the National Development Plan and Poverty Reduction Strategy, UNDP markedly improved integration of HIV/AIDS, Millennium Development Goals and United Nations General Assembly Special Session. However, at the time of the evaluation, it was uncertain how efficiently the plans would translate into action on HIV/AIDS. UNDP seemed to have missed opportunities to translate strategies into actionable operational plans, particularly in the National Strategic Plan on HIV/AIDS.

Information provided by impact studies and the Human Development Report were reported to have strengthened awareness of the policy, planning and managerial implications of HIV/AIDS, and support for sound responses. Some of the studies have contributed to subsequent specific actions including mainstreaming by the public service and other ministries. However, there was some difficulty in implementing responses to such awareness.

UNDP advocacy, research, policy support and training, and the 2003 report on culture and HIV/AIDS were specifically noted to have resulted in greater prominence of gender issues in HIV/AIDS responses. Involvement and empowerment of women (and men, who had previously not engaged HIV/AIDS) was also seen as an important outcome in communities targeted by community conversations.

Support to the Swaziland organizations of PLWHA and other support groups, along with interventions around workplace policies, the private sector and the community level, have helped reduce stigma, and increase recognition of rights and involvement of PLWHA. Engagement with journalists and editors has also improved media involvement. UNDP assistance has also helped to enhance NERCHA's credibility and ability to coordinate the national multi-sectoral response, although limitations still to exist, including a need to strengthen coordination with the Ministry of Health and Social Welfare.

Leadership: The LDP has led to changes and action by trainees from the government, traditional leadership, civil society and the private sector. A number of striking initiatives by individuals have arisen from the LDP and the potential "reach" of the interventions was substantial. More than 70 percent of local chiefs have been reached by the intervention, for example. Nevertheless, it was difficult to assess whether leadership breakthroughs have added up to a significant scale or depth of impact, or how sustainable leadership outcomes tend to be.

The Human Development Forum convened by UNDP also seems to have enhanced leadership for influencing critical policies and responses within government, organizations, the private sector and communities. While there was an indication of UNDP facilitation of stronger leadership by national level politicians and officials in Swaziland, as evidenced by several policies and political pronouncements, further details about UNDP roles in this were not provided.

Capacity development: Capacity for Swaziland's HIV/AIDS response has been strengthened substantially through UNDP programmes. At the national level, LDP has developed individuals' leadership skills and attitudes and initiated institutional changes that have enhanced HIV/AIDS responses within national ministries. UNDP also had a role in strengthening NERCHA's organizational development and capacity for coordination, mobilization of resources and policy development.

At more decentralized levels, LDP has led to substantial development of capacity in targeted districts and communities. There are many reports of changes in capacity, competencies and actions in organizations, traditional leadership and communities targeted by the programme. However, the proportion of LDP trainees who have gone on to use their skills, and the scale of outcomes could not be established.

Community conversations have proven to be another powerful method for generating capacity at the local level. They have stimulated youth involvement and led to formation of youth groups and greater openness. There were also reports of increased uptake of voluntary counseling and testing, treatment for sexually transmitted disease, and condom use, although data to establish scale and association with UNDP were not available.

UNDP also achieved results in building capacity of civil society organizations. Involvement in LDP and community conversations, as well as other support, has helped to stimulate NGO and other civil society activity on HIV/AIDS, as well as enhance organizations' leadership and delivery capacity. A more strategic, holistic response to HIV/AIDS has been facilitated through UNDP support to a well-placed network of NGOs, as well as through direct support and specific engagements to enhance activities and networking of role players at national and other levels.

A notable feature of UNDP interventions has been strengthening organization and involvement of PLWHA both at national level and at the local level, where community conversations have built PLWHA involvement and strengthened support.

However, UNDP missed opportunities to support human resources planning, management and development in follow up to impact studies which highlighted human resource challenges presented by HIV/AIDS in Swaziland.

Mainstreaming: UNDP supported planning, research and other processes that have facilitated more focused mainstreaming of HIV/AIDS by government ministries. Leadership training helped clarify roles of different sectors and reports of individual initiatives to address AIDS within sectors were given. UNDP roles in development of the NDS, Poverty Reduction Strategy, and other poverty and planning have helped mainstream HIV/AIDS into development planning. However, it was not yet clear, at the time of the evaluation, whether HIV/AIDS had been integrated adequately and how far plans would be translated into effective mainstreaming.

UNDP has also facilitated establishment of workplace responses in government sectors, through its impact studies, support for development of policy and manuals, and through initiatives of leadership trainees. Although focal points have been appointed in Ministries, progress in implementation has been slow. Further support might be necessary to ensure outcomes. It was also noted that LDP had helped to stimulate private sector initiatives to address HIV/AIDS, both in the workplace and as part of broader corporate social responsibility. However, resource constraints had undermined effectiveness of the UN's We Care workplace programme, and the arts and media response.

Imaginative efforts to mainstream HIV/AIDS into Information and Communication Technology programmes have occurred, but there was no substantial indication that these had been effective.

Partnership coordination for country results: UNDP leadership through the Round Table, the UN Country Team, and the UN Theme Group on HIV/AIDS made a difference to inter-agency synergy, especially with bilateral donors. In addition, UNDP collaborated with other agencies on a number of other projects that have benefited from UNDP input and have achieved some successes. However, it could not be ascertained whether these represented the most strategic use of UNDP resources.

The Human Development Forum has also contributed to better coordination and networking of stakeholders from government, civil society, the private sector and other constituencies. At local level, there were further examples of UNDP initiatives leading to effective partnerships.

6.9 ZAMBIA

6.9.1 Methodology

The Zambian assessment was undertaken by a national consultant who was joined for five days in November 2004 by international consultants to consolidate data collection and validation. Data collection used document review and interviews of beneficiaries, donors and government officials, using prepared schedules, as well as field visits to the Southern and North-West provinces. A validation workshop helped with triangulation.

6.9.2 Context

Zambia confronts HIV/AIDS in a context of serious development challenges, including limited economic growth and weak institutions. Poverty levels are at approximately 80 percent in rural areas and 53 percent in urban areas. The country's Human Development Index ranking in 2004 was 164, having declined since the mid 1980s due to economic stagnation and the effects of HIV/AIDS on life expectancy.

Zambia has a mature HIV/AIDS epidemic. Adult population HIV/AIDS prevalence was estimated at 16 percent by the 2001-2002 demographic and health survey (DHS). Infection rates may have stabilized and even begun to decline. Levels are substantially higher in women than in men, and urban adult prevalence was estimated at 22 percent compared

Strategic Issues and Key Implications of Main Report for UNDP Action in Zambia

The Zambian case study suggests several strategic issues of broad relevance:

- UNDP has the advantage of strong relationships with government, but opportunities have been missed to use these relationships to enhance HIV/AIDS responses and to mainstream HIV/AIDS.
- Zambian experience shows that UNDP can play an important role through its ability strategically and rapidly target key gaps in country responses, such as the need to strengthen the decentralized response to HIV/AIDS, an area which often remains under-supported by other partners.
- Coordination with the World Bank and other partners can enable UNDP to leverage its resources and interventions to enhance overall impact at country level.
- Strategic use of national UN Volunteers (UNVs) is a particular comparative advantage of UNDP. In the Zambian experience there

are opportunities to strengthen outcomes and sustainability by developing more holistic, better resourced approaches to UNV programmes.

- UNDP has an advantage of flexibility to provide resources and support in response to a range of needs, but this can create risks of thinly spread resources and apparent or real lack of strategy. It also risks limiting consolidation and sustainability of particular initiatives.
- UNDP's ability to be an efficient, reliable funder of civil society organizations (CSOs) needs to be reviewed and strengthened if CSO support is to be a major feature of future programmes.
- UNDP's partnership coordination and leadership role needs to be clarified at the country level, considering country context and emerging roles of UNAIDS. UNDP can also benefit from improved communication.

In the future, in Zambia UNDP should:

- Consolidate and build on past successes, especially at the district level, in an updated UNDP country HIV/AIDS strategy that gives greater urgency to HIV/AIDS and draws upon UNDP's strong relations with the government for greater impact.
- Increase focus on capacity development for the National HIV/AIDS Council and other core agencies, and review UNDP Country Office capacity for HIV/AIDS activities.
- Give greater attention to partnerships, especially with UNAIDS and the World Bank, to facilitate effective use of the significant increases in external resources flowing from other partners.
- Support more effort on prioritization, monitoring, evaluation, sustainability, and knowledge-sharing.
- Consider increasing Country Office support to achieve optimal results, as its capacity for HIV/AIDS work has often been stretched.

11 percent in rural areas. An estimated 700,000 Zambian children have lost parents to AIDS.

Zambia established an HIV/AIDS Programme in the Ministry of Health in 1986 and produced a series of Medium Term Plans for HIV/AIDS. The National HIV/AIDS Council (NAC) and a Secretariat were established in 2000 outside the Ministry of Health. The NAC, the draft HIV/AIDS National Policy, and the National HIV/AIDS/STI/TB Intervention Strategic Plan 2002-2005 reflect an increasingly multi-sectoral approach to HIV/AIDS. Antiretroviral therapy (ART) has become a high profile component of the response since 2003. Increasing government commitment was shown by active, high-level political leadership, national budget allocations for ART, development of workplace programmes, and other responses in ministries since 2003. The NAC has had very limited effectiveness. At the time of the evaluation, more attention was being given to strengthening coordination, monitoring and evaluation, and to the decentralized HIV/AIDS structures formed in 2002. Civil society has been an

important role player in the HIV/AIDS response. Prominence is being given to strengthening the private sector response.

A large number of bilateral and multilateral development partners have devoted high levels of resources to HIV/AIDS in Zambia. Large scale resources have been made available in recent years by the Global Fund, World Bank and PEPFAR. Many donors have supported vertical programmes, and the government has tried to discourage this to improve coordination and equity. UNDP has been a notable exception due to its emphasis on responding to priorities defined by the government. UNDAF strategies on HIV/AIDS include a focus on supporting development of a national multi-sectoral HIV/AIDS coordinating mechanism; mainstreaming and capacity development in line ministries; a national response that covers youth, stigma and discrimination, rights for women and orphans; and information, education, and counseling and support for care.

6.9.3 UNDP response

Prior to 2000, UNDP supported home based care

and sex worker interventions. Since then, UNDP's HIV/AIDS programme has targeted key structures and organizations with a set of catalytic interventions. It has emphasized approaches that are participatory, "bottom-up", rights-based, and recognize the roles of gender and poverty. UNDP has supported:

- Developing capacity of coordinating institutions at provincial and district level
- Strengthening community based structures at village level
- Developing the capacity of the national coordinating mechanism, the NAC
- Strengthening responses of the private sector and civil society, including people living with HIV/AIDS (PLWHA) organizations, advocates for orphans and faith based organizations
- Strengthening ministries through the provision of expert UNVs to assist focal point persons
- Support for advocacy and research related to Behavior Change Communication, care and support, voluntary counseling and testing, rights-based approaches, and strengthening political support for the national response.

The share of the UNDP Country Office budget for HIV/AIDS has increased from 4 percent to 35 percent since 2000, with funds largely diverted from an agriculture programme where UNDP's role had become redundant. Nevertheless, UNDP resources remain small compared to those of many other donor programmes. UNDP has tried to focus on gaps that have been neglected by others and that have potential to leverage other resources. UNDP has played a central role in the UN system workplace programme. The Regional Center has been very actively engaged in Zambia.

6.9.3.1 Outcomes associated with UNDP response

Governance: UNDP support has been influential in helping NAC function and develop a clearer idea of its role in the multi-sectoral response. UNDP has also played a key role in a strategic shift in understanding of benefits of decentralized HIV/AIDS programme planning and management and how to achieve it. Its support to decentralized planning processes and capacity development have been central to developing and strengthening new institutional arrangements at district and provincial levels, including mechanisms for community involvement. Citizen demands for services and rights related to HIV/AIDS are increasingly represented in district workplans. Nevertheless, action has been

hampered by limited linkages of HIV/AIDS structures and processes to the local government system, including formalization of accountability and authority. This may be an emerging opportunity for UNDP to use its governance expertise for increasing results at district level.

Support to the National Network of Zambian People Living with HIV/AIDS (NZP+) and strong involvement of PLWHA's in district AIDS planning task forces (DATFs) have helped to enhance PLWHA rights, visibility and influence in planning and programmes. Support for other NGOs has also enhanced recognition of rights of other vulnerable groups such as workers and orphans. UNDP also had a role in creating greater awareness of multi-sectoral HIV/AIDS issues, and role clarity in relation to Millennium Development Goals (MDG), through advocacy and support of the MDG review and Demographic and Health Surveys DHS.

Leadership: UNDP has had a key role in mobilizing leadership, including traditional leaders, at decentralized levels though training, community mobilization, advocacy campaigns and other support. Results are reported mainly in the pilot North West province, but at the time of the evaluation, it appeared that learning could be leveraged to other provinces and districts. NGOs supported by UNDP such as NZP+ and KKCF have also provided leadership in advocacy and representation of vulnerable groups, although the degree to which this was directly associated with UNDP support could not be ascertained.

Capacity development: UNDP supported NAC capacity development at a stage when the NAC was new and support from other donors was limited. UNDP contributed a major proportion of NAC core funding and supported key running costs, project funding, and technical assistance. Although NAC functionality has remained severely limited, other donors have increased support to it. The NAC might have collapsed completely without UNDP support in the interim.

Positive outcomes are widely reported in relation to UNDP capacity development at the district level, primarily through contributing national UNVs and through training, assistance in planning, and resources for information communication and technology and transport. There have been increases in action at decentralized levels, existence of plans,

increased funding flows to HIV/AIDS projects at the community level and government requests for roll-out to all districts. UNDP's role is central to these successes, and its support has strong potential for achieving results at scale due to recent roll-out of UNV support to 69 of Zambia's 72 districts, and synergy with the World Bank's CRAIDS and DCI support at provincial level.

Questions were raised about the sustainability of UNV-dependent capacity development initiatives, and the need for a more holistic approach to supporting them if they are to be effective. However, the immediate benefits of the UNVs were substantial and, while these concerns are real, they should not hold up deployment of UNVs.

UNDP also added to capacity development in civil society, with support to organizations and particular activities such as training that have strengthened organizations such as NZP+. However, there were perceptions that UNDP can be an unreliable and inefficient funder of civil society organizations, with negative implications for effectiveness and sustainability of its efforts.

UNDP also contributed to strategic information related to the MDG evaluation and Poverty Reduction Strategy Paper (PRSP) that has been used in policy. However, it was uncertain how effective the Human Development Report had been at country level.

Mainstreaming: UNDP helped to facilitate a shift in perception towards seeing HIV/AIDS as a development and multi-sectoral issue at national and district level. This has, to varying extents, been translated into plans and actions. UNDP support in the PRSP, Transitional National Development Plan and economic governance facilitated inclusion of HIV/AIDS in these plans. However, while HIV/AIDS is mentioned in plans as a cross cutting issue, there is little integration into all relevant components of plans, and a medical bias was noted in PRSP HIV/AIDS sections.

Extensive Regional Programme support has been given to mainstreaming training in ministries and lower levels of government. UNDP also facilitated decisions to allocate national budgets to HIV/AIDS and promote responses within ministries. Mainstreaming initiatives have also occurred in several Ministries, but the impact of these changes

and how much progress could be attributed to UNDP could not be determined at the time of the evaluation.

UNDP was widely considered to have enhanced mainstreaming and multi-sectoral involvement in HIV/AIDS at the district and local level through training, tools and other support. At the time of the evaluation there was a need to consolidate this.

UNDP support for NZP+ and the Zambian Business Coalition had positive outcomes in raising and sustaining awareness of workplace HIV/AIDS issues, including infected workers' rights. However it could not be ascertained that UNDP support had led to other, effective action in workplace programme development.

No significant mainstreaming of HIV/AIDS into other UNDP programmes in governance, environment and economy was noted. However, district level outcomes seemed to be attributable at least in part to leveraging experience of UNDP's decentralization support programme.

Partnership coordination for country results: A prominent outcome of UNDP programmes at the district level has been effective mobilization and leveraging of other donor resources, particularly through coordination with CRAIDS and DCI. However a number of important potential partners knew little about UNDP initiatives, and opportunities for stronger coordination have been missed through limited communication. UNDP was well engaged in the donor harmonization dialogue but was unable to join in pooling funds.

The UNDP Resident Coordinator, Assistant Resident Representative and Programme Advisor have played technical and other leadership and coordination roles within the UN family, as well as through participation and coordination roles within the Expanded Theme Group and its technical committees. Smaller UN agencies, in particular, appreciated UNDP coordination, facilitation and support roles and highlighted the benefits of a technically strong programme advisor. However, it was not possible to form an opinion of how strong UNDP coordination and leadership roles had been overall. UNAIDS appeared to be assuming an increasing role in coordination, and some felt that UNDP had missed opportunities to assist the government and donors in defining HIV/AIDS strategic priorities more clearly.

6.10 ZIMBABWE

6.10.1 Methodology

The Zimbabwe country assessment was undertaken by a national consultant in late 2004. It was based on documentary evidence, extensive interviews using specially designed interview guides, one focus group discussion, a case study of a health district, and a validation workshop to complete the triangulation. No member of the international consultant team visited Zimbabwe in connection with the country assessment.

6.10.2 Context

During this evaluation period, the macroeconomic environment in Zimbabwe continuously deteriorated, causing the fastest-ever decline in the economy. An estimated 60 percent of the population lives below the poverty line. A worsening budget deficit, growing at 9 percent per year, has triggered an inflationary spiral. Capacity to provide social services declined at all levels, and socio-political tensions have risen. Bilateral development partners and the Bretton Woods Institutions ceased new commitments, but UN agencies continued to operate in the country.

Patriarchy and gerontocracy characterize Zimbabwe's population of 11 million. Poverty and the dynamics of cultural change have contributed to a weakening of traditional community structures, especially in urban areas. The HIV/AIDS epidemic has put them under further strain. Adult HIV prevalence was estimated at 24.6 percent in 2003; it was previously estimated at 34 percent in 2002 based on different methodology. The number of annual AIDS deaths rose from approximately 12,000 in 1988 to a staggering 177,000 in 2003.

The Zimbabwean leadership has shown some commitment to addressing HIV/AIDS, as reflected in adoption of a National AIDS Policy; enactment of an AIDS levy; selecting Millennium Development Goal (MDG) six, on disease reduction, as an area of focus; endorsement of international instruments and declarations such as the UNGASS Declaration of Commitment; and support to projects with people living with HIV/AIDS (PLWHA). HIV/AIDS is now reported to be on the agendas of many leaders, including government officials, civil service managers, religious leaders, and political parties. The government has declared the epidemic a national disaster. Nonetheless, the government's response has not matched its statements. Despite public pronouncements, a lack of openness about leaders who die of

Strategic Issues and Key Implications of Main Report for UNDP Action in Zimbabwe

The Zimbabwe case study suggests several strategic issues of broad relevance:

- Capacity retention, where capacity has been developed, is a major problem. UNDP, like other partners, has had great difficulty, at least in Zimbabwe, in effecting change in the environment that is such a critical factor in capacity retention. It was not clear whether UNDP has tried to stimulate such change.
- UNDP merits strong recognition for sustaining its cooperation in Zimbabwe in extremely difficult conditions. Yet, the Zimbabwe case poses a fundamental strategic issue for UNDP, namely the extent to which it can and should devote scarce human and financial resources to a country, or even to an issue within the country, that is critical to any concept of its long-term future, such as HIV/AIDS, when capacity utilization and retention are so negatively affected by the social and economic environment.
- The sustainability of the accomplishments of UNDP on HIV/AIDS in Zimbabwe is a serious issue. At its most extreme, the Zimbabwe situation illustrates a conflict between UNDP's humanitarian and development missions.
- Relations between UNAIDS and UNDP were found to merit senior management attention. Zimbabwe was not the only country where this issue has surfaced.

In the future, UNDP should:

- Formulate and communicate an updated UNDP country HIV/AIDS strategy with greater emphasis on the issue in the work of UNDP; this should help the government to move increasingly from words to action and implementation.
- Encourage the government to give greater attention to HIV/AIDS as a development issue and adopt a more assertive posture with the public authorities with greater attention to civil society organizations and to capacity retention.
- Clarify roles and resolve misunderstandings with UNAIDS, with support from UNDP Headquarters as needed.
- Focus more on the UNDP integrating and leadership roles, and on the monitoring, evaluation and sustainability of interventions in a difficult environment.

AIDS indicates continuing denial and stigma. Advocacy was reported to be minimal.

The National AIDS Council (NAC) operates under the Ministry of Health and Child Welfare (MOHCW)

and is considered to be stuck largely in a biomedical model. Its location under the MOHCW reduces its autonomy and the effectiveness of its work of coordinating the response of many entities. Staff departures for better opportunities elsewhere have also weakened the NAC. The NAC manages the HIV/AIDS levy resources. Upward, participatory annual planning takes place at district and provincial levels, and increasing protection of PLWHA was reported at local levels, with PLWHA members of local multisectoral district AIDS action committees. Civil society organizations play a crucial and increasing role in fighting AIDS, both nationally, through parliamentary action, and locally. Nonetheless, they have weak leadership and often to face difficulties mainstreaming AIDS into their work.

6.10.3 UNDP response

UNDP has been heavily engaged in HIV/AIDS in Zimbabwe, though perhaps somewhat belatedly. Stand-alone intervention began in 2000. UNDP supported strategy development and advocacy at both the national and local levels. UNDP mainstreamed HIV/AIDS into its projects outside the health sector and in the UNDP workplace. It produced a draft HIV/AIDS policy for the public service, assisted with the establishment of an HIV/AIDS Coordination Unit to oversee implementation, and carried out training workshops to develop action plans and workplace programmes for each major agency. It also supported integration of HIV/AIDS into macroeconomic models used by the Ministry of Finance. The UNDP South African Capacity Initiative (SACI) project has supported the MOHCW in training of a new primary care counseling cadre and mapping of the health system capacity for scaling up antiretroviral therapy (ART). It assisted the Zimbabwe Business Council on HIV/AIDS to develop competencies to assess HIV/AIDS impact on business performance. With UNDP support, the Zimbabwe Human Development Report 2003 focused on HIV/AIDS, under the title "Towards Reducing Vulnerability – the Ultimate War for Survival."

During the period of this evaluation, UNDP annual spending on HIV/AIDS in Zimbabwe has fluctuated greatly— from as low as USD 41,000 and 2 percent of the total programme in the year 2000, to USD 1,387,000 and 31 percent of the programme in 2001. In 2004, spending was USD 2,227,000 and 22 percent of the programme. While Country Office

capacity was limited, the UNDP Country Office in Zimbabwe was unique among those in case-study countries to have initiated outcome evaluation.

6.10.3.1 Outcomes associated with UNDP response

Governance: UNDP project support has directly contributed to the strengthening of national governance institutions concerned with HIV/AIDS through adoption of appropriate laws and policies, including the National AIDS Policy, National Gender Policy, Legal Age of Majority Act, acceptance of the UNGASS Declaration, and the choice of the government to focus on the MDG goals of poverty, gender and HIV/AIDS. UNDP support to parliamentary information centers, including training of Members of Parliament (MP), is thought to have helped inform MPs and help civil society hold them accountable. However, there is an inherent tension in this area in Zimbabwe, as UNDP has promoted civil society partnership but new NGO legislation has polarized government-civil society relations. While UNDP supported the NAC, it appeared not to have intervened in the issue of the location of the NAC in the MOHCW – a source of weakness in UNDP's work and of tensions among government stakeholders concerned. This represents a missed opportunity to reflect Government of Zimbabwe acceptance that HIV/AIDS is not only a health issue but also a multi-sectoral development issue. Increasing protection of the rights of PLWHA prevails at the district level, thanks to UNDP project support. PLWHA were reported to participate in district and ward AIDS committees. Successful decentralization of the NAC is directly attributable to UNDP project support. Government capacity to budget for HIV/AIDS remains low. The establishment of the Partnerships Forum in 2003 to promote scaling up ART was an important accomplishment, but the weak leadership of most civil society organizations/NGOs led to difficulty in mainstreaming HIV/AIDS in their work.

Leadership: There is increased commitment by Zimbabwean leaders at all levels to an effective HIV/AIDS response. How firm this commitment is remains to be determined, through much-needed surveys, as a result of the lack of openness about the causes of death of AIDS patients, particularly those of low social status. The gradual engagement of MPs in HIV/AIDS issues is an important accomplishment of UNDP leadership.

Capacity development: UNDP has made important contributions to the greater awareness of HIV/AIDS in Zimbabwe. Its Zimbabwe Human Development Report (ZHDR) was particularly important in this respect, and has been widely praised, though irresponsible reporting in the media--mentioned in the ZHDR--has contributed to, rather than reduced, HIV/AIDS stigmatization. Further training of journalists to report on HIV/AIDS in Zimbabwe is needed. A positive capacity development by-product of the contracts concluded by UNDP with local researchers for the ZHDR and macroeconomic analyses with the Ministry of Finance has been their engagement in work in other countries. District-level responses were strengthened, but the extent of the strengthening was not clear, particularly since confusion and duplication of roles were reported between district and ward AIDS committees. UNDP concentrated its support in the public sector and paid relatively little attention to NGOs at a time when they were assuming increasing importance as providers of social services.

Mainstreaming: UNDP supported mainstreaming in ministries, UNDP projects, and in the UNDP workplace. The We Care Programme encouraged action on HIV/AIDS in the UNDP workplace, but needs scaling-up and encouragement of staff to reveal their HIV status. Increased private sector involvement in HIV/AIDS was reported, with UNDP financing of business leader training in a workshop. UNDP has also initiated some limited partnerships with civil society organizations in the Zimbabwe AIDS Network (ZAN), in connection with the ZHDR. UNDP support to macroeconomic modeling produced a government economic policy

package for 2005-2006 integrating HIV/AIDS as a factor. UNDP's work in this area is widely hailed as a success, and with the withdrawal of the Bretton Woods Institutions, it would have been difficult to find a donor to fund macro work if UNDP had not done so. Despite the progress, there are significant gaps between government pronouncements on mainstreaming and other HIV/AIDS issues and the reality of daily life in the country, and between HIV/AIDS awareness and knowledge of specific prevention techniques and the provision of support and treatment. Such gaps represent formidable challenges to all stakeholders.

Partnership coordination for country results: UNDP Zimbabwe has given greater attention to implementation than to UNDP's coordination role. However monitoring and evaluation has been weak; the Country Office staff should be trained on outcome indicators and monitoring and evaluation. Misunderstandings reaching the level of reported "animosity" between UNAIDS and UNDP are disturbing. UNAIDS was reported to criticize the work of UNDP in Zimbabwe and to allege that the level of UNDP funding shows that UNDP is not a major player in AIDS work. UNAIDS has taken exception to an approach in the ZHDR described as "scaring people." There is a need to resolve these issues before they damage the image of the UN family. Coordination was strengthened when the UNDP Resident Representative assumed the chair of the HIV/AIDS Theme Group. UNDP had an important resource mobilization success in Zimbabwe, with its role as Principal Recipient after the long-delayed signature of the Global Fund Round One grant to Zimbabwe.

ANNEX 7. SYNTHESIS OF GLOBAL POLICY INTERVIEWS

As part of the evaluation, the international consultant team undertook semi-structured, confidential and off-the-record global policy interviews with a panel of 22 key informants. All interviewees were asked to express personal, professional views, rather than institutional perspectives. Most of the interviews were conducted in person; some were conducted by phone. Notes were taken during the interviews, written up and thereafter distributed to members of the international consultant team. The interview results were taken into account in the main text of the report. This annex provides information on the interviewees and contains an overall synthesis of their observations.

POPULATION OF KEY INFORMANTS AT THE GLOBAL POLICY LEVEL

Nine of the interviewees were UNDP staff; 13 were from outside UNDP. Fifteen were from UN agencies; seven were from outside the UN system. UNDP's major partner institutions in UNAIDS were represented among the interviewees including UNAIDS, WHO (Headquarters and WHO/AFRO), UNICEF, UNFPA and the World Bank. Even those interviewees from outside the UN system were deeply engaged in HIV/AIDS work through work with the Global Fund to Fight AIDS, TB, and Malaria; the World Bank;¹ and bilateral donors. Several of the interviewees had observed UNDP's HIV/AIDS activities from the perspective of working on HIV/AIDS in different organizations. The major 3 HIV/AIDS financiers in the 10 case-study countries—the Global Fund, PEPFAR and the World Bank—all had key informants among the panel of interviewees. No non governmental organization (NGO) or foundation personnel were included among the global interviewees, on the grounds of limited familiarity with UNDP's work on HIV/AIDS at the country level. The interviewees are listed in Annex 8.

AWARENESS OF UNDP'S WORK ON HIV/AIDS

Aside from its overall role at the country level within the UN system, UNDP and its work on HIV/AIDS were poorly known. As one interviewee commented,

¹ Formally, the World Bank is a UN specialized agency. It is also a sponsor of UNAIDS. However, for the purposes of the evaluation it is considered to be outside the UN system because its work, working methods, and country representation differ greatly from those of other UN agencies.

UNDP “has been invisible” on HIV/AIDS. External informants, and sometimes even UNDP staff, found it difficult to identify specific positive, or negative, AIDS-related outcomes in the case-study countries with which UNDP has been associated. While many informants responded thoughtfully, it was only with difficulty that they addressed a question about the counterfactual of no UNDP engagement on HIV/AIDS—a manifestation of limited knowledge of UNDP's work on HIV/AIDS. It also suggests a problem of defining and communicating UNDP's role(s) on HIV/AIDS in the case-study countries. In addition, several observers interpreted the same information on country situations in dramatically different ways, which hints at the problem of adequately defining UNDP's roles and goals in relation to HIV/AIDS, particularly at the country level.

UNDP's comparative advantages on HIV/AIDS

Observers commented at length on UNDP's comparative advantages in addressing HIV/AIDS in the case-study countries. However, they sometimes failed to distinguish what they thought UNDP's comparative advantages actually are and what they considered UNDP's comparative advantages should be. There were some references to poor use by UNDP of its comparative advantages, particularly in relation to other UN agencies. Informants tended to think that UNDP's comparative advantages in addressing HIV/AIDS issues had changed over time and could be expected to change further in the future.

The main conceptions of UNDP's current comparative advantages on HIV/AIDS, listed in order of frequency and importance attached by the informants, were:

1. Service as coordinator and voice for the UN system and Country Team—This was the most widely remarked comparative advantage and a central theme throughout the interviews. One observer from outside the UN system commented that UNDP can and should bring other donors to the dialogue at the country level, even when those donors may be inclined not to participate and to operate outside it.
2. Ability to facilitate the effective involvement of other donors, particularly smaller UN agencies and those with financial resources but little field presence or knowledge of country situations—

Several commentators saw this role as particularly important in the future, with the growth in the Global Fund, PEPFAR, and World Bank MAP resources, where UNDP could assist countries to draw down their funds.

3. Service in building country capacity, particularly, as one interviewee put it, the ‘architecture of AIDS institutions’ at the country level and, as another interviewee observed, the capacity to manage external resources; AIDS impact on the workforce, and AIDS-linkages to civil service issues were also mentioned—Capacity building for implementation was a theme in several commentators’ views, and reference was made to an ‘implementation gap’ in UNDP AIDS work. However, the observations tended to be generic rather than linked specifically to HIV/AIDS and to the specific situations of individual case-study countries. Beyond generic reference to capacity building, one informant said that UNDP needs to address the question of ‘capacity for what?’
4. Ability to address and communicate AIDS as a development issue—This included mainstreaming HIV/AIDS issues into other sectors and helping partners in host countries as well as among bilateral donors move beyond narrow or—as one key informant expressed the problem so vividly ‘stovepipe’—approaches. UNDP support for national human development reports (NHDRs) and its work on the Millennium Development Goals (MDGs) were cited in this connection.
5. Closeness to country situations and contact with political, parliamentary and government leaders—This included references to UNDP’s ‘neutrality,’ its ‘objectivity,’ its work on policy and the policy environment, and (more generally but not universally) to trust in UNDP by host country leaders. UNDP’s capacity to convene and mobilize decision makers was cited.
6. Community action and capacity to work with the civil society—These were frequently evoked, including UNDP’s work with and for decentralized HIV/AIDS responses. Several commentators, however, suggested that UNDP was at a comparative disadvantage, relative to other partners, in working with the civil society and NGOs, and should focus on the public policy dimensions and the public sector response.

UNDP AND ITS DYNAMIC ENVIRONMENT

Most observers thought that UNDP must adapt to the changing institutional and financial landscape and environment for AIDS programmes in developing countries. A small number, in contrast, thought UNDP should not change in the face of a rapidly changing external environment. It was also observed by several commentators that it is extremely easy to be critical of UNDP on HIV/AIDS, as in other areas, because of the breadth of its areas of concern.² Several informants commented that the ‘Three Ones’ initiative of UNAIDS—for one national strategic framework, one national coordination institution for HIV/AIDS, and one single monitoring and evaluation framework—poses both threats as well as opportunities for UNDP. Those who commented on the matter found that the increasing tendency for UNAIDS to become operational posed role problem issues for UNDP.

A number of informants commented that UNDP was becoming financially much smaller, relative to other development partners. Giving greater emphasis in the work of country offices to the resource mobilization function was not necessarily thought to be an appropriate response to this problem. Partnerships, it was said, had been too loosely conceived, and UNDP needs to explain the concept and define expected partnership-specific results. Several observers considered UNDP a difficult partner, possibly because of the breadth of its concerns, and one spoke of UNDP having a ‘big mouth’ with more words than action.

STRATEGIC OUTCOMES OF UNDP’S ENGAGEMENT ON HIV/AIDS IN THE CASE-STUDY COUNTRIES

There was a fairly wide consensus among the interviewees that, in the absence of UNDP engagement on HIV/AIDS over the period of the evaluation and previously, there would be less awareness of the disease and less attention to it as a development issue to be mainstreamed into all development activity, both globally and at the level of individual developing countries. Similarly, it was thought that, without UNDP involvement, there would have been less attention to governance dimensions of HIV/AIDS. However, there were also a number of comments that

² This is also a common external complaint about the World Bank—an institution much more richly endowed with human and financial resources.

UNDP had been late engaging on HIV/AIDS at a deeper level. This may be a reflection of failure of the international community more generally. Many informants responded with difficulty to the question about the counterfactual of no UNDP engagement and found it hard to identify specific changes in relation to HIV/AIDS, globally or at the country level, with which UNDP could be said to have been associated. This is a manifestation of the phenomenon of poor knowledge and understanding of UNDP's work on HIV/AIDS.

Opportunities thought to have been *well exploited* by UNDP included: work with the Global Fund and (with somewhat less emphasis) other donors; work on awareness, advocacy and mainstreaming; and 'upstream' activities. Concerns were, however, expressed regarding UNDP exit strategies in its cooperation with other donors, and reference was made to a reputational risk to UNDP in its assumption of the role of Principal Recipient of the Global Fund. There were several references to the critical importance of building sustainable local capacity to manage and effectively and efficiently use external resources for HIV/AIDS programmes.

Opportunities thought to have been *missed* by UNDP included: delays in making the SACI project operational and, more generally, bureaucratic weaknesses and delays within UNDP itself; competition and tensions with other agencies, especially UNAIDS; and failure to scale-up success, as in the community conversations programme in Ethiopia, when other partners' funds were available.

Success factors thought to have contributed positively to UNDP's AIDS work cited by interviewees included: the central place of UNDP within the UN system at the country level; quality of the Resident Representative (RR)/Deputy RR; opening up the Theme Group beyond UN agencies; innovation, brainstorming, and addressing the underlying causes of HIV; confidence of client governments in their own their policies and programmes and in UNDP; taking a demand-based approach to HIV/AIDS services in response to the country situation; focusing on concrete, practical activities, such as costing of HIV/AIDS activities and programmes; and absence of donor competition.

Obstacles to effective UNDP AIDS engagement cited by interviewees included: use of jargon and a tendency

towards rhetoric and overstatement, as in 'transformational leadership' and 'breakthrough initiatives'; difficulty in moving from concept to implementation; lack of focus;—one informant spoke of "drift" as characteristic of the UNDP AIDS response; poor internal coordination among UNDP bureaus, especially between the Country Offices and Headquarters, and weak regional presence—one speaker referred to an 'insularity' of Country Offices as leading to a risk of loss of relevance; the challenge of maintaining appropriate balance between capacity building and programme implementation, especially under Global Fund grants; limited political courage and willingness to take risks, particularly among country offices—it was said that UNDP should be more willing to challenge host governments; concentration on delivery of workshops more than results, and 'paper engagement' more than substantial involvement; and the difficulty of getting beyond awareness raising and generating a response to answering the question, 'What next?'

STRATEGIC ISSUES EMERGING FROM THE GLOBAL INTERVIEWS

Strategic issues that emerged from the interviews also reflect many matters raised by the country case studies. These include:

- 1) *Timing and character of the evaluation.* A number of informants strongly welcomed the evaluation, and several UN agency personnel expressed a wish that similar confidential, off-the-record feedback on the work of their agencies could be organized. However, many interviewees observed that UNDP's AIDS evaluation may have been launched too soon and that meaningful outcomes from UNDP's interventions could not be expected by 2005. It was also noted that retrospective evaluation was extremely difficult to conduct in an environment of extremely rapid change (such as the one prevailing in HIV/AIDS), since the goals themselves change frequently.
- 2) *Changing nature of the needs of the international community and UNDP's clients and UNDP's consequential comparative advantages in relation to client needs.* Nearly all members of the panel of key informants considered that UNDP must change as the epidemic changes and the environment for its work on HIV/AIDS changes. The fact that the major HIV/AIDS donors in the

case-study countries fall outside the United Nations Country Team system was thought to pose challenges for UNDP. One logical response followed in some of the case-study countries is to concentrate UNDP energies on an expanded UN Theme Group on HIV/AIDS that consciously brings in non-UN partners. Several interviewees linked their observations on UNDP's AIDS-related work more broadly to the theme of UN Reform, and expressed the hope that the current UN Reform discussions would be taken as an opportunity to strengthen the UN Resident Coordinator system with UNDP in the lead.

- 3) *Limited documentation of experience.* The interviewees frequently observed that UNDP's experience in HIV/AIDS had been poorly documented—a point confirmed in the country case studies—making it difficult to transfer this experience across countries, despite the central role of UNDP in knowledge sharing. This situation makes outcomes evaluation hazardous, despite all efforts at triangulation, and excessively dependent on interviews. UNDP and its partners must insist on stronger monitoring and evaluations, which implies the need for more careful planning at the design stage of UNDP interventions. The weakness of existing monitoring and evaluation and other outcome data made it extremely difficult for the evaluation team to assess the depth and sustainability of outcomes associated with UNDP intervention.
- 4) *The exceptionality of HIV/AIDS.* Informants were unclear on the exceptionality of HIV/AIDS. As an organization concerned with the entire range

of development issues in the case-study countries, UNDP is well positioned to define and explain the nature of and reasons for AIDS exceptionality.

- 5) *Institutional crowding and its implications for UNDP.* Several commentators observed that the growth of PEPFAR, the World Bank's MAP operations, and the Global Fund threaten UNDP's relevance and central position on HIV/AIDS at the country level. Similarly, the growing field presence of UNAIDS was thought to pose role definition issues for UNDP. UNDP's lack of clarity on its own role in UNAIDS contributed, in the view of some observers, to a perceived lack of relevance among the UNAIDS co-sponsors.
- 6) *Sustainability of UNDP interventions.* Some informants considered that UNDP interventions on HIV/AIDS lacked sustainability, in part because they were inadequately framed in country-specific context. It was said that UNDP had created many pilot programmes that had not been pursued.
- 7) *Redefining and communicating UNDP's HIV/AIDS roles.* The limited knowledge of UNDP's HIV/AIDS roles, and the changing environment, including appointment of a new UNDP Administrator, give the organization an opportunity to reconceive and communicate its AIDS strategy and roles. They permit internal reflection on how to go beyond 'building awareness' and beyond 'generating a response.' The interviews suggest that perhaps the next stage of UNDP AIDS work could be summarized under a theme of 'facilitating impact.'

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ANNEX 10. ACRONYMS

3 by 5 Initiative	WHO Initiative to have 3 million people on ARV therapy by the end of 2005
ACAT	Africa Cooperative Action Trust, Swaziland
ADC	AIDS Development Committee, Zambia
AGEI	African Girls Education Initiative, Swaziland
AGOA	African Growth and Opportunities Act, Lesotho
AIDS	Acquired immune deficiency syndrome
AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ANC	African National Congress, South Africa
ANC	Ante-natal Clinic, South Africa
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral (drugs)
ASSA	Actuarial Society of Southern Africa
AU	African Union
BCC	Behavior Change Communication
BCHA	Business Coalition Against HIV/AIDS
CARe	Centre for Actuarial Research, South Africa
CBO	Community Based Organization
CC	Community Conversations
CCE	Community Capacity Enhancement, Swaziland
CCEP	Community Capacity Enhancement Process, South Africa
CCF	Country Cooperation Framework, UNDP
CCM	Country Coordination Mechanism, GFATM
CDC	Centers for Disease Control, United States
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHAL	Christian Health Association of Lesotho
CHAZ	Churches Health Association of Zambia
CMTC	Crisis Management and Technical Committee
CO	Country Office, UNDP
COSAD	Council Against Smoking Alcohol and Drugs, Swaziland
CRAIDS	Community Response on HIV/AIDS, Zambia
CSB	Corn Soya Blend
CSO	Civil Society Organization
DATF	District AIDS Task Force
DCI	Development Cooperation Ireland
DDCC	District Development Coordinating Committee, Zambia
DfID	Department for International Development, United Kingdom
ECD	Empowerment for Community Development, Lesotho
ECHO	European Commission Humanitarian Office
EMSAP	Ethiopian Multi-Sectoral HIV/AIDS Project
EO	Evaluation Office, UNDP
ESRA	Economic and Social Reform Agenda, Swaziland
EU	European Union
FAO	United Nation Food Agricultural Organization
FBO	Faith Based Organization
FDI	Foreign Direct Investment
FDRE	Federal Democratic Republic of Ethiopia
FGM	Female Genital Mutilation
FLAS	Family Life Association of Swaziland
FSE/CC	Federation of Swaziland Employers/Chamber of Commerce, Swaziland
G7/G8	Group of 7/8 major industrial nations
GDP	Gross Domestic Product

GEATM	Global Fund to Fight AIDS, TB and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS, South Africa
GCF	Global Cooperation Framework
GNP	Gross National Product
GOA	Government of Angola
GOL	Government of Lesotho
GOS	Government of Swaziland
GRN	Government of the Republic of Namibia
GTZ	German Agency for Technical Cooperation
HAMSET	HIV/AIDS, Malaria and Tuberculosis Control Project, Angola
HAPCO	HIV/AIDS Prevention and Control Office, Ethiopia
HBC	Home Based Care
HDF	Human Development Forum, Swaziland
HDR	Human Development Report, UNDP
HIV	Human Immunodeficiency Virus
HP	Health Post
HQ	Headquarters
HS	Health Station
HSDP	Health Sector Development Programme, Ethiopia
HSRC	Human Sciences Research Council, South Africa
HTP	Harmful Traditional Practices
IC	International Consultant
ICC	Interim Community Councils, Lesotho
ICWC	International Committee of Women Living with HIV/AIDS
IDASA	Institute for Democracy in South Africa
IDC	Inter-departmental Committee
IDP	Integrated Development Plan
IEC	Information, Education and Communication
ILO	International Labour Organization
IMF	International Monetary Fund
I-PRSP	Interim Poverty Reduction Strategy Paper
ISRDP	Integrated Sustainable Rural Development, South Africa
JPO	Junior Professional Officer
KKCAF	Kenneth Kaunda's Children's Foundation of Africa, Zambia
KMG	Kembata Women Self-Help Organization, Ethiopia
KZ	Kwanza, national currency, Angola
L4D	Leadership for Development, UNDP
L4R	Leadership for Results, UNDP
LAPCA	Lesotho AIDS Programme Coordinating Authority
LCN	Lesotho Council of Non Governmental Organizations
LDP	Leadership Development Programme
LDR	Leadership for Development Results
LDS	Lutheran Development Services, Swaziland
LENASO	Lesotho Non Governmental AIDS Service Organizations
M&E	Monitoring and Evaluation
MAP	Multi-Country Assistance Programme (on AIDS), World Bank
MDG	Millennium Development Goal
MED	Ministry of Education, Angola
MEPD	Ministry of Economic Planning and Development, Swaziland
MINPAN	Ministry of Planning, Angola
MINSÁ	Ministry of Health, Angola
MLRR	Ministry of Land, Resettlement and Rehabilitation, Namibia
MOF	Ministry of Finance
MOH	Ministry of Health

MOHSS	Ministry of Health and Social Services, Namibia
MOLG	Ministry of Local Government, Lesotho
MOP	Ministry of Planning
MTP	Medium Term Plan, Namibia
NABCOA	National Business Coalition on HIV/AIDS, Namibia
NAC	National AIDS Commission/Council
NACOP	National AIDS Coordination Programme, Namibia
NACOSA	National AIDS Coordinating Committee of South Africa
NACP	National AIDS Control Programme, Namibia
NAEC	National Aids Executive Committee, Namibia
NAMACOC	National Multi-Sectoral Aids Coordinating Committee, Namibia
NC	National Consultant
NCCI	Namibia Chambers Of Commerce and Industry
NCP	Neighborhood Care Point, Swaziland
NCTPE	National Committee on Traditional Practices, Ethiopia
nd	No Date
NDP	National Development Plan
NDS	National Development Strategy
NDTF	National Disaster Task Force, Swaziland
NEPAD	New Partnership for Africa's Development
NERCHA	National Emergency Response Committee (later transformed to Commission), Swaziland
NGO	Non-governmental Organization
NORAD	Norwegian Agency for Development
NPC	National Planning Commission
NPRAP	Namibia Poverty Reduction Action Plan
NSP	National Strategic Plan
NUL	National University of Lesotho
NZP+	Network of Zambian People Living With HIV/AIDS
OAU	Organization of African Unity
ODA	Official Development Assistance
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAC	Provincial AIDS Council
PAPPR	Prioritized Action Programme for Poverty Reduction, Swaziland
PATF	Provincial AIDS Task Force, Zambia
PAYE	Pay As You Earn, Swaziland
PDCC	Provincial Development Coordinating Committee, Zambia
PEP	Post Exposure Prophylaxis, Swaziland
PEPFAR	President's Emergency Plan for AIDS Relief, United States
PGDP	Provincial Growth and Development Plan, South Africa
PHC	Primary Health Care
PIU	Project Implementation Unit
PLOWA	People Living Openly With AIDS
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PNLS	National Programme to Fight AIDS, Angola
PR	Principal Recipient, of GFATM Grant
PRRO	Protracted Relief and Recovery Operations, Swaziland
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
PSCAAL	Private Sector Coalition Against AIDS, Lesotho
PSD	Programme Support Document, Swaziland
RC	Resident Coordinator, UNDP
RCF	Regional Cooperation Framework

RR	Resident Representative, UNDP
RICA	Royal Initiative to Combat AIDS, Swaziland
SACI	Southern Africa Capacity Initiative, UNDP
SACRO	Swaziland Association on Crime and Rehabilitation of Offenders
SACU	Southern Africa Customs Union
SADC	Southern Africa Development Community
SAFAIDS	Southern African HIV/AIDS Information Dissemination Service
SAMDI	South African Management Development Institute
SANAC	South African National AIDS Council
SASO	Swaziland AIDS Support Organization
SDPRSP	Sustainable Development & Poverty Reduction Strategic Programme, Ethiopia
SHAPE	Schools Health and Population Education Programme, Swaziland
SIDA	Swedish International Development Agency
SIPAA	Support for International Partnerships against AIDS in Africa
SNAJ	Swaziland National Association of Journalists
SNL	Swazi Nation Land
SNNP(R)	Southern Nations, Nationalities and Peoples (Region), Ethiopia
SOS	Save Our Souls, Swaziland
SRF	Strategic Results Framework
STI	Sexually Transmitted Infections
SWACI	Swaziland Capacity Initiative
SWAp	Sector-wide Approach (to aid coordination)
SWAPOL	Swazis for Positive Living
TAC	Treatment Action Campaign, South Africa
TASC	The AIDS Support Center, Swaziland
TB	Tuberculosis
TDP	Transitional Development Plan, Zambia
UK	United Kingdom
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNAM	University of Namibia
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDG	UN Development Group
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organization
UNFIP	UN Fund for International Partnership
UNFPA	United Nations Population Fund
UNGASS	UN General Assembly Special Session (on AIDS)
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
UNSG	United Nations Secretary General
UNV	United Nations Volunteer
US	United States
USAID	United States Agency for International Development
USDOL	United States Department of Labor
VAC	Vulnerability Assessment Committee, Swaziland
VCT	Voluntary Counseling and Testing
WB	World Bank
WFP	United Nations World Food Programme
WHO	World Health Organization
ZANARA	Zambia National Response to AIDS
ZBCA	Zambia Coalition on HIV/AIDS
ZNAN	Zambia National AIDS Network

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