UNDP Yemen

Capacity building of National AIDS Programme 2004-2007 External Evaluation

Evaluation Report

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Disclaimer

Abbreviations

ART	Antiretroviral Treatment
CBD	Community Based Distribution
CSOs	Civil Societies Organizations
DAC	Development Assistance Committee
IEC	Information, Education and Communication
FP	Focal Points/Persons
GFATM	Global Fund to fight AIDS, TB and Malaria
GIPA	Greater Involvement of People living with HIV/AIDS
GTZ	German Development Cooperation
HARPAS	UNDP HIV/AIDS Regional Programme for the Arab States
MDG	Millennium Development Goal
MOHP	Ministry of Health and Population
NAP	National Aids Programme
NGOs	Non governmental Organisations
NPC	National Population Council
PLWHA	People living with HIV and AIDS
PR	Principal Recipient
RH	Reproductive Health
QA	Quality Assurance
SCIH	Swiss Centre for International Health
SRH	Sexual & Reproductive Health
STI	Swiss Tropical Institute
TOT	Training of Trainers
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNV	UN-Volunteer
WHO	World Health Organisation

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Executive Summary

UNDP supports the National AIDS Programme (NAP) of Yemen through a project called "Capacity building of the National AIDS Programme 2004-2007". At the end of the project phase, and in view of the future role of UNDP as principal recipient of the GFATM UNDP commissioned an external evaluation focusing on overall performance, lessons learned and recommendations regarding the design and implementation of a potential follow-up HIV/AIDS project.

The evaluation was conducted in November 2007 by a team composed of an international team leader and a national co-evaluator. Document review, interviews with key stakeholders and a field visit were the main methodologies used.

5 main outcomes of the project:

1. Advocacy at all levels
2. IEC/Education materials/Awareness raising on HIV/AIDS
3. Mainstreaming of HIV/AIDS in policy reduction strategies and other main policies and strategies
4. Law reform and human rights
5. Capacity strengthening of NAP staff in HIV/AIDS advocacy, high risk and vulnerable group interventions, operations research and counselling

Selected strengths:

- High relevance of project objectives
- Project continued despite important constraints
- Project reached important number of beneficiaries from diverse sub-groups
- Working relations with various particularly vulnerable groups established
- Committed project team
- Synergies with HARPAS regional programme established

Selected weaknesses:

- Weak quality of processes, approaches and technical advice.
- Activities are often punctual and not part of strategic, systematic process
- Lack of integration of Sexual and Reproductive Health and link to Primary Health Care
- Potentials for multisectoral collaboration were not fully exploited
- Little innovation
- Complex institutional set up, risk of substitution, low national ownership and limited sustainability
- Coordination, management and administration weaknesses at all levels
- Project lacks a monitoring system
- Weak knowledge management and sharing

While the overall achievement rate of less than 50% (estimation) represents an insufficient level of project performance, the result needs to be interpreted taking account of the important constraints in terms of unavailability of project coordination staff during 12 months and the difficult working context, marked by efficiency and capacity limitations at the national partner level.

Selected lessons learned

• To foster national ownership, full involvement, real partnership and capacity building of national partners through technical advice are important priorities
• A systematic, strategically guided and more focused approach will be needed to increase effectiveness and outcome
• Coordination (and IMPLEMENTATION of plans) is THE top priority in the HIV response in Yemen for all actors, at all levels
• Clarification of roles (UNDP/NAP/partners) and simplifying institutional set-up are essential
• Successful partnerships (“working with champions”) should be consolidated to effectively manage change.
• A major missed opportunity is the lack of collaboration on HIV with local councils and the integration of HIV in the decentralisation process.
• The current setting offers plenty of opportunities for mainstreaming of HIV and making the HIV response more gender sensitive.

Based on the findings of the evaluation and the role that UNDP is supposed to play according to the UN division of labour, **three possible and alternative scenarios for the future** were developed.

Scenario 1 (UNDP continuing a separate, specific project under NAP) is not recommended by the evaluators. Scenario 2 (UNDP supporting a separate, specific project with another counterpart) could be an option- albeit with some reservations. The scenario recommended by the evaluators is for UNDP to focus on performing well as GFATM PR and in addition fully mainstream HIV/AIDS into its Yemen portfolio. Opportunities for the future include mainstreaming HIV into policy and strategy instruments following the UNDP guidelines, linking HIV and gender empowerment, human rights, governance, capacity building of the civil society, law reform, etc. Programme areas of UNDP supported activities which are likely to have a **high potential with regards to mainstreaming HIV/AIDS** are:

- Decentralisation and local development Programme
- Strengthening national capacity for human rights
- Public financial management reform
- Aid harmonisation
- Poverty reduction
- Youth community access centres

1 Introduction

1.1 Rationale, purpose and objectives of evaluation

UNDP supports the National AIDS Programme (NAP) through a project called "Capacity building of the National AIDS Programme 2004-2007" (Project ID : 00039821). Actual implementation of activities started in 2005. The end of the project phase was extended from September 2006 to December 2007.

The 2004-2007 project phase is now coming to an end. In view of the future role of UNDP as principal recipient of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) the question arises whether and how UNDP should in addition continue a project based support to the national HIV response.

The overall objective of the evaluation was to obtain a critical assessment of the project's overall performance and record significant lessons that can be drawn from the experience. Based on these lessons learnt recommendations should be formulated regarding the design and implementation of a potential follow-up HIV/AIDS project. In line with the UNDP programming approach, the evaluation focused on the following areas:

- Assess the overall project and determine its contribution to the National Response to HIV/AIDS effort
- Assess the project in terms of effectiveness and general efficiency
- Assess the capacity building component of NAP within the project
- Assess the human rights component of the project
- Assess the role of UNDP in the cooperation/coordination with UN system response to HIV/AIDS
- Assess the extent to which UNDP has tapped into the resource mobilisation available in the country to fund the HIV activities in the context of this project
- Assess and identify project partnerships strengths and effectiveness for enhancing the national multisectoral response
- Come up with concrete recommendations for the following project
- Document lessons learned and the best practices that are emerging within the UNDP supported activities

For more details, see the Terms of Reference, vs 7.11.2007.

1.2 Context

Yemen is one of the poorest countries in the world ranking 151 out of 177 countries in the 2005 UNDP Human Development Index, underscoring the need to enhance the accessibility of the population to the basic necessities of their livelihood[1]. The country is not on track to reach most Millennium Development Goals by 2015 without substantial redirection of policies, injection of additional funds and institutional and human capacity building[2].
According to available data, Yemen is considered a **low HIV/AIDS prevalence country with an emerging epidemic**. Official prevalence figures given by the government and UNAIDS rank around 0,2% in the adult population. However, surveillance data is weak and incomplete and WHO estimates the true prevalence to be considerably higher and that the country could be

[1] 2005 MDG Needs Assessment, Yemen
[2] UNDAF 2007-2011

moving towards a concentrated epidemic[3]. Reported HIV/AIDS cases increased from one registered case in 1990 to 2189 in mid 2007. Incidence is higher among vulnerable groups, emphasizing the need to direct interventions to high risk groups.

Before the start of the project, UNDP supported WHO in conducting a HIV/AIDS **Situation Analysis study** in Hodeidah, Taiz, Aden and Hadhramut. Most of the study findings are still valid today. It was found that main factors that facilitate the spread of HIV in Yemen, both among high risk and vulnerable groups as well as the general population include poverty, a socio-cultural transition, variations in the sexual subcultures between sections of the Yemeni population, low HIV-risk perception and population movements including a migrant worker tradition emerged as the main underlying factors to HIV vulnerability. The vulnerable groups identified included the "Marginalised Group" (Al Akhdam), women, refugees, returnees, the youth, truck drivers, fishermen, prison inmates and the poorest in the society. Although at least 84% of any respondent category had heard of HIV/AIDS, there were high rates of false beliefs on HIV transmission. Awareness of HIV/AIDS and other STDs was lowest, and false beliefs on transmission highest, among the marginalised group. People living with HIV/AIDS were viewed as evil and dangerous, and radical measures of isolation and other forms of punishment were considered necessary by many respondents. Stigma and discrimination against PLWHA is an important problem, also including serious discrimination by health providers.

The national response to HIV/AIDS in Yemen has started in the nineties after the creation of the National AIDS Programme (NAP) in 1986. The NAP leads the response on behalf of the Ministry of Health and Population. The main focus of previous efforts was laid on prevention campaigns. It was only in 2007 that thanks to the GFATM support the first patients could be started on Antiretroviral treatment. Despite mechanisms in place (multisectoral HIV/AIDS taskforce for national stakeholders, UN theme group on HIV/AIDS, joint UN team on HIV/AIDS), coordination is not effective and these coordination bodies are not meeting regularly. One of the other main issues the national HIV response faces is how to translate policies and commitments into implementation and programmes of quality and scale.

The current epidemic situation and the emergence of committed stakeholder groups, as well as the available donor support offer a **window of opportunity** for Yemen to effectively curb the spread of the epidemic before reaching levels that would seriously affect the public health and impact on economic growth.
The total budget needed for HIV/AIDS prevention and treatment is estimated to be $364 million over the period 2006-2015[3], which is a relatively modest sum.
Since 2005 Yemen is receiving HIV related GFATM support to scale up the response. The grant was initially managed by NAP and NPC. However, due to low performance and absorption capacity[4], the Principal Recipient responsibility was recently shifted to UNDP with NAP, NPC and the Blood Safety Centre taking the role of sub-recipients.

1.3 Evaluation scope

According to the Terms of Reference, the evaluation considered all aspects of the project – from concept, design, relevance of the project and execution/ implementation modality, including institutional arrangements at all levels. The evaluators were also asked to assess the appropriateness of the operational strategies adopted by the project to achieve the set of objectives and make recommendations in the light of strengths and weaknesses identified.

[3] WHO Yemen summary country profile for HIV/AIDS treatment scale up 2005 and UNAIDS, WHO, UNICEF Yemen Epidemiological Factsheet, 2005
[4] GFATM, Grant Performance Report Yemen, August 2007

The evaluation was to be conducted within 15 working days that included a two week joint mission in the country. The in-country mission took place between the 10th and 21st of November 2007.

1.4 Evaluation Team composition and independence

The evaluation team was composed of one international team leader and a national co-evaluator. The team leader, Claudia Kessler, is an international Public Health expert specialised in HIV/AIDS mainstreaming and Sexual and Reproductive Health. She also is trained in organisational development and has longstanding evaluation experience.
The team leader has never worked for any of the concerned organisations. At the level of the Swiss Tropical Institute, for which she works, Hans Peter Bolliger has been a consultant to UNDP for developing the GFATM proposal.

The national co- evaluator, Nagiba Abdulghani Alshawafi, is a Public Health expert specialised in Community Medicine with a focus on Reproductive Health. She is intimately familiar with the national system and has worked for the Ministry of Health and Population directing the Reproductive Health Department. She also worked for UNFPA RH projects in the MOPHP and as a short term advisor for UNDP and has contacts with NAP and NPC. She has conducted this evaluation in her capacity as an independent consultant.

Both the team leader and the co-evaluator declare having no conflict of interest and conducted this evaluation from a fully independent position.

For the purpose of this mission the complementarity of the internal and the external sight has proved very fruitful and the collaboration between the two collaborators proved very efficient.

1.5 Evaluation methodology, information sources, quality assurance and limitations

The evaluators based their work on the DAC evaluation criteria and the Terms of Reference.
The main methodologies for collecting data and information consisted in:

- Document review
- Interviews or focus group discussions with key partners and stakeholders based on 3 questionnaires developed with leading questions
- A two day field visit to Taiz and Aden

The programme of the mission as well as the list of people met and the list of documents evaluated can be seen in the Annexes.
Most of the key stakeholders could be met during the mission in country, allowing a good picture regarding the internal and external assessment of the project performance and outcome. Stakeholder groups met include the NAP and some of NAP's HIV Focal Points, UNDP and the project team, NPC, the Deputy Minister of Primary Health Care, UNFPA, UNICEF, WHO, the association of People living with HIV/AIDS, the network of marginalised people, various NGOs, local health authorities, a representative of a local council and a representative of the religious leaders network.

As mentioned in the annex, some of the documents or compilation of information requested by the evaluators, however, could not be provided by the project.

Quality assurance was most effectively done through the outsider/insider composition of the mission. The broad stakeholder involvement for interviews and the field visits further contributed to QA and allowed triangulation and validation of findings from the document review and

between different interviews. A debriefing to UNDP and the project team on the last day of the mission allowed to validate findings and recommendations and to get feedback on some of the issues. These comments have been taken into account when drafting the report. The evaluators deplore that it was not possible to find a time when the NAP director, the national counterpart, could have attended the debriefing. Based on comments received from the project manager and the former NAP director on the draft, the report could be finalised in January 2008.

Limitations: The duration of the mission did not allow fully exploring all the details regarding the project in depth, particularly in terms of the outcome and impact at the beneficiary level. Impact and sustainability were not part of the Terms of Reference of this evaluation. The incomplete records and documentation in addition add to gaps in the full picture. The evaluators, however, are confident that the information that could be gathered is sufficient and representative enough to allow assessing the project performance, drawing conclusions and making suggestions for the future.

2 Main evaluation findings

2.1 Relevance

Relevance looks at the extent to which an aid activity is suited to the priorities and policies of the target group, recipient and donor.
The objectives of the project are still valid and address priority needs of the country, in line with the

- National AIDS strategy
- UNDAF, UNAIDS Technical Support Division of Labour
- UNDP and HARPAS HIV strategy
- The results of the 2003 UNDP/WHO situational analysis
- Expressed needs of development partners and national partners at all levels

The activities and outputs of the project are consistent with the overall goal and the attainment of its objectives. The project can be considered to be of high relevance.

2.2 Effectiveness and Performance

For the purpose of the evaluation, the project activities were grouped in 5 main outcome fields for the assessment of effectiveness[5]:

1. **Advocacy at all levels**
2. **IEC/Education materials/Awareness raising on HIV/AIDS**
3. **Mainstreaming of HIV/AIDS in policy reduction strategies and other main policies and strategies**
4. **Law reform and human rights**
5. **Capacity strengthening of NAP staff in HIV/AIDS advocacy, high risk and vulnerable group interventions, operations research and counselling**

Effectiveness represents the extent to which an aid activity attains its objectives.
Major factors influencing the achievement or non-achievement of the objectives are explored.

The list of activities mentioned under the various objectives should not be understood as an exhaustive list of all conducted activities. They represent a selection of main activities as obtained from the available reports, interviews and site visits.

2.2.1 Advocacy at all levels

Main activities conducted under this objective include:

- Advocacy activities for religious leaders[6]
  - Initial awareness raising
  - Sent a delegation to HARPAS regional workshops
  - TOT workshops on HIV with religious leaders, 2 imams /governorate to become HIV Focal Points (2006, 2007)
  - Manual for religious leaders on HIV developed in collaboration with UNICEF
- Advocacy activities using mass media
  - Several articles were published in the print press, reporting on some of the workshops organised by the project

[5] As described later in the project design chapter, the project document structure presents some inconsistencies. This is why the evaluators chose a slightly modified structure for evaluating effectiveness.
[6] For further information, see also HIV/AIDS and Islam, Positive Muslims, 2004

    - While radio and TV programmes for advocacy were planned, these activities were not implemented
- Advocacy and capacity building for NGOs and community groups
    - Advocacy and health education trainings on HIV were organised for NGOs and community groups
    - Support was provided to the creation of the "Zeid Almoushki network" which combined six associations of marginalised people (Al Akhdams) in Taiz, recently an assessment study was conducted on the situation of this sub-population
    - In Aden the evaluation team met some NGOs who had benefited of capacity strengthening support through other UNDP supported projects, had however not yet collaborated with the HIV project.
- Advocacy activities for other target groups
    - In 2005 the Ministry of agriculture had benefited of an advocacy workshop
    - Recently the project has initiated contacts with members of parliament
    - The evaluators did not see any advocacy tools developed during the project phase.

Outcome and Discussion:

The project has succeeded building on the foundations laid by the HARPAS training activities. The collaboration that could be established with an important group or religious leaders at the national and governorate level can be considered a success of the project. Religious leaders have started addressing HIV in Friday speeches, using an integrated reproductive health approach. The representative of the group who the evaluators met is a very dynamic and committed, open- minded change agent. The collaboration with religious leaders should be understood as a major opportunity for the future. UNICEF, who has collaborated with the project for the development of the manual for religious leaders considers this collaboration a good practice for inter- UN collaboration. However, this manual has been finalised one year ago. The religious leaders deplore that it still has not been printed. This seems to be due to communication problems and the lack of a project coordinator in the first half of the year. The printing should be organised as soon as possible and dissemination of the manual should happen without delay.

The effectiveness of the mass media advocacy campaigns cannot be assessed due to the lack of available documentation.

The project working with the marginalised groups and contributing to their empowerment through capacity building and supporting their network creation is another positive outcome of the project, also in view of the aim to improve the human rights situation. This group is suffering major discrimination, lives under extremely difficult conditions and is, according to all available studies, particularly vulnerable to HIV and AIDS. The evaluators only saw a draft version of the assessment study report, which included quantitative data on demographic and access data. A final report including qualitative data on knowledge, attitude and behaviour and conclusions and recommendations is not yet available. It will be important to disseminate the report primarily to the group itself and engage with them in a dialogue on findings and conclusions.

The collaboration between the project and the group has been initiated only recently. It is important to consolidate the achievements and continue supporting their capacity strengthening and organisational development either through direct project support or by linking them to other available resources and sources of support.

Overall, the advocacy activities succeeded in touching an important number of diverse beneficiaries. There are, however, considerable quality concerns linked to the advocacy activities. Most of the interventions remained patchy, often limited to punctual workshops and

lacked to be embedded in a comprehensive concept of needs assessment- capacity building-follow up activities and ongoing support. It is also an omission of the project that no strong collaboration with local councils was developed. Local councils will have to play an essential role in the HIV response in the future considering the planned decentralisation process which includes health. They will need capacity building to know their role and be able to effectively contribute to the HIV response in their areas of responsibility. Examples of successful collaboration with local councils are available from many other countries (e.g. Tanzania multisectoral AIDS councils, Mozambique, etc).

2.2.2 IEC/Education materials/Awareness raising on HIV/AIDS

Main activities conducted under this objective include:

- IEC materials: repeated support was provided to the NAP for printing and reprinting of existing materials (booklets, brochures, promotional materials).
- Repeated awareness raising workshops were held for vulnerable groups in the governorates: marginalised people, fishermen, truck drivers, airline staff, youth centres.
- Condoms: Information about condoms was included in all awareness raising activities. Contrary to the plan, the project did not directly contribute to distribution and improved access to condoms.
- Community based distribution and animators/volunteer networks: a CBD approach was not developed and piloted; while preparations are ongoing, no tangible achievement in terms of developing networks of animators and volunteers are reported.

Outcome and Discussion:

According to the list of conducted workshops received, a total of at least 1423 participants benefited of advocacy or awareness raising workshops. While the information is not complete on gender distribution of participants, based on the available data women made up roughly 40% of the participants. The workshop costs are calculated at an overall average of 30$ per participant for 1-3 day workshops, which seems reasonable, considering the travel costs implied for some of the participants.

During the field visits, the evaluation team was given anecdotal reports on positive changes in attitudes and behaviour at population level over the past two years. The activities of the project are believed to have contributed to the observed change.

As with the advocacy activities, the quantity of activities can be assessed satisfactory, while reservations have to be highlighted in terms of quality.

When looking at the support regarding IEC materials, the project has not contributed effectively to developing new materials or improving the quality of existing tools. There is also frustration by the World Health Organisation over the fact that UNDP printed their logo- and only theirs- on an IEC material that was developed by NAP in collaboration with WHO. UNDP merely financed the printing of the materials.

Another major missed opportunity is that the project has failed addressing an effective integration of services and resources between HIV and Reproductive Health. Both at the national and decentralised level NAP staff works mostly in parallel to their RH colleagues and contrary to them, does not have regular access to condoms for distribution. The fact that there are two vertical and separate lines of condom supplies (HIV condoms and RH condoms) arriving at the local level should have been addressed with the NAP. This leads to the deplorable situation that Focal Points and others trained by the project do now dare informing the population about condoms, but have to refer interested persons to the next health centre or pharmacy. In addition HIV Focal points suffer from insufficient IEC materials and equipment to effectively perform their duties.

Also, those who have received training, complain of a lack of access to operational funds. Public funding for HIV/AIDS activities seems not to trickle down to the field level. They can currently

only implement activities when punctual funding through a donor is available. This seriously limits continuity and ownership and results in action plans left unimplemented. Cases where activities where pre-financed by the local level and not reimbursed are not rare. Such incidents are a disincentive for HIV Focal Persons to remain active.

2.2.3 Mainstreaming of HIV/AIDS in policy reduction strategies and other main policies and strategies

When assessing this objective the evaluators looked directly at the outcome in terms of the existing instruments, focusing less on the process level in terms of activities. A general weakness in Yemen remains the weak translation of policy instruments into programmes and action at the operational level.

A. **2007-2011 Aids Strategy:** the strategy draft was developed by NAP with the technical assistant provided by consultant who was funded in the frame of the evaluated project. The strategy is not available yet in an English translation. It follows a broad multisectoral, comprehensive and rights based approach and was elaborated with broad stakeholder participation. It can be considered a very good instrument. Unfortunately its use is pending awaiting final approval by the Ministry of Health since one year already. The project should try facilitating the final approval process of the instrument.
B. **MDG needs assessment 2005**: In 2004 Yemen was selected as the eighth pilot country for the UN millennium project. The needs assessment was led by the Ministry of Planning with support by UNDP. HIV is not mentioned under the challenges in the summary. While Yemen faces an emerging epidemic and certainly is confronted with other issues of higher acute priority, HIV would have deserved mention as a major emerging challenge. Where mentioned, HIV is only presented as a health problem in the document. Links to HIV being a development problem and to any of the other sectors are missing. The needs assessment document presents a missed opportunity of effectively mainstreaming HIV/AIDS.
C. The **Socio economic development plan for poverty reduction**, Yemen **2006-2010**, **DPPR**: Again, HIV is only addressed marginally as a health problem. HIV is mentioned under the control of sexually transmitted infections, but contrary to other priorities, no target is specified that would help measuring progress (table page 98). Access to antiretroviral treatment is not mentioned under the health sector target referring to therapeutic medicine. HIV/AIDS is not presented as a development problem, and the vicious cycle between poverty/economic growth and HIV/AIDS is not addressed. Major missed opportunities are that HIV/AIDS, vulnerability factors and the potential contribution of these sectors to the HIV response is not mentioned for the following sectors/chapters: human rights, education, youth and sports, women's empowerment, social safety nets/welfare/security, world of work and productive sector.
There is no mention of HIV in the investment plan. Since HIV should not only be addressed through the health sector alone, a specific budget line is usually recommended to ensure budget allocation across sectors for the HIV response.
In conclusion, it needs to be stressed that the current DPPR does not fulfil the UNDP quality criteria for HIV/PRSPs (Policy Note with checklist 2002, see also Joint Programme on Integrating AIDS into PRSPs 2007).

2.2.4 Law reform and human rights

Main activities conducted under this objective include:

- Support the drafting of a law for people living with HIV/AIDS

Based on a needs assessment study conducted in 2004/5 by a UNDP funded consultant and based on the HARPAS model and workshops, a draft law was elaborated in collaboration between UNDP, consultants and the NAP. The finalised draft law has been submitted in August 2007 to the MOHP where it is pending, since the Ministry questions the relevance of a separate and specific law on HIV/AIDS.

- Empowerment of PLWHA

  Following up on a regional workshop organised by HARPAS, initial support was provided to the creation of an association of PLWHA in Sana'a in the last quarter of 2007. The plan to decentralise and create associations in the governorates has not yet been translated into action. Apart from a workshop organised in 2006, the UNDP HIV project's contribution so far consisted mainly in providing moral support.

Outcome and Discussion:

The process of the elaboration of the draft law is perceived by many respondents as an unfortunate one. Respondents (including representatives of the multilateral agencies and the NAP) question the methodology and findings of the assessment study. A major weakness in the process is also the absence of consultation with most other multilateral agencies and the lack of involvement of people living with HIV/AIDS in the process of developing the draft. Opening up to consultation at this late stage will bear an important risk in terms of shared ownership of any product elaborated.

The evaluators share the view of the Ministry of Health and Population and many of the respondents, including the religious leaders. It is highly questionable whether a specific law for PLWHA is needed. The trade off between the intended visibility and priority allocated to the issue has to be balanced against the risk of further contributing to stigma and discrimination through a separate law. The evaluators would support integrating relevant paragraphs and articles into other existing laws or laws to be developed (e.g. patients' law, public health law, human rights law, labour legislations, etc). The evaluators also have serious reservations regarding the content of the current draft law (see Annex 5.4). The Yemeni draft law goes far beyond HARPAS model.

While the draft includes many very positive elements and articles with the obvious aim to protect the rights of PLWHA, many of the proposed articles are not according to international human rights standards. The current texts bear a serious potential for further stigmatisation and discrimination of PLWHA. Certain articles will lead to positive discrimination of PLWHA than can result in perverse effects as further explained in the annex. In addition, the death penalty provided to a person who intentionally transmits the virus is inadmissible by UN- standards.

The current text needs to be revised in consultation with all stakeholder groups, including the association of PLWHA, taking into account some of the reservations. Integration into other laws is strongly recommended.

The association of PLWHA is a dynamic self-help group that definitely deserves further support in terms of capacity building and organisational development.

2.2.5 Capacity strengthening of NAP staff in HIV/AIDS advocacy, high risk and vulnerable group interventions, operations research and counselling

Main activities conducted under this objective include:

- Training workshops for the HIV Focal Points (management and computer training) in the governorates
- Training workshops for the female assistant HIV Focal Points in the governorates (October 2007)
- Some individual courses offered to NAP members
- The NAP was also provided with support for the organisation of the World Aids day in 2006

- On 2006 workshops for paramedical staff were held in 5 governorates
- A UNDP funded consultant supported the NAP in the process of developing a new National AIDS strategy based on a broad consultation
- Supervisory visits were only once conducted in a joint mission. In 2007 some supervision activities were performed by the UNDP project team.
- Equipment (computers, digital cameras, aluminium barrier, etc) was purchased for NAP and the HIV Focal Persons of six governorates.

Outcome and Discussion:
All respondents acknowledge that, while much progress still needs to be made (also in view of the recent decision of the GFATM to hand over the PR role to UNDP- a decision based on the weak capacity of NAP and NPC), the National AIDS programme's capacity has become stronger over the past years. NAP is said to be more confident and competent in performing its role. However, since the programme is supported by many different donors (UNDP, WHO, the Netherlands, GFATM, UNICEF, UNHCR, etc), the attribution of the effect to a specific project or donor support is difficult to asses.
UNDP funds three positions at the NAP: the project manager, an accountant and a secretary. Only the secretary, however, provides services to the NAP outside of the project scope. Achievements in terms of capacity building of this project are recognised mainly at an individual level, particularly with regards to the HIV Focal Persons. The effect of these training interventions would have been more sustainable if the project would have succeeded establishing a regular supervision and follow up mechanism, or integrate the supervision and monitoring missions into an existing system. Also, both at national and decentralised level, further efforts towards a real integration of HIV with sexual and reproductive and other health services are needed in the future.

For the director of NAP, "capacity building" includes training of staff according to their duties for staff working in NAP centrally or at governorate level in management, counselling, VCT and TOT. It also includes improving the infrastructure through provision of materials and equipment that enable them to work more effectively. They would have welcomed more support in terms of technical assistance for jointly developing new approaches, as they for example have good experiences with GTZ/Evaplan. At the central institutional level, the counterpart feels not to have received a major contribution towards its capacity building. On one hand, the demand for training courses seems to have been limited at the NAP central level due to capacity shortages. On the other hand information flows between the needs of NAP staff at the decentralised level and the project/NAP at the central level were not always effective. Trainings were not followed by sufficient support in making sure that the trained persons had access to the necessary operational funds, equipment and IEC material to work effectively. Supervision, monitoring, reporting and feedback as well as coordination remain major weaknesses of the NAP's activities at all levels.
The NAP director recognises at the same time, that their capacity to effectively run the project was very limited due to the fact that the GFATM activities have absorbed most of their capacities and time and because of the limited number of qualified staff at NAP. The NAP still does not have an own overall action plan to which the various donors could subscribe. Currently, NAP has parallel plans for each donor. Financially, NAP is heavily dependent on external donor support. The only available operational costs are coming from this source. The government does allocate operational costs for NAP's activities. However, in reality, they are not available and thus not utilised since the release of these funds is very complicated. Both NAP and UNDP are aware that organisational development of the NAP remains a challenge and structural weaknesses continue to contribute to capacity limits. A further potential threat to the NAP's capacity is the fact that its current director will leave to become the UNAIDS country

officer on the first of December 2007. Since the successor is not yet in place, transition may slow down the programme's performance.

2.3 Project Management and Efficiency

2.3.1 Project Design

- Relevance: As mentioned before, the project design was and is very relevant to priority needs in the given context. Overall, the planned activities and outputs of the programme are consistent with the overall goal and the attainment of its objectives.

There are, however, some weaknesses that should be highlighted regarding the project design:

- Participation and counterpart contribution: According to the NAP director, national partners (NAP, NGOs, etc) were not involved early enough to fully participate in the original design; the NAP was given the opportunity to comment and modify the proposal before signature. The project team highlights that at the time when the project was planned, there were only two NGOs that had the capacity to be involved. The fact that this is today very different with a large number of NGOs having the capacity to contribute to the HIV response reflects a very positive change.
  The project document did not address the issue of the counterpart contribution explicitly.
- Planning consistency, logic and M&E: The planning framework does not follow a consistent logic and standardised classifications. The labelling of main outcomes/outputs varies within the document (particularly when comparing the text and the table in section II). Levels of impact/outcome /outputs/ activities/indicators are mixed and not used according to usual planning concepts, such as the logical framework. There is no appropriate M&E framework and indicator formulation is weak. So are the management arrangements. The plan is not budgeted.
- Scope: Retrospectively the scope of the plan must be judged as rather too complex and ambitious- a stronger focus would have allowed concentrating efforts and achieving more in-depth outcomes. It has created problems to the project team that the design was made for double the available budget. In 2007, a decision to focus on 6 governorates mainly was taken. This decision is not well understood by the national partners.
- Synergies: The project document does not refer to and create links of synergies to other UNDP projects/activities
- Innovation: at the moment of project design several of the main objectives may have been rather innovative. Currently, many other actors, including NPC and others supported by the GFATM, are engaged in the same kind of activities with often exactly the same beneficiaries or resource groups. UNDP missed the opportunity to introduce innovation in terms of the approaches applied to reach the objectives.

2.3.2 Financial management and administration:

The evaluators did not find any evidence of serious mismanagement of funds. While details could not be tracked in the short time available, funds seem to have been spent according to the reported expenditure. The capacity shortage both at the level of the counterpart and the project team itself has resulted in a reduced absorption capacity and irregular waves of expenditure, happening mostly during the times when a project coordinator was in place. The highest expenditure took place in 2007. At the time of the evaluation, some 75'000 $ are still available of the original budget (320'000 US$ in the project document, 310'000 US$ in the project budget balance). According to the project coordinator, another 53'000 US$ were disbursed in late November and December 2007 for supporting the organisation of the World AIDS day, activities

for HIV awareness raising in the governorates and for buying digital cameras for NAP focal points.
Annex 5.5 shows the expenditure per year against the available budget. While in 2005 eight different budget lines were used to allocate expenditure, as from 2006 the number of lines was reduced to six and all expenditure was allocated to "1.Management/oversight" or "2. training, awareness". It is not clear to the project accountant and the evaluators why the other budget lines are not used.
Documentation on the total project budget balance and the financial reports at the project level was received in a complete form. However, financial reporting does not follow the same time periods and uses different labelling of activities as compared to the periodic work plans. In addition, due to the DEX mode[7] of the project which includes the UNDP employed project accountant, there is a lack of financial autonomy at the level of the national partner and the project. This mode was installed reacting to the weak capacity of the national partner to manage funds and clear expenses and in order to minimise financial risks. While partners recognise some advantages in terms of being relieved of the financial management, this modality jeopardises national ownership. "We don't want colonies for each project", as the deputy Minister of Health put it. The project team and the national partner do not have an overview over the overall financial execution rate. Also, modalities regarding spending authorisations on running costs (main issues are transportation, mobile phone and catering/hospitality expenditure) are not clear and transparent to the project team.
Mobilising local funds: Due to the limited absorption capacity of the national counterpart (very engaged with GFATM activities while confronted with shortage of human resources) and due to the absence of a national project coordinator during repeated periods the project was- despite prolongation of the phase- not able to spend all available funds. Therefore no attempt was made to seek for additional funding locally, as was originally planned in the project document.

Overall administration:
The project manager is supported by an accountant and a secretary at the project level and receives administrative support from UNDP. Due to difficulties in recruiting qualified staff and the long selection process for identifying a project manager the project was signed in 2004, but implementation only started in mid 2005.
There are serious weaknesses to report regarding administration:

- Most respondents (in and outside of UNDP) judge the administrative procedures as very bureaucratic and slow. There is a long procedural path between an initiative at the field level and the response at national level. The DEX mode means that advances are disbursed per event, or since recently per group of events. This considerably slows down the system. Several cases were reported where demands from the field level were only responded to after months or not at all. In addition, people at the operational level are not fully aware of the options offered by the project.
- Gaps in project coordination: due to difficulties of UNDP in identifying and retaining qualified staff there were 3 gaps of 6 months where no project manager was in place. During this time, the NAP director and the UNDP Programme officer tried their best to keep the project "alive"- however, few activities were implemented during these times. The UNDP supported implementation was therefore reduced to 1,5 years and suffered from lack of continuity, lack of hand over and much time was lost with the new staff trying to understand the system.
- The evaluators observed big weakness in reporting, documentation and filing. Some project reports are unavailable (two reports only were received: June-December 2006, draft report June-November 2007). The 2005 report could not be found during the

[7] DEX= direct execution by UNDP as opposed to NEX= national execution

mission. The other two missing reports do not exist since there was no project coordinator during these periods. The quality of existing reports is inconsistent and not based on a standard template.
Workplans are incomplete and various instruments exist for a same periods (e.g. for the second half of 2007). Documents are filed not using any systematic classification. Evaluators and the project team therefore had big difficulties accessing some of the documents needed for the evaluation.

The most obvious negative consequences of the administrative weaknesses are:

- **Low responsiveness** to needs and **inefficient use of resources**
- **Low institutional memory** and missed opportunities for knowledge sharing and dissemination of good practices or lessons learned (internally and externally).

The evaluators need to stress, however, that the responsibility for the weak project management cannot be "blamed" to the project team- responsibility needs to be shared between UNDP, the NAP and the project team. The current project manager is in place since less than half a year. While NAP stresses that he has received a full briefing, the project manager himself does not feel he has received sufficient information allowing him to build on existing experience and mechanisms. It is the complex interaction between three systems (the UNDP system, the national counterpart system and the project system) that have not been successfully aligned that led to the existing situation.
The two 6 months gap in the project manager position have seriously affected continuity and performance of the project, both in terms of administration and- even more so- implementation.

2.3.3 Institutional set up

The institutional project set up is very complex. As described above, the project operates in three distinct "sub-systems": (1) UNDP (with the Programme Officer, the UNDP accounting and administration, periodic support by a UNV, etc), the (2) NAP with its national and decentralised structures and the (3) project team, composed of three staff who have UNDP contracts but are "seconded" to NAP for the project implementation. With the exception of the project secretary, who works mostly for NAP, the other two staff are, however, not fully integrated as NAP staff and do not perform other duties for the programme. The NAP director felt she could not supervise this staff since they have UNDP contracts and line managers. NAP has no transparent and regular coordination or reporting system of its overall activities to which the project team would have access. Joint planning sessions were held for the project activities.
NAP is faced with the problem that each donor usually requires specific reporting forms.
While on paper the roles and functions are clarified, in reality, the project coordinator and administrator are torn between two systems, neither of which considers that they are part of that system. Also, the current set up involves risks of substitution and is not sustainable, since NAP has not created new positions, which will be filled once the UNDP support will end. In addition, restricting the national counterpart to *one* programme in the health sector with a low absorption capacity further resulted in limiting the capacity of the project to contribute to a strong and a fully multisectoral response.
Alternative and probably better functioning set ups could have been:

- UNDP funding positions in NAP: lead for recruitment and contracting with NAP; all project staff performing also other duties for NAP
- UNDP funding a technical advisor for NAP and possibly additional counterpart programmes/organisations: project implementation strictly left to NAP and other counterparts. Role of the advisor limited to technical support, helping to develop approaches and solutions, etc. Diversifying partners could have resulted in higher effectiveness of the project.

Contributing to the complex set up and confusion for some of the national and multilateral partners is a certain lack of clarity of division of roles in UNDP regarding HIV/AIDS. Partners do not fully understand who is doing what in UNDP regarding HIV/AIDS and several respondents questioned the role of the UNV.

2.3.4 Role of UNDP in cooperation/coordination in UN system response to HIV/AIDS and project partnerships

UNDP is a very recognised player in the national HIV response of Yemen. The competence and commitment of the UNDP programme officer, the resident coordinator and the project manager are very much appreciated by several of the respondents. The development of the GFATM proposal is perceived to be a best practice example in uniting agencies for collaboration around HIV and AIDS. Also, the division of labour within the UN system is clear.
While acknowledging these strengths, several respondents deplore that UNDP sometimes continues to work in isolation. Coordination mechanisms in the country remain extremely fragile and little performing. The UN theme group has not met since 1 year and respondents saw not much progress recently towards a coherent UN plan regarding the HIV response. The national multisectoral HIV task force is not operational at all. While acknowledging that the ownership for both coordination platforms lies elsewhere, UNDP could and should have invested more efforts in making coordination a reality.
In terms of project partnerships main successes can be acknowledged for the partnership with:

- religious leaders
- the marginalised "Al Akhdam" groups and network
- good collaborative links between the HIV Focal persons met and the project team at the operational level
- strong partnership and creation of synergies between UNDP Yemen and HARPAS

Missed opportunities for project partnerships are the not fully established partnership between UNDP and NAP at the national level and the missing partnership with other UNDP projects working sometimes with the same beneficiaries.

During the project's existence, the National Population Council (NPC) has emerged as a new player in the national HIV response. The NPC's mandate is multisectoral awareness raising. They work with exactly the same beneficiaries which results in a risk of duplication. NPC stresses that with the GFATM funds, there are sufficient resources to continue that work. Currently, the NPC's mandate in terms of the HIV response corresponds much closer to the multisectoral objectives of the evaluated project as compared to the NAP, which has a much more medical focus. This development should be taken into account when exploring options for the future.

2.3.5 Gender sensitive approach

The Terms of Reference for the evaluation did not include gender as an issue to be addressed. Gender being an institutional priority for UNDP and intrinsically linked to the HIV/AIDS response, the evaluators decided to briefly analyse the project also in terms of how gender issues were mainstreamed.
When selecting workshop participants, volunteers, or when supporting NGO networks the project aimed at representation of both sexes. Workshops for representatives of women's organisations, female assistant HIV Focal Persons (FPs) and for female religious leaders were held. Health education and counselling is often done on a gender basis, offering women services by female providers and vice versa.
Overall, however, the project did not apply a fully gender sensitive approach. The project document/design itself is completely gender blind. In addition, while services supported through the project are often offered separately to women and to men, the content and strategies are not

developed for and adapted to the specific needs of the various target groups. Women and men, as well as the various age groups and other sub groups of the population have different needs and resources in relation to HIV/AIDS. Awareness raising and behaviour change interventions are known to be much more effective when based on a target group specific needs assessment and a design of the campaign and training that addresses the specific issues of the given population.

Another missed opportunity is the fact that the project did not address the question regarding the gender distribution of the HIV focal points in the governorates. Today, all HIV FPs are men. They have benefited of a series of capacity building opportunities, have received equipment, are employed to perform this role and in principle have access to resources, such as the GFATM funded car or operational budgets, etc (even though in practice they, too, often have difficulties accessing these resources). The female HIV FPs only have the status of assistants, are usually performing this role part time in addition to another ordinary duty, do not have access to the same resources and have received much less training- at least up to date. Originally, this division of role seems to have been set up to protect female FPs from aggression by the target group when talking about sensitive issues, such as HIV/AIDS. The female FPs met during the evaluation, however, feel strongly that the current opening of the dialogue around HIV/AIDS would allow them to assume a similar role as the one performed by their male colleagues. The evaluators suggest that the current set up should be re-evaluated in view of a real gender balance both at the level of HIV FPs and their assistants.

3 Overall conclusions, lessons learned and recommendations

In conclusion, based on the evaluation findings the main strengths and weaknesses of the project "Capacity building of NAP 2004-2007" can be summarised as follows:

3.1 Main Strengths

- ☑ High relevance, needs addressed by project objectives are still considerable
- ☑ Project continued despite important constraints (gaps in project coordinators, not full funding level available, major capacity shortages of counterpart, etc)
- ☑ In quantitative terms, the project succeeded in reaching an important number of beneficiaries from diverse sub- groups. Due to incomplete data it is, however, difficult to establish the exact number of beneficiaries reached.
- ☑ The project team succeeded establishing working relations with various particularly vulnerable groups (e.g. Al Akhdam, PLWHA, etc)
- ☑ Very dedicated and recognised staff at all levels, activities increased during time when project coordinators in place
- ☑ Effective creation of synergies with HARPAS and support in scaling up initiated activities in Yemen

3.2 Main Weaknesses

- ⇒ Many of the project interventions suffer of quality issues regarding processes and approaches; many patchy and punctual activities that are not part of a systematic strategy; weakness of technical advice.
- ⇒ The project failed to contribute to an integrated approach of linking HIV to Sexual and Reproductive Health and to Primary Health Care. Potentials for multisectoral collaboration were not fully exploited.
- ⇒ The project is perceived as little innovative, both in terms of the main activity lines as well as by the approaches supported.
- ⇒ Currently the institutional set up is complex and unclear and bears a risk of substitution. National ownership is weak. In the current set up, sustainability of the project is very limited. While UNDP understands the project as a temporary support to help the partners help themselves, the counterpart tends to treat the activities as a "UNDP project".
- ⇒ Serious coordination weaknesses are reported at all levels. While many of these weaknesses lie outside of the project sphere, the project and UNDP have not succeeded in addressing these weaknesses.
- ⇒ The project management suffers of major weaknesses- the responsibility for which needs to be shared by UNDP, the NAP and the project team.
- ⇒ Slow and bureaucratic mechanisms and processes result in a low responsiveness to partners.
- ⇒ The project has no Monitoring system. Such a system could have been developed using the guidance given by existing UNDP instruments (UNDP: Leadership for Results 2005; Responding to HIV/AIDS, Measuring Results)
- ⇒ Due to weaknesses in knowledge management and dissemination and the resulting low visibility of project, its contribution to the general HIV response in Yemen remained limited.

Overall, according to the NAP director, the project is estimated to have achieved not more than a maximum of 40% activities as compared to the plan. At the same time, some unplanned activities were supported. Due to the gaps in reporting and the weaknesses in filing, it was not possible to the evaluators to objectively verify this outcome.

While the achievement rate of less than 50% represents an insufficient level of project performance, the result needs to be interpreted taking account of the important constraints in terms of unavailability of project coordination staff during 12 months and the difficult working context.
While overall the assessment of this project is not a very positive one, the limited performance of the project needs to be interpreted taking account of a context marked by enormous efficiency and capacity problems. The responsibility for the observed weaknesses cannot be allocated to a specific person or to one of the collaborating parties alone. UNDP in Yemen currently has many resources (both in terms of qualified staff and experiences from this particular project) that can benefit the future HIV response in Yemen. When looking to the future, some lessons learned from the past should be taken into account.

3.3 Lessons learned

- To date, the Yemeni government has not taken full ownership of the HIV response and does not accord the necessary priority to the response. To foster national ownership, full involvement, real partnership- which would also include the move towards the "NEX" (National Execution) mode- and capacity building of national partners through technical advice are important priorities.
- Should there be a new project phase, a systematic, strategically guided and more focused approach will be needed to increase effectiveness and outcome.
- Coordination (and IMPLEMENTATION of plans) is THE top priority in the HIV response in Yemen for all actors, at all levels- if UNDP through the GFATM Principal Recipient role can make a difference to strengthen coordination, this will have a huge impact.
- Clarifying roles (UNDP/NAP/partners) and simplifying institutional set-ups will be essential.
- "Work with champions"- cooperating with those who are willing to move and who have proved that they can perform is likely to bring the best results. Successful partnerships should be consolidated to effectively manage change.
- A major missed opportunity so far is the close collaboration around HIV with local councils and the integration of HIV in the decentralisation process.
- The current setting offers plenty of opportunities for mainstreaming of HIV and making the HIV response more gender sensitive. Opportunities for the future include mainstreaming HIV into policy and strategy instruments following the UNDP development approach, linking HIV and gender empowerment/human rights/governance/capacity building of the civil society/law reform, etc.

4 Future scenarios

According to the division of labour, the UNDP strategy on HIV/AIDS and UNDAF, UNDP has a lead role in the following domains of the support to the national AIDS response:

- **HIV/AIDS and human development**
- **Governance** (incl. PRSP, decentralisation and involvement of Civil Societies Organizations (CSOs) of HIV/AIDS responses
- **AIDS, human rights** (incl. enabling legislation) and **gender**

Based on the comparative advantage of UNDP in Yemen and the division of labour, the evaluators have developed three alternative future scenarios how UNDP could support the HIV response in Yemen. These three scenarios are to be understood as being complementary to the future role of UNDP as principal recipient of the GFATM funds. A possible fourth scenario could of course also be to limit the role of UNDP in Yemen to that of being the PR for the GFATM. Meeting the high expectations and the responsibilities linked to this role will be a great challenge and much work for UNDP. However, the current team has the potential to eventually further contribute to the HIV response of Yemen. Also, it should be recognised that the GFATM support does not cover all the needs of the country in terms of the HIV response. The evaluators are not in the possession of the latest GFATM proposal. However, most of the funds will likely be used to develop the medical response and raise awareness both in the general population and vulnerable groups. Unmet needs remain in addressing HIV in a broad developmental sense and for mainstreaming HIV and AIDS into developmental activities- both of which are considered UNDP's core competence.

4.1 Future Scenario 1

➲ In addition to the PR role for the GFATM, UNDP continues a separate, specific project under NAP

Comments:
NAP, the MOHP and other UN agencies are not in favour of an additional specific project. Concerns relate to capacity shortages at the level of the counterpart who is fully absorbed in meeting the responsibility linked to the GFATM activities. Partners also stress that such as setting could lead to confusion over roles (both of UNDP and the NAP) and unclear separation of support flows. Partners would not favour any parallel activities supported by UNDP, unless they are clearly outside of and distinct from the GFATM scope (e.g. in the field of microfinance, vulnerability, empowerment, etc). They stress that UNDP's role is not in supporting small scale projects at the field level, but rather in providing support at a strategic level. Partners are also concerned that such a setting could dilute UNDP's efforts towards the PR role.

Recommendation:
The evaluators are not in favour of scenario 1.

4.2 Future Scenario 2

➲ In addition to the PR role for the GFATM, UNDP continues a separate, specific project with another counterparts (e.g. the Ministry of Local administration, capable CSOs, etc).

Comments:
Such a scenario could build on the existing collaborative experience and comparative advantage. Some of the "champions" from the past could continue benefiting from support.

This solution would, however, need a new institutional set up and a clear and sharp focus. It would mean developing a new approach to technical advice and be intensive in terms of human resource and financial investments. At a time when UNDP will be focusing most of its capacity and efforts on developing a strong, effective and efficient role as GFATM PR this may be an ambitious option.

Recommendation:
The evaluators judge this to be a possible option, with certain reservations.

4.3 Future Scenario 3

➲ In addition to the PR role for the GFATM, UNDP fully mainstreams HIV into all the relevant programmes in its portfolio in Yemen.

Comments:
Main opportunities for mainstreaming HIV/AIDS exist in the UNDP practice areas "democratic governance" and "poverty reduction". Such a scenario would round up UNDP's role in HIV in Yemen and build on institutional comparative advantage. It would nicely reflect the organisation's theme "the answer lies within". It would offer a clear role to UNDP which would be distinct from the GFATM PR role. The scenario would have the potential for substantial impact with modest inputs- and could represent a win-win situation. The core business of other practice areas could be strengthened by fully mainstreaming HIV/AIDS and they would definitely offer many opportunities to contribute to a broad based and multisectoral HIV response.

Recommendation:
Scenario 3 is the preferred option of the evaluators and is **strongly recommended** for further consideration by UNDP. When chosing scenario 3, the following **implications** would need to be taken into account:

- **The current project would in consequence close** at end of this phase. Currently the project team is composed of competent and committed staff who represent an **asset in terms of human resources**. It should be considered how far these resources could be integrated either in the GFATM work or for upcoming mainstreaming support.
- Proper **hand over of initiated activities to other sources for support** is needed (especially the marginalised group and the association of PLWHA**)**. The group of religious leaders is very dynamic and has a lot of very good ideas for future activities. They have the potential to make a significant contribution to raising awareness and reducing stigma. UNDP and NAP would have a responsibility in linking these groups to support opportunities in the GFATM funded projects or those funded through other partners, such as UNICEF (who work with NGOs, the education sector, local councils, religious leaders, youth friendly clinics, amongst others).
- Scenario 3 should not be understood as the easy way out. To properly implement the scenario the following are key prerequisites:
    - Mainstreaming HIV/AIDS is not a very costly option, but a **budget would need to be allocated to this scenario.**
    - The success of mainstreaming HIV/AIDS into activities that have another core business always strongly depends on the explicit **commitment of and the leadership role assumed by the top management-** the same would apply to UNDP in Yemen.
    - To effectively mainstream HIV/AIDS, **expertise** and continued **technical support needs to be offered and available** for the other projects. It is recommended to provide this support through a designated unit and by allocating the responsibility and necessary resources.

During their short mission, the evaluators did not get insight into the other programmes of UNDP. From studying the project/programme fact sheets, a lot of potential opportunities would in principle emerge. Below mentioned are just a few initial ideas for mainstreaming opportunities by programme (focusing on those which seem most relevant), which would, however, then need to be validated and revised by an assessment of the real needs, opportunities and resources of these programmes.

Decentralisation and local development Programme: strengthening capacity of Ministry of Local Affairs in HIV response, capacity building for local authorities in management (including financial) and their role in social development, including health and HIV. Learn from other countries (e.g. Tanzania, Mozambique, Lesotho, South Africa, etc[8]).
Strengthening national capacity for human rights; integrative justice sector development: integrate human rights regarding health and PLWHA; GIPA in law reform, support self help groups, help develop legal support services, capacity building, support monitoring and enforcement mechanisms, advocacy and awareness raising of police, etc.
Public financial management reform: Priority setting and budget allocation for multisectoral HIV response from top level to decentralised level. Advocacy and awareness raising. Tracking and financial monitoring, costing of HIV activities, etc.
Aid harmonisation: include cooperation and coordination, alignment and principles of "the three ones" into harmonisation efforts in Yemen.
Poverty reduction; Fishery Quality control for export: awareness raising on SRH &HIV when working with fishermen and in the context of eco tourism (do no harm principle). Explore including marginalised groups into that project.
Youth community access centres: integrate capacity building on SRH&HIV into work with youth groups, ICT for health and HIV (interactive websites, e- learning, etc), comprehensive counseling services, link recreational activities to SRH &HIV- linking that to UNICEF work.
Future projects for women's empowerment would obviously offer great potential for mainstreaming and creating synergies.

[8] for further information, see: http://www.tgpsh.or.tz/hiv-aids/download-section.html- go to CMACs books 1-3 for training manuals for local government authorities, and Bringing the AIDS Response Home- Empowering District and Local Authorities in Lesotho, Tanzania and Mpumalanga, South Africa http://www2.gtz.de/Dokumente/social-development/HIV-AIDS/en-local-response-longversion-2006.pdf for experiences from Lesotho, Tanzania and South Africa.
In addition, the SDC toolkit on mainstreaming HIV/AIDS in its printed version contains a CD Rom with practice examples from working with local governments in Mozambique. http://www.deza.ch/ressources/resource_en_24553.pdf

5 Annexes

5.1 Annex: Agenda/Programme of evaluation mission in country

Friday 9.11. 2007	Travel of international consultant to Yemen
Saturday 10.11.	Briefing of evaluators by Khaled Magead, Fuad El Sabri and Maruan El Krekshi Document study
Sunday 11.11	Concept and Questionnaire development by evaluators
Monday 12.11.	Meeting Deputy Minister PCH Meetings HIV focal Points Sana'a city and Sana'a governorate Meeting with representative of marginalised network Discussions with project team
Tuesday 13.11	Meeting with UNFPA Meeting with association of PLWHA Discussions with Project team Document study
Wednesday 14.11.	Meeting with UNICEF Discussions with Khaled Magead Meeting with NPC and Head of NGO Meeting with WHO Meeting with NAP
Friday 16.11.	Travel to Taiz
Saturday 17.11.	Meetings in Taiz (see list of people met) Travel to Aden
Sunday 18.11.	Meetings in Aden (see list of people met)
Monday 19.11.	Travel from Aden to Sana'a Meeting with representative of religious leaders
Tuesday 20.11.	Meeting with AIDS unit in NPC Drafting of Debriefing Presentation by evaluators
Wednesday 21.11	Debriefing Report writing
Friday 23.11.	Travel international consultant back to country of residence

5.2 Annex : List of persons met

In Sana'a City

Mr. Khaled Magead	Programme Officer in UNDP
Dr. Fuad Alsabri	HIV/AIDS Project Manager/Coordinator in UNDP since June 2007
Dr. Maged Al-Jonaid	Deputy Minister of PHC, MOPHP
Dr. Fouzia Gharama	Director of National AIDS Program, MOPHP
Dr. Abdulwahed Algurbani	HIV/AIDS Focal Point in Sana'a City
Mr. Muhammed Humran	HIV/AIDS Focal Point in Sana'a governorate
Mr. Ismail Hassan Shaiban	Finance Manager in UNDP HIV project, cine June 2006
Mr. Numan Khaid Muhamed	Head of National Network of development for Poverty
Dr. Himyar Abdulmoghni	RH National Program Officer in UNFPA
Mr. Alawi Hassan and 2 members	Head of PLWHA Supporting & Backing Group
Ms Buthaina Al- Iryani	HIV/AIDS and Youth specialist, UNICEF
Ms Judith Léveillée	Chief Child Protection, HIV and AIDS, UNICEF
Dr. Salma Anaskolo	WHO AIDs Advisor to National HIV/AIDs Program
Mr. Nabil Ali Alhaj	Head of Almagd Association for Awareness & Development in Human Rights
Sheik Jabri Ebrahim Hasan Kamel	Islamic Preacher, Social Reformer, Member of Local Council
Dr. Abdullah Al-Arashi	Executive Manager, AIDS Project Unit, GFATM, in National Population Council
Ms Dena Assaf	UNDP Deputy Resident Representative (during debriefing)

In Taiz

Dr. Abdulbaset Mahyoub	Director of PHC in Health & Population Office
Dr. Muhamed Abduldaiem	Deputy General Director of Health & Population Office
Dr. Saeed Sufian	National AIDS Program Focal Point
Mr. Badei Almekhlafi & other members	Head of Zeid Almowshiki Network for Marginalized

In Aden

Dr. Hana'a Alsaqaf	Director of PHC in Health & Population Office
Dr. Nabil Abdulrab	National AIDS Program Focal Point
Ms. Amani Alarousi	National AIDS Program Focal Point Assistant
Dr. Muhamed Abdulhalim	District Almualla Health Director and member of Local Council in the district
Ms. Radia Yassin Abdulla	Head of Social Comprehensive Services in Social Services Association
Ms.Huda Mahmud Mahfuz	Head of Woman Sustainable Development
Ms. Feroza Hamed Shamsuddin	Director General of cultural information and humanitarian services centre
Ms. Samira Abdulla Nassr	Director of Alferdous Association for Women Development
Ms. Hassan Khassem	Member of Developmental Charity Association
Mr. Abdulhakim Ali Farag	Albureiqa District HIV/AIDS Focal point

5.3 Annex: List of documents evaluated

- WHO; Yemen, summary country profile for HIV/AIDS treatment scale up 2005
- UNAIDS, WHO, UNICEF Yemen Epidemiological Fact Sheet, 2005
- Rogers Busulwa; HIV/AIDS Situation Analysis study, conducted in Hodeidah, Taiz, Aden and Hadhramut, Republic of Yemen. UNDP, WHO, NAP, MOHP. July 2003
- HIV/AIDS Advocacy Tools for the Republic of Yemen, Making use of Situation Analysis study findings, Prepared by Rogers Busulwa. UNDP/WHO, July 2003
- United Nations Development Assistance Framework , Republic of Yemen, 2007-2011
- 2005 MDG Needs Assessment, Yemen
- The Socio economic development plan for poverty reduction, Yemen 2006-2010
- GFATM/LFA, Grant Performance Report Yemen, August 2007
- UNAIDS Technical Support Division of Labour, 2005
- HARPAS/UNDP: Draft Arab Model Law On Rights and Duties of People Living With HIV/AIDS1
- UNDP HIV/AIDS corporate strategy on HIV/AIDS
- UNDP HIV/AIDS and poverty reduction strategies; Policy note August 2002
- UNAIDS/UNDP/WHO Joint Programme on Integrating AI DS into PRSPs, 2007
- NPC: list of sub recipients
- Fact Sheets of UNDP activities in Yemen
- National HIV/AIDS strategy 2007-2011, draft in Arabic, 2006
- National Population Policy and mid term targets 2001-2005
- Human Rights Gap study report, 2004 in Arabic

Project documents:

- Project Document of the Government of the Republic of Yemen. Capacity Building to NAP and mainstreaming into poverty and HR projects, 2004
- Project Budget Balance fiscal year 2005,2006,2007
- Workplan and estimated budget January- December 2007
- Workplan and estimated budget September-December 2007
- Financial Report and Activity progress report for the year 2005
- Financial Report 20.5.-31.12.2006
- Financial Report January-June 2007
- Financial Report July-November 2007
- Activity report June-December 2006
- Draft activity report July-November 2007
- Draft Law of 2007: concerning the rights and duties of PLWHA
- NAP materials to be reprinted
- Selection of IEC materials developed and used by NAP
- Selection of newspaper articles on workshops organised by project
- List of workshops which conducted by Capacity Building of NAP to respond to HIV/AIDS Project (UNDP Support).

Documents requested, not available:

List of mass media campaign activities
List of Focal points and Peer educators trained
Project baseline assessment, mid term and post intervention study report
Training tools for IEC activities
Report of field trips
Trend of numbers of condoms distributed through project supported interventions

5.4 Annex: Comments on draft law

- The introduction includes some factual errors or imprecision, which may also be linked to the weak translation of the document into the English language, e.g.:
  - *"disease **communication** (*transmission*) by sexual interaction **by any form whatsoever**"*- there are many forms of sexual interaction, particularly also protected intercourse, which are free of transmission risks.
  - *" use of contaminated **injections**"*- should be replaced by "injection materials, unsafe use, etc"
  - *"the virus' dissemination is concealed from scientists".* While it is true that many questions around the immune response are still unanswered, the transmission mechanisms and much of the immunological consequences of infection are known to scientists.
  - *"weak and vulnerable categories such as children and women"*-unfortunate link between women and "weak".
- Articles 9 (" *right to open sick leave with full pay until his health condition stabilizes* … or, if not….. *pending referral to pension*") bears a risk of **positive discrimination** (giving HIV positive persons more rights than to patients suffering from another chronic infection/disease, such as cancer or TB). Such a right may have perverse effects falling back on PLWHA. Employers will likely not be willing to employ a person known to be HIV positive, since they might have to pay sick leave over decades to that employee. From other countries, like Haiti for example, cases are known where people have faked HIV tests (to show positive results) in order to access certain rights, when there is positive discrimination (e.g. with food for PLWHA).
- The right to free antiretroviral and other treatment is to be welcomed and is in line with free treatment for TB or cancer patients in Yemen. However, **questions of sustainability** should be carefully considered. Currently ARTs are available in a few urban centres thanks to external funding (GFATM). Will the national system be in a position to afford taking over once the external support ceases?
- Several articles raise human rights concerns:
  - **Obligation to disclosure**: Art 13,26,27 (guardian of child to school; before marriage, to partner)- Art 27 doctor must inform married partner (confidentiality breach)
  - Art 21-22: **forced compliance** with PH authorities, to report, to subordinate to treatment
  - Art 28: **right to divorce** a partner known to be HIV positive

  While the local socio cultural and legal context needs to be taken into consideration, these articles are not in line with international human rights understanding.
- Art 45 regarding blood safety is too narrow; other tests like the one for Hep B, Syphilis, etc should also be mentioned
- There is **no article** that addresses the **right to receiving health services without discrimination.** In Yemen, discrimination by health workers is a major issue. Such an article should therefore be included.
- Part 5,art 50 penalties: the consequences of these articles under Sharia should be carefully considered. Art 50 (1) " If a guilty intentionally kills a specific person by communicating HIV to him with any means whatsoever and the criminal intent exists and his conduct resulted in the death of the victim, **he shall be subject to intentional killing penalty**…".
  An intentional virus transmission is always very difficult to prove. However, in any case, UNDP cannot support a law that calls for a death sentence for whatever crime committed. In addition, the penalty articles and the severe punishments linked to them may have a perverse effect. It could discourage people from undergoing testing, since they may prefer to ignore their status rather thank risking to face most severe punishments when transmitting the virus despite being aware of their status.

5.5 Annex - Project Budget Balance by fiscal year

	Budget 05	Exp 05	Available Budget 06	Exp 06	Available Budget 07	Exp 07*
1. **Management/ oversight**	122'780	**21'081**	75'200	**59'998**	39'336	**116'193**
2. **Training, awareness**	104'320	**7'260**	35'500	**14'022**	56'120	**32**
3. **Baseline HR**	35'00	**18'201**	11'102	**0**	14'000	**0**
4. Workshops, Advocacy HR	9'500	**3'000**	60'000	**0**	13'200	**0**
5. Advocacy, Mass media	2'000	**0**	31'000	**0**	26'000	**0**
6. NAP capacity building	17'000	**2'500**	25'00	**0**	49'000	**0**
7. Workshops for HR stakeholders	3'000	**0**	-	**-**	-	**-**
8. Training for NAP	2'000	**0**	-	**-**	-	**-**
Total	310'000	**52'044**	266'802	**66'020**	196'656	**117'774**

* expenditure registered in the system as of 20.11.2008