United Nations Development Programme

HIV/AIDS

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

COUNTRY STUDIES

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Evaluation Office, September 2006
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ALSO IN THIS SERIES

Evaluation of UNDP's Role and Contributions in the HIV/AIDS Reponse in Southern Africa and Ethiopia, Main Report, New York: UNDP, 2006

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CONTENTS

INTRODUCTION

This report is a companion volume to the main report on the evaluation of UNDP's role and contributions in the HIV/AIDS response in Southern Africa and Ethiopia, prepared by the Evaluation Office of the United Nations Development Programme.[1]

HIV/AIDS is the leading cause of death in Southern Africa. Almost one-third of the world's population infected with HIV/AIDS lives in the region. In some countries, the HIV/AIDS prevalence rate is as high as 40 percent, and the disease continues to spread. The socio-economic impact of the epidemic is so severe that it is reversing developmental gains that have been made in the region.

Following the adoption of the UN Millennium Declaration in September 2000, eight Millennium Development Goals (MDGs) were drawn from the actions and targets contained in the Declaration. One of the goals is halting and turning back the spread of HIV/AIDS. The United Nations has recognized that failing to reach this MDG will compromise all others. Unless there is a large and effective multisectoral response to HIV/AIDS, the virus will continue to spread and cause devastation. In light of this, UNDP has incorporated HIV/AIDS into its corporate strategy, making it one of its core goals.

The UNDP Evaluation Office in New York commissioned an independent evaluation of UNDP's role and contributions to the HIV/AIDS response in Southern Africa and Ethiopia. The main purpose of the evaluation was to assess, within the context of the MDGs and the Declaration of Commitment, UNDP's role in achieving key AIDS-related outcomes at the country level in order to learn from experience and improve the effectiveness of UNDP assistance. The evaluation was to be strategic in character and forward looking.

The evaluation was conducted in 10 countries in Africa: 9 countries in Southern Africa—Angola, Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe--and Ethiopia, in the Horn of Africa. Most of the countries were chosen due to their extremely high HIV/AIDS prevalence. The focus of the evaluation was the period beginning in 1999 and ending in 2004, with emphasis on outcomes that could be plausibly associated with UNDP's role and contributions.

The evaluation was undertaken by a team of four international consultants and by one national consultant in each country. The national consultants undertook country studies and drafted country reports, which are contained in this volume. The country studies and visits by the international consultants to 6 of the 10 countries were conducted between November 2004 and February 2005.

1 The main report, titled 'Evaluation of UNDP's Role and Contributions in the HIV/AIDS Response in Southern Africa and Ethiopia' was finalized May 2006 and presented to the UNDP Executive Board June 2006. The report and the management response are available on UNDP/EO's website www.undp.org/eo.

THE EVALUATION PROCESS

During the first phase of the evaluation, the international and national consultants participated in a two-day workshop in Johannesburg, South Africa. The aim of the workshop was to get a shared understanding of the purpose, methods and outcomes of the evaluation and develop an approach for how the evaluation would be conducted. National consultants were also briefed on their expected tasks. These included:

- conducting an inventory of UNDP programmes at country level
- outlining the evaluation methodology to be followed
- developing the research instruments to be used in consultations with stakeholders
- developing the main evaluation report format
- creating individual work plans, including the joint scheduling of international consultant visits to six countries

The next phase of the evaluation involved country-level assessments in which national consultants were engaged in consultations with the identified stakeholders. Using the pre-designed evaluation instruments, different categories of people to be consulted were identified. Consultations took different forms for the different stakeholders. For senior policy level officials, donors and representatives of UN agencies, consultations took the form of interviews on a one-to-one basis. For UNDP staff, meetings were held with concerned staff members. Focus group discussions were held with people at the community level, such as chiefs, youth, women, members of non-governmental organizations, and people living with HIV/AIDS. In 6 of the 10 countries, international consultants joined the national consultants in the assessment. These included Angola, Ethiopia, Lesotho, Malawi, South Africa and Zambia.

The focus was on outcomes and changes achieved, rather than on activities and processes of individual projects supported by UNDP. The focus of the evaluation was not limited to specific HIV/AIDS activities. Other UNDP programmes were reviewed that may have mainstreamed HIV/AIDS into their activities and addressed key factors that affect HIV/AIDS, or that may have missed the opportunity to do so.

Five outcome themes formed the basis of the evaluation:

- Governance in relation to HIV/AIDS
- Leadership for development
- Capacity development
- Mainstreaming of HIV/AIDS
- Partnership coordination for country level development results

METHODOLOGY AND APPROACH

The evaluation methodology included documentation, participatory assessment (through interviews with country offices, development partners, programme managers, and implementing agencies, and focus group discussions) and validation with key persons. The evaluation addressed the efficiency of UNDP's role and contributions, the degree of change affected by UNDP, accountability, and identification of programmes, partnerships, and results that helped change the way UNDP performed its work.

The country studies employed two key methods: interviews with stakeholders and document review. Interviews with informants included various institutions and organizations, including UNDP staff, UN country team representatives, government representatives from ministries of Health, National AIDS Councils, and other government departments; national and local non governmental organizations; participants of the UNDP Leadership for Development Results Programme; programme managers within the UNDP and other agencies; donor agencies; civil society and faith based organizations; and private sector entities. Document review included sources such as government policy frameworks and progress reports; UNDP project documents and frameworks; and documentation of institutes, associations and other development agencies.

Due to country-specific challenges, there were some changes to the evaluation methodology and final country studies in the case of two country studies: Angola and Malawi. For the Angola country study, recruitment difficulties prevented the initially recruited national consultant from completing the draft country assessment and other preparatory tasks prior to the international consultant's visit. The study did not include field visits and had fewer interviews and surveys with public officials and non governmental organizations. In the case of the Malawi country study, the country assessment report was limited due to capacity constraints, thus it is not included in this volume. However verifiable and relevant information pulled from the draft assessment was included in the Main Report of this evaluation. Summaries of all country case studies may be found in Annex 6 of the Main Report.

ANGOLA COUNTRY STUDY

HIV/AIDS

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

By Yema Ferreira and A. Edward Elmendorf

The authors thank the UNDP Country Office Angola for the invaluable help it provided.

ANGOLA

CONTENTS ANGOLA COUNTRY STUDY

1. INTRODUCTION

AIDS is the leading cause of death in the Southern Africa region. The socio-economic impact of the pandemic is so severe that it is reversing development gains made in the 1980s.

Halting and turning back the spread of HIV/AIDS is one of the Millennium Development Goals (MDGs) adopted by the UN. In light of this, UNDP has incorporated HIV/AIDS into its corporate strategy, making it one of its core goals during the second multi-year funding framework period. In late 2004, the UNDP Evaluation Office commissioned an evaluation of UNDP's role in the HIV/AIDS response in hopes of improving the effectiveness of UNDP assistance. UNDP's contributions were examined in 10 countries in Africa from 1999 to 2004.

The methodology used for the evaluation was data and document collection and review, interviews, and subsequent validation of preliminary findings in a feedback meeting with the available principal stakeholders. Information was collected and interviews were conducted with officials from the Government of Angola Ministerial Departments and different UN agencies in Angola, and in an overall meeting with local non-governmental organizations (NGOs).

In the case of Angola, the methodology adopted for the country studies was compromised. There was limited time for report completion following the country visit. The study did not include field visits, had fewer contacts with public officials, and did not undertake surveys or other contacts beyond a general, exploratory meeting with NGOs. Also, recruitment difficulties did not allow the initial national consultant to complete the draft country assessment or other preparation tasks prior to the international consultant's visit. As a result, it was agreed that a new national consultant, hired following the visit of the international consultant, would prepare a country report. This report would be prepared in cooperation with the international consultant but, due to constraints of time and experience, would not be the kind of country assessment report outlined in the original terms of reference. The international consultant visited Angola in mid-February 2005. Ultimately, the international consultant joined as a second author and principal editor of the study.

2. COUNTRY BACKGROUND AND HIV/AIDS SITUATION

The HIV/AIDS situation in Angola, including its epidemiology, needs to be understood in the context of the country's health indicators and social, economic and political situation. In 2002, life expectancy at birth in Angola was only 40 years, and the infant mortality rate was an extraordinarily high 154 per 1,000 live births. The country's population of 13.5 million was growing at a high rate of 3.0 percent per year. Nonetheless, thanks principally to its petroleum resources, Angola had a per capita gross domestic product of USD 857 in 2002.

Angola is also emerging from a civil war that spanned three decades. The war destroyed most of the country's health system. It also eroded social services and prevented the development of human capacity. As a result, Angola has some of the worst human development indicators in the world. The country's human development index rank in 2002 was the lowest among all of the case-study countries in this evaluation. During the war and in the immediate post-conflict era, government officials and other actors in Angola were more concerned with the emergency situation and issues—such as demobilization of ex-combatants, resettlement of displaced populations, and food aid—than with long-term issues. As a result, little attention and few resources were allocated to HIV/AIDS.

Since the end of the war, Angola has gradually moved from an emergency situation into a period of transition towards development. This has meant that more attention can be given to HIV/AIDS. The process of reconstruction has begun, but the rehabilitation of health and social infrastructure has not advanced significantly enough to increase access to healthcare and other services by the majority of the population.

The limited data on the epidemiology of HIV/AIDS in Angola suggest that the first cases of AIDS in Angola were diagnosed in 1985. The civil war made it difficult to carry out studies to determine HIV/AIDS prevalence. Sentinel surveillance was inconsistent, and national information was limited. However, some information exists on HIV seroprevalence among pregnant women seeking antenatal care. Studies of pregnant women attending

antenatal clinics in Luanda suggest a rapid expansion of HIV infection. The rate of infection among this group went from 3.4 percent in 1999 to 8.6 percent in 2001. In Cabinda, a province bordering the Democratic Republic of the Congo, prevalence went from 6.8 percent in 1992 to 8.5 percent in 1996. Other groups also were tested: Among commercial sex workers in Luanda, HIV prevalence increased from 20 percent in 1994 to 33 percent in 2001;[1] prisoners had a 12 percent prevalence rate; patients seeking care for sexually transmitted infections, 12.1 percent; tuberculosis patients, 10.4 percent; mine workers, 9 percent; military personnel, 3.2 percent; and blood donors, 1 percent. According to a Futures Group International study in 2002, these figures taken together point to an epidemic that has reached a generalized stage.[2]

The Joint United Nations Programme on AIDS (UNAIDS) 2001 estimates placed adult prevalence at 5.5 percent.[3] More recent studies, however, suggest lower rates. According to UNAIDS, Angola's prevalence was 3.9 percent in 2003. The study of HIV prevalence, sponsored by the U.S. Centers for Disease Prevention and Control, which covered every province, showed an adult national prevalence rate of only 2.8 percent.[4] Some of the provinces bordering neighbouring countries facing an HIV/AIDS crisis show higher rates, the most prominent of them being Cunene with 9 percent.

The main modes of HIV transmission in Angola are sexual, mostly by heterosexual contact (52 percent); transfusion, including accidents with infected material (38 percent); and mother-to-child transmission (10 percent).

3. COUNTRY RESPONSE

3.1 NATIONAL RESPONSE

In 1987, the Ministry of Health established the National Programme to Fight AIDS (PNLS), marking the beginning of the government's fight against AIDS. Several action plans were elaborated thereafter. They failed to be fully implemented due mainly to the civil war and lack of financial support.

With the opening of a UNAIDS office in 1998, the national response to the epidemic intensified and became more effective. UNAIDS, through its different sponsors, directly engages with the government, supporting the design and implementation of public policies as well as resource mobilization from Angola's development partners to finance government and civil society organization actions.

In 1999, the first National Strategic Plan (NSP) to fight HIV/AIDS was adopted for the 2000-2002 period. That same year, the government instituted a mother-to-child transmission prevention programme, although implementation did not begin until 2002.

In 2002, the National AIDS Commission (NAC) was created with a mandate to coordinate and oversee the fight against HIV/AIDS and other epidemics at the national level. Also in 2002, the government created the first centre in Luanda for the treatment of people infected with HIV, the Multiperfil Clinic. Unfortunately, it has had very limited coverage.

In 2003, using a participatory, multisectoral and multi-disciplinary process, the authorities prepared and adopted the NSP 2003-2008. That same year, discussion on laws to protect people living with HIV/AIDS intensified, as did government activity in the formation of policies for the provision of anti-retroviral treatment and activities related to the operationalization of NAC plans.

In March 2004, the first AIDS hospital was inaugurated in Luanda. Although there have been marked improvements in care and assistance to people living with HIV/AIDS, very few hospitals have been in a position to provide comprehensive, high-quality specialized services to this group. Furthermore, these services have been concentrated in Luanda and provincial capitals, making access difficult for the majority of the population.[5] Also in 2004, an AIDS law was approved and promulgated. At the time of the fieldwork for this study, the authorities had yet to issue regulations for implementation of the law, thus

1 UNAIDS, UNICEF, WHO, "Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: 2002 Update," Angola, 2002.
2 Gaillard E, "HIV/AIDS in Angola: Epidemiological Projections of HIV/AIDS in Angola, Methodology, Parameters, Sources and Hypothesis," The Futures Group International with UNICEF and UNDP, draft, no date.
3 Defined as people aged 15 to 49 years.
4 Centers for Disease Control, "Seroprevalencia do VIH em Mulheres Grávidas em Consulta Prenatal, Relatório Geral," Powerpoint Presentation, Angola, 2004.
5 Rossi L, Jorge F, "Estudo da Resposta das Organizções Não Governamentais (ONG) Angolanas no Combate a Epidemia do VIH/SIDA," Ministério da Educação, 2004.

rendering it ineffective. A law regarding HIV in the workplace was also approved.

In January 2005, the PNLS was renamed the National AIDS Institute. This change gave it greater visibility within the Ministry of Health hierarchy and direct access to the Office of the Minister.

In addition to the government's response, national NGOs have been working in the fight against HIV/AIDS since the 1990s. Some, such as Luta Pela Vihda and Acção Humana, provide care and psychosocial services to people living with HIV/AIDS. However, most work is on prevention. NGOs that focus on HIV/AIDS have evolved in the last few years but face many problems, such as institutional weakness, extraordinarily limited capacity for service delivery, and lack of funding. In addition there is very little collaboration between the NGOs and the government—due largely to strained relationships.

The financial situation of the country with regard to HIV/AIDS has changed dramatically during the past several years with the approval of a USD 90 million grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and a USD 21 million grant from the World Bank for the HIV/AIDS, Malaria and Tuberculosis Control Project (HAMSET). A country coordination mechanism was created in Angola for the preparation of a proposal for the GFATM. The country coordination mechanism, or National Coordination Mechanism as it is called in Angola, includes partners from the Angolan government, bilateral and multilateral agencies, national and international NGOs, faith-based institutions for people living with HIV/AIDS, and the private sector.[6]

3.2 UNDP RESPONSE

The UNDP country office (CO) had relatively little information and documentation on UNDP HIV/AIDS-related activities prior to 2002. The CO underwent a reprofiling exercise in 2001 that significantly altered UNDP's operations. However, a few HIV/AIDS activities are documented from the period before 2001 and shed light on the evolution of UNDP involvement in HIV/AIDS in Angola.

Prior to 2002 and reprofiling, UNDP HIV/AIDS-related activities were almost entirely limited to studies. In 1999, UNDP supported the first socio-economic impact study of HIV/AIDS in Angola. In 2001, UNDP and the United Nations Educational, Scientific and Cultural Organization (UNESCO) sponsored a survey on Angolan's perceptions and knowledge regarding HIV/AIDS and their human development levels. This study was the basis for a project on HIV/AIDS in the education sector.

2002 marks the beginning of a new era for UNDP regarding HIV/AIDS in Angola. With the Ministry of Education, UNDP began support to a project titled 'Strengthening the Education System in Angola to Combat HIV/AIDS'. The aim of this project is to use the education system to reduce the impact of HIV/AIDS in Angola. The project's main activities are training social actors (teachers, community leaders, members of the Armed Forces and media), building networks and services for the social actors' target groups, and designing educational materials. The project also produced a second study of the socio-economic impact of AIDS in Angola.[7]

In November 2002, UNDP facilitated a study tour for senior Angolan officials to visit Uganda. The objective of the visit was to learn lessons from the Ugandan experience in combating HIV/AIDS in terms of policies, programmes and actions. As the study tour was conceived, the delegation was to include senior personnel from the National Assembly, the Council of Ministers, the PNLS, the Ministry of Education, and the Ministry of Family and the Promotion of Women.

UNDP provided technical support in the formation of the NSP, the regulations for the work of the NAC, and the preparation of the proposal to GFATM. UNDP was also involved in drafting the AIDS law and was instrumental in integrating HIV into Angola's Interim Poverty Reduction Strategy Paper (I-PRSP).

In accordance with UN global policy, the UNDP CO made efforts to tackle HIV/AIDS in the UNDP workplace. After a series of meetings in 2004, three elected peer educators attended a one-week training

6 Global Fund to Fight AIDS, TB and Malaria, "Fourth Round Proposal from Angola," 2004.

7 Gaillard E, "HIV/AIDS in Angola: Epidemiological Projections of HIV/AIDS in Angola, Methodology, Parameters, Sources and Hypothesis," The Futures Group International with UNICEF and UNDP, draft, no date.

course on HIV/AIDS in October. The training prepared them for awareness raising and referral. In addition, the UNDP human resources (HR) staff has periodically sent employees information on UN policy regarding HIV/AIDS and the rights of seropositive personnel.

In January 2004, UNDP was selected as principal recipient for the GFATM grant to Angola. As principal recipient, UNDP is responsible for managing the grant, disbursing the grant to beneficiaries, and monitoring and evaluation. In addition, UNDP is charged with building government capacity to take on the principal recipient role within two to three years. Reconciling the immediate focus on project implementation with the need to build government capacity in order to assume the principal recipient role has been a challenge for UNDP.

4. OUTCOME OF UNDP CONTRIBUTIONS AND SUPPORT

This section reviews outcomes under the five themes that were used by the evaluation team to examine UNDP's contributions to the HIV/AIDS response in each of the case-study countries: governance, leadership for development, capacity development, mainstreaming of HIV/AIDS into overall development activities, and partnership coordination for country results. It then places this material in context with financial data on HIV/AIDS and the challenges affecting UNDP's work on HIV/AIDS in Angola.

4.1 GOVERNANCE

During 2003, UNDP participated in the preparation of the NSP, providing both financial and technical support to its formation and adoption. While other UN agencies were involved, the UNDP CO focal person for HIV/AIDS was a key player. In addition, much of the information contained in the NSP regarding projections and impact was derived from the 1999 UNDP socio-economic impact study.[8] The NSP has been translated into provincial plans in a process that also benefited from UNDP input. There is now a need to make these provincial plans operational.

8 Annan J et al, "Final Report: HIV/AIDS SURF Mission to Angola," JSA Consultants and UNDP Bureau of Development Policy, Pretoria, 26 February 2002.

UNDP contributed technical assistance and support to the preparation of Angola's AIDS law, which outlines duties and obligations of people living with AIDS. However, many say that the law is incomplete. Some argue that people living with HIV/AIDS are normal citizens and should have the same duties and obligations as others. Others find the law weak because it has few provisions about children, and Angolan children are especially vulnerable because the government does not have an anti-retroviral distribution plan for this group. In addition, the AIDS law does not outline the responsibilities of the state towards people living with AIDS. Some stakeholders have identified these issues as an opportunity for additional UNDP involvement. (It should be noted that, in contrast to the overall AIDS law, Angola's law on HIV in the workplace is seen as a good piece of legislation.)

UNDP also assisted in preparing the rules and regulations for the NAC. The NAC is led by the President of Angola and composed of ministers and vice-ministers from several ministries, as well representatives from the medical faculty of the University of Angola and the Armed Forces. The mandate of the NAC is coordination, management, monitoring and evaluation. Some stakeholders feel that the NAC is non-operational and non-representative. It does not, for example, include people living with HIV/AIDS. It is also said that democratic processes within the NAC have yet to be respected. Several stakeholders see an opportunity here for UNDP to intervene in both clarifying the role of the NAC and pushing for it to be more representative.

As this report was being completed, UNDP was working with the Ministry of Health to develop regulations for the AIDS Law, the National Institute to Fight against AIDS, and the National Commission to Fight AIDS and Endemic Diseases. For this purpose, a technical working group has been constituted, including members from the government, civil society and UN agencies.

In addition to the NAC, Angola now has an AIDS Institute, a National Coordination Mechanism for the GFATM, and a Project Implementation Unit created for the World Bank-financed HAMSET Project, which also serves as a Secretariat to the NAC. The AIDS Institute is an upgrade of the PNLS and is an implementation body.

Beyond its project-specific work, UNDP has been engaged in dialogue on HIV/AIDS issues with political leaders and other stakeholders on HIV/AIDS in the country. From the interviews conducted for this report, it appears that UNDP has contributed substantially to the increased awareness by Angolan leaders of HIV/AIDS issues that have emerged in the country during the period of this review.

4.2 LEADERSHIP FOR DEVELOPMENT

The UN Theme Group on HIV/AIDS brings together all UN agencies at the Resident Representative level for consultation on all UN agency HIV/AIDS policies and programmes. Different agencies have different objectives regarding HIV/AIDS, so together they analyze how their programmes can be integrated at the country level. In Angola, the Theme Group also has a technical group called the UN Technical Working Group on HIV/AIDS. Due to a high level of turnover and frequent change in leadership, the UN Theme Group on HIV/AIDS has not been very active during the period covered by this evaluation. There was a six-month gap between the last and the current Resident Representative. During that time, the Theme Group was not a priority. There has been low participation and even lack of representation from some agencies. Recently, however, the group agreed on a new set of terms of reference and is working to revive itself. Determined leadership and follow-through will be needed.

In 2004, UNAIDS adopted the 'Three Ones' principles, which call for one agreed-upon HIV/AIDS action framework, one national HIV/AIDS coordinating authority, and one agreed-upon country-level monitoring and evaluation programme. These principles are meant to facilitate coordination of national responses and avoid duplication and fragmentation of HIV/AIDS responses. According to key observers, the Three Ones are not working in Angola. Although the NAC mandate includes monitoring and evaluation, it is widely considered to be non-operational. In this situation there might be an opportunity for UNDP to take the lead, in cooperation with other donor institutions, to clarify and operationalize the roles of each of the various existing Angolan bodies.

In April 2005, UNDP started a sub-group of the UNAIDS Technical Working Group to harmonize UN activity on education and HIV/AIDS. The group includes UNICEF, UNESCO and UNDP.

The study visit to Uganda by an Angolan delegation (organized through the UNDP Regional Centre in South Africa) provided an opportunity for Angolan leaders to learn lessons from a country with an extensive, positive experience in the fight against HIV/AIDS. The delegation included a member of the National Assembly, a member of the Council of Ministers, the Director of the PNLS, one representative from the Ministry of Education, and one representative from the Ministry of Family and the Promotion of Women. Unfortunately, there was no follow-up to the visit, nor is there any documentation of actions that may have resulted from it. Under these circumstances, it is difficult to identify specific outcomes from this valuable leadership development initiative.

UNDP Angola has not made use of instruments offered by UNDP's Bureau for Development Policy for leadership development in the area of HIV/AIDS. The Leadership for Results Programme was launched by the Bureau in 2002. The Leadership for Development Programme, a component of the Leadership for Results Programme, involves building the capacity of individuals from all sectors of society (such as government, NGOs, private sector and faith-based organizations) to become new leaders in the fight against HIV/AIDS. The programme is part of a global UNDP initiative to build leadership and commitment in different sectors of society to address the underling causes of the epidemic. In Africa, Leadership for Results Programmes are being implemented in Botswana, Ethiopia, Ghana, Lesotho, Senegal, South Africa and Swaziland. Angola might benefit from such programmes.

4.3 CAPACITY DEVELOPMENT

The 2001 UNDP survey of Angolan perceptions regarding HIV/AIDS created tangible results. The survey generated new information about Angolan level of knowledge about HIV/AIDS. This new information was used to design an appropriate intervention, namely, the education project 'Strengthening the Education System in Angola to Combat HIV/AIDS'.

UNDP sponsored a subsequent study commissioned by UNESCO and UNICEF on the socio-economic

impact of HIV/AIDS in Angola.[9] The study was meant to be used as an advocacy tool for programming and mobilizing the government, civil society and donors, but it was never published. Although the study was used in informal ways, the fact that it was not published and had limited distribution restricted its influence.

A positive, unforeseen capacity-building outcome has arisen from the UNDP education project that was designed based on the 2001 UNDP survey. The education project was conceived to cover five provinces, with coordination in Luanda. As implementation progressed, it became evident that managing the project from Luanda would be difficult. As a result, the project was decentralized. Provincial nuclei were created in each province and linked to the provincial Education Delegations.[10] Each nucleus was responsible for managing activities and funds at the provincial level and reporting to Luanda. The Luanda Headquarters unit remains responsible for management at the national level, training, monitoring and evaluation.[11] A positive, unanticipated side effect of this measure has been to begin to create learning and capacity for project management and implementation at the local level.

UNDP achieved some progress in building its own capacity to intervene in the national response to HIV/AIDS, although this increase in capacity appears not to have been sustained. In 2002, UNDP Angola benefited from a support mission of the UNDP Regional Project under the Bureau for Development Policy in Pretoria and JSA Consultants Ltd., Accra, for assistance in HIV/AIDS programming. The mission identified a need for the UNDP CO to build its capacity by engaging an HIV/AIDS focal point and by making HIV/AIDS into a separate practice area. Changes made in the CO regarding HIV/AIDS appear, in part, to derive from recommendations made by this mission. UNDP engaged a full-time person as the focal point for HIV/AIDS starting in 2002. According to many interviews with donor agencies, this person was the driving force behind UNDP involvement in HIV/AIDS and contributed significantly to the Government of Angola's HIV/AIDS accomplishments. Unfortunately, the HIV focal point was hired under the Junior Professional Officer Programme. This programme is financed by the candidate's government of origin for a maximum of two years, which affects continuity. A new person has recently been hired for the post. However, HIV/AIDS is still not its own practice area but is part of the UNDP CO Poverty Cluster.

4.4 MAINSTREAMING HIV/AIDS RESPONSES

HIV/AIDS appears in the UNDAF 2005-2008 as a cross-cutting theme and under one of three areas of strategic intervention, 'Rebuilding the Social Sectors'. In line with the UNDAF, controlling the spread of HIV/AIDS figures as an outcome in the Country Cooperation Framework (CCF) for 2005-2008 under 'Rebuilding the Social Sectors'. Expected outcomes for UNDP within this area are:

- Integration of HIV/AIDS in the national curriculum, through both formal and informal education
- Building and strengthening of community social networks where HIV/AIDS is discussed and services are provided to women, men, adolescent mothers and orphans living with HIV/AIDS
- Implementation of baseline studies that evaluate the impact of HIV/AIDS on the educational system and design and implementation of prevention strategies
- Inclusion of a long-term cost-benefit analysis of an effective multisectoral response to HIV/AIDS in the Ministry of Finance's economic policy framework
- Operationalization of the NAC, ensuring the capacity of the national and provincial AIDS programmes are strengthened
- Evaluation of and planning for the HR impact of HIV/AIDS by the national government
- Decentralization of the NSPs

This agenda represents a substantial expansion of planned HIV/AIDS-related outcomes as compared with the CCF for 2001-2003. The 2001-2003 CCF foresaw a poverty reduction strategy being formed and effectively implemented, and the adoption of comprehensive strategies to prevent the spread and mitigate the impact of HIV/AIDS. An Interim Poverty Reduction Strategy has been

9 Gaillard E, "HIV/AIDS in Angola: Epidemiological Projections of HIV/AIDS in Angola, Methodology, Parameters, Sources and Hypothesis," The Futures Group International with UNICEF and UNDP, draft, no date.
10 Provincial divisions of the Ministry of Education.
11 Grangeiro A, "Avaliacao do Projecto Fortalecimento do Sitema Educativo de Angola," draft, February 2005.

adopted, with inclusion of a fairly routine section on HIV/AIDS. Some strategic actions were taken in connection with the formation of the National AIDS Strategy, but it would be hard to assert that comprehensive, implementable strategies to prevent the spread and mitigate the impact of HIV/AIDS have been adopted.

The UN agencies' HIV in the Workplace Programme in Angola has made some (although relatively little) progress. There has not been much activity since the training for the programme, but peers reported that they were thinking of planning some outreach activities, as people were not yet seeking their help. There was an expressed desire to link the work of the peer educators to the UNDP HR staff and the UN clinic, but some concerns were raised about confidentiality in the clinic. The HR staff is well involved in HIV/AIDS issues and periodically sends information to employees on their rights relating to HIV/AIDS.

The UNDP project 'Strengthening the Capacity of the Educational System to Combat HIV in Angola' has succeeded in beginning to mainstream HIV/AIDS in the Angolan education system. The project trains social actors (such as teachers and other community members) in five provinces and has recently expanded its activities with the military and the police to two additional provinces. In 2003 and 2004, 237 social actors were trained. Of these trainees, 136 carried out prevention activities in their communities. Their activities included workshops, condom distribution and surveys. A total of 345 social actors have been trained. The project has reached 7,968 beneficiaries in 65 schools from primary through tertiary education.

UNDP is largely credited with inclusion of HIV/AIDS issues into Angola's I-PRSP. This is a substantial gain, even though most stakeholders interviewed thought that the I-PRSP needs improvement. Discussion of HIV/AIDS appears in the I-PRSP as the fourth out of 10 priority areas, closely followed by education and health respectively. Although the section on HIV/AIDS is not very extensive, it is not very short when compared to the Education and Health sections. The I-PRSP makes the link between poverty and gender inequity and the spread of HIV/AIDS and touches on the need for collaboration between all sectors for results. It does not, however, recognize the spread of HIV/AIDS as an impediment to development. Strengthening the integration of HIV/AIDS issues into the PRSP process could be a future UNDP priority, particularly with regard to effective management of the significant new external resources flowing to HIV/AIDS activities in Angola.

In 2004, the UNDP CO discussed mainstreaming HIV/AIDS issues into all projects. However, it was decided that ongoing projects could not be altered,[12] and very few new projects have been approved since the discussion. The issue of HIV/AIDS began to appear very loosely written into some projects starting in 2004. In the Governance Cluster, for example, HIV/AIDS is reportedly under consideration for inclusion in UNDP training of magistrates, in a decentralization project and in a gender project. Even though activities had not yet begun in the field at the time this report was written, these initiatives merit pursuit and expansion.

4.5 PARTNERSHIP COORDINATION FOR COUNTRY RESULTS

UNDP's most important contribution to partnership coordination for country results in Angola has been in regard to the GFATM. External observers in the donor community widely credit the persistence of UNDP CO staff with completion and approval of the GFATM grant. UNDP's involvement in the preparation and drafting of the GFTAM proposal contributed to its selection as principal recipient of the grant. As one interviewee put it, UNDP Angola has become the window through which GFTAM funds can reach projects in Angola, and this could not happen through the government at this time.

There have been some successful partnerships with other UN agencies, such as the previously mentioned studies with UNESCO and UNICEF. Other strategic partnerships with bilateral donors have occurred, most prominently with the Norwegian Agency for International Development (NORAD) in funding the UNDP education project. NORAD's funds were specifically meant for activities with national NGOs. The money was not used in the end, because most of the NGOs identified for the project

12 It is difficult for the writers to imagine that ongoing projects cannot be altered; the effort to do so may, however, outweigh the expected benefits.

through a study of the response of national NGOs to the epidemic[13] did not have the capacity to handle the funds. A more imaginative approach might have identified alternative ways of managing funds for the NGOs, but the problem is an excellent illustration of the more general issue of incredibly low institutional capacity throughout Angola.

The education project, Strengthening the Capacity of the Educational System to Combat HIV in Angola, has brought about a new kind of partnership in Angola between the government and NGOs. The project has allowed for participation of local NGOs by integrating them into the provincial nuclei. In one province, Kwanza-Sul, NGOs make up the majority of the local staff. This is the province with the highest level of project activity. This type of partnership is extremely relevant to the project in that it expands capacity to respond to the epidemic, promotes community involvement, and incorporates innovative measures initiated by the organizations working with and representing people most affected by the problem.[14] Outside the education project, however, UNDP staff recognize that UNDP has few partnerships with civil society. This area merits more attention in the future.

Several stakeholders described the UNDP CO as having very slow, bureaucratic procedures for disbursement of financial resources. The quarterly activity reports of the education project repeatedly allude to instances where project actions were delayed or compromised, due to untimely availability of funds. These delays could also be attributable to weaknesses in project management, rather than in the CO, but the issue merits examination because such concerns have been raised in other contexts as well.

4.6 HIV/AIDS SPENDING IN ANGOLA

According to the World Bank's HAMSET Project appraisal, the Government of Angola devoted on average 1.5 percent of gross domestic product to the health sector from 1997 to 2001, while the average for the Southern Africa Development Community countries was 3.3 percent. Average per capita health expenditure during the period was USD 10.9. However, spending increased significantly in 2001, reaching USD 19.6 per capita— approximately twice that of similar African countries. The proportion of spending in the provinces increased from 44 percent of the total in 1999 to 55 percent in 2001. However, spending is not evenly distributed. In 2001, the interior provinces only spent USD 4.6 per capita, but the coastal and eastern provinces spent almost USD 12. The difference can be attributed in part to the fact that many of the interior provinces were occupied by the political faction UNITA and access was restricted. Nevertheless, these data underscore the fact that the government should make a special effort to provide a more equitable distribution of funding.

The Angolan State Budget for 2005 provides for 1,270,455,430 Kz (0.14 percent) for the PNLS and 1,174,526,524 Kz (0.13 percent) to fight important endemic diseases including HIV/AIDS. Data on past HIV/AIDS-related expenditures in Angola reported in the NSP are not disaggregated by object of expenditure. Thus, while the data can give us an idea of how much the authorities plan to spend on HIV/AIDS, the budget does not give us the context of that spending. For example, how much is each institution expected to spend? How does proposed spending compare with prior spending? How is the spending distributed geographically, by health system level, and by target population? An effort was made to collect more systematic data on health and HIV/AIDS spending in connection with this study, but it proved impossible to do with the available human and financial resources.

UNDP's CO has estimated that, in 2004, UNDP spent USD 720,000 on HIV/AIDS in Angola. In 2003, the corresponding figure was USD 560,000. In both years, this was approximately 7 percent of UNDP's total country programme spending, including trust funds. These figures represent marked growth, compared to the approximate USD 16,000 spent in 2002, which was less than 1 percent of total country programme spending. These data suggest that HIV/AIDS issues have risen from low to medium urgency in the work of UNDP in Angola. Whether this is sufficient in light of UNDP's corporate priorities, the UNDP CO strategy, and the relatively low prevalence of HIV/AIDS in the country, merits further examination by the CO.

13 Rossi L, Jorge F, "Estudo da Resposta das Organizções Não Governamentais (ONG) Angolanas no Combate a Epidemia do VIH/SIDA," Ministério da Educação, 2004.

14 Grangeiro A, "Avaliacao do Projecto Fortalecimento do Sitema Educativo de Angola," draft, February 2005.

4.7 CHALLENGES AFFECTING UNDP'S ACHIEVEMENTS ON HIV/AIDS IN ANGOLA

Angola is going through a period of transition. Its partnerships with development agencies, national and international NGOs, and other stakeholders are no longer entirely centred on humanitarian assistance. Within the UN System, the UN Office for the Coordination of Humanitarian Assistance (OCHA) and World Food Programme were at the centre. In the new post-war context, all actors, including UNDP, face the challenge of redefining their roles in Angola.

UNDP has suffered a high level of personnel turn over, sometimes going through extended periods of time with no replacement for key staff. At times, this has been a major challenge in moving forward. The Theme Group is an example where HIV/AIDS related activities lost their priority due to changes in personnel.

Angola has a prevalence of HIV infection far below that of its neighbours. There has only been one widely publicized case of a woman coming out and affirming herself to be HIV-positive. Stigma and discrimination are very high. These factors make it very difficult for people to think of HIV/AIDS as a real problem that can affect them. This makes it difficult to engage people into taking action. UNDP is well placed to help Angola tackle this general attitude.

Many stakeholders would like to see the UNDP CO change from what they see as a slow bureaucracy to a responsive service provider and shift from supporting isolated projects to supporting national programmes. UNDP is also perceived as placing excessive emphasis on planning, often at the expense of implementation. Unfortunately, the extremely limited capacity of Angolan public and private institutions may limit how much can be achieved in the fight against HIV/AIDS in a short period of time. As previously mentioned, the Three Ones were thought not to be working in Angola when this report was written. There is an NAC, an AIDS Institute, a National Coordination Mechanism for GFATM, and a Project Implementation Unit for HAMSET, but the complexity of this set of institutions may cause coordination problems. There is a need to clarify roles and responsibilities.

It also should be noted that UNDP's role regarding HIV/AIDS in Angola was not well understood by many of the stakeholders with whom we met. Furthermore, the stakeholders found it difficult to differentiate between UNDP HIV/AIDS-related activities and those of other UN agencies. This points to a lack of strategic definition and communication by the UNDP CO of its role regarding HIV/AIDS.

Another area appearing to be missing in work of UNDP CO Angola is results-oriented reporting, monitoring and evaluation. The CO's HIV/AIDS-related activities in outside projects were either not systematically documented or the documentation was not made available to the evaluation team. The reports examined contained very little information beyond project activities. As a consequence, the results of those activities and the impact they have on the people, structures and community, are often left for the reader to infer.

5. CONCLUSIONS AND RECOMMENDATIONS

The main HIV/AIDS-related contributions of UNDP to the national response in Angola have been the following:

- An increased awareness of HIV/AIDS among Angolan leaders
- Capacity building in the Government of Angola through informal and continuing contacts
- A framework of institutions for action on HIV/AIDS, although this framework still lacks clearly defined roles and practical operational activity
- Significant new external financial resources from GFTAM with plausible clear association

With its low HIV prevalence rate of 2.8 percent, Angola has an unprecedented opportunity to avoid the devastation being caused by the pandemic in Southern Africa. The visit of Ambassador Stephen Lewis, Special Representative of the United Nations Secretary General on HIV/AIDS in March 2005 was a great opportunity for Angola. It drew the authorities' attention to real possibilities for action.

Possible future HIV/AIDS-related actions for UNDP in Angola could include:

- Instituting central and continual focus on prevention throughout UNDP's programme and policy dialogue, in order to take advantage of Angola's window of opportunity for dramatic action to prevent HIV/AIDS while seroprevalence is low
- Contributing to the operationalization of provincial AIDS plans
- Contributing to the operationalization of the NAC and clarification of the structures and roles of the National Coordination Mechanism, the AIDS Institute and the HAMSET Project Implementation Unit
- Enriching the AIDS Law
- Redefining, communicating and implementing UNDP's own transition in strategy and roles regarding HIV/AIDS as a result of the changing environment, and reviewing the level of urgency merited by HIV/AIDS in the UNDP country programme
- Taking greater risks, such as expanding successful programmes (e.g., the education project) to a national scale
- Drawing more fully on existing UNDP instruments
- Assisting in the collection, analysis and dissemination of disaggregated information on HIV/AIDS spending in the context of health spending by the public authorities, NGOs, and the country's development partners, possibly in cooperation with the HAMSET Project
- Focusing on capacity building to facilitate use of World Bank and GFATM financial resources by beneficiaries not accustomed to World Bank and GFATM procedural requirements, including dissemination of guidelines, training of applicants for funding, and support to design of large programmes based on UNDP and other pilot programmes
- Including results-oriented monitoring and evaluation in all UNDP activities
- Giving high priority to implementation and capacity building support for use of GFATM funds
- Reassessing and strengthening UNDP CO capacity to support Angolan national, provincial, and local authorities and civil society organizations on HIV/AIDS, including—if necessary—revision of the terms of employment of the HIV/AIDS focal point and engagement of a full-time NGO focal point
- Engaging more substantially with national civil society organizations
- Speeding up and simplifying UNDP administrative and financial functions in consultation with UNDP Headquarter units
- Moving from reflection to action on mainstreaming HIV/AIDS into all UNDP projects
- Strengthening HIV/AIDS issues in the Angola PRSP process
- Collaborating with the Ministry of Planning on mainstreaming HIV/AIDS into other Government of Angola programmes and strategies

ANNEX 1. ACRONYMS AND ABBREVIATIONS

CCF	Country Cooperation Framework
CO	Country Office
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAMSET	HIV/AIDS, Malaria and Tuberculosis Control Project (World Bank)
HR	Human Resources (personnel management)
I-PRSP	Interim Poverty Reduction Strategy Paper
Kz	Kwanza, national currency
MDG	Millennium Development Goal
NAC	National AIDS Commission
NGO	Non-governmental Organization
NORAD	Norwegian Agency for International Development
NSP	National Strategic Plan
PNLS	National Programme to Fight AIDS
PRSP	Poverty Reduction Strategy Paper
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNESCO	United Nations Educational, Scientific and Cultural Organization

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ANNEX 3. PEOPLE INTERVIEWED

GOVERNMENT ORGANIZATIONS

Dr. Basilio Cassoma, Director of Planning, Cabinet, Ministry of Health
Manuel Costa, Director, MAPESS
Monica Edaltina, HIV Focal Point, MAPESS
Pedro Luis Fonseca, Director of Studies and Planning, Ministry of Planning
N'Zau Miguel, Director of Training, Chamber of Commerce
Ducelina Serrano, National Director, National AIDS Institute
Alexandra Simião, Vice-Minister, Ministry of Education
Dr. Sebastião Veloso, Minister, Ministry of Health

UNDP

Francisco Almeida, Assistant Resident Representative
Nimi Assimbi, Project Coordinator
Luzia Benchimol, Peer Educator
Boubou Camara, Deputy Resident Representative
Camilo Ceita, Programme Specialist
Claudia De Paula, Consultant
Iolanda Fortes, International Consultant
Ida Makolulu, Personnel Assistant
Gabriela Nascimento, Programme Associate
Bernard Ouandgi, Senior Economist
Vanda Santos, Junior Programme Officer
Malaquias Tenente, Peer Educator
Rosário Veigas, Peer Educator

UN SYSTEM

Amimo Agola, Consultant, UNFPA
Jonathan Cauldwell, Planning and Field Operations Officer, UNICEF
Rick Corsino, Country Director, World Food Programme
Dr. Balbina Félix, National Programme Officer, World Health Organization
Mario Ferrari, Representative, UNICEF
Julio Leite, Assistant Resident Representative, UNFPA
Daude Regol, HIV Project Officer, UNICEF
Dr. Alberto Stella, Coordinator, UNAIDS

BILATERAL DONORS

Cathy Bowes, Director of Projects, USAID
Alida Endresen, Counselor, NORAD
Raúl Feio, Senior Advisor, EU
Nina Strom, Second Secretary, NORAD

WORLD BANK

Laurence Clark, Resident Representative
Olivier Lambert, Sr. Operations Officer (Country Office)

NATIONAL NON-GOVERNMENTAL ORGANIZATIONS

Francisco Antonio, AMSA
Lauriano Campos, ANATENO
N'sungu Kiangani, CAASDA
Ana Leitao, CAJ
Pombal Maria, Acção Humana
Artur Sapalo, AJO
Timoteo Sebastiao, VIJU
Celso Silva, Luta Pela Vihda

BOTSWANA COUNTRY STUDY

HIV/AIDS

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

By Simon Muchiru and Ikwo Arit Ekpo

The authors thank the UNDP Country Office Botswana for the invaluable help it provided.

BOTSWANA

CONTENTS BOTSWANA COUNTRY STUDY

Boxes, tables and figures

1. COUNTRY BACKGROUND

1.1 INTRODUCTION

This report is an independent outcome evaluation commissioned by the UNDP Evaluation Office in New York. The evaluation was conducted in 9 countries in Southern Africa and Ethiopia, covering the period from 1999 to 2004. The evaluation focused on UNDP's contribution to the implementation of the national response to HIV/AIDS, with particular emphasis on the outcomes achieved in the areas of governance, leadership for development, capacity development, partnership coordination and mainstreaming of HIV/AIDS. The evaluation was conducted between November 2004 and November 2005 by a team of international and national consultants. Botswana was not among the countries that were selected for international consultants' visits, but it has benefited from the technical guidance of the international consultant who was resident in Botswana. The process of literature review included data collection, one-on-one interviews, and focus group discussions.

Located north of South Africa, Botswana is 582,000 square kilometres[1] of land, the majority of which (95 percent[2]) is not arable or used for crops. The population is currently estimated at 1.7 million people.[3]

At its independence in 1966, Botswana was one of the poorest countries in the world. After independence, the country embarked on an effort to end hunger, alleviate poverty, ensure peace and justice, and provide equal access to resources—education, health and employment to its people. Since 1966, Botswana's economic growth has experienced dramatic and structural transformation. Today, the mining sector accounts for one third of gross domestic product (GDP), while ranching and beef production makes up only 2.6 percent in 1999-2000. As a result of economic diversification, the contribution of diamonds has declined from 52.6 percent in 1983-1984 to 36.5 percent in 2000-2001. In 2000, Botswana had an annual per capital GDP of USD 3,170.[4] By 2002, the country had achieved a GDP of USD 7,184.[5] Primary and secondary education is free. Health care is mostly free or is provided for at a minimal fee of BWP 2.[6] The infrastructure is fairly developed and essential services are accessible to most people in most parts of the country. Botswana made history by graduating from being classified as one of the least developed countries in the world to a middle income developing country.

Interviews with the Central Statistics Office revealed that despite Botswana's impressive economic performance, approximately 36.7 percent[7] of the total population still live below the poverty line. HIV/AIDS has exacerbated the situation by mainly affecting economically productive people, particularly young people who constitute the majority of the population. HIV/AIDS has increased the mortality rate and reduced life expectancy, which has dropped from 65.3 years in 1991 to 55.7 years in 2001. In 2004, 17.1 percent of the population between 18 months and 64 years of age was estimated to be living with HIV/AIDS.

Botswana was ranked 128, in the human development index of 2004 and 128 on the gender related development index by UNDP. While unemployment and the impact of HIV/AIDS have remained daunting challenges, the government is committed to sustainable human development as demonstrated by its high expenditures in social services, education and health. As a result of government interventions, poverty levels have fallen from 56 percent in 1986 to 37.4 percent in 2004.[8] This is in line with Vision 2016,[9] which aims to reduce the number of people living below the poverty line to 23 percent by 2007 and 0 by 2016. The government also hopes to achieve an 'AIDS free' generation by the year 2016. By addressing poverty, the government hopes to arrest conditions that fuel the spread of HIV/AIDS and limit the effectiveness of the national response to the epidemic. Poverty reduction is a major goal for the National Development Plan 9 and Districts Development Plan.[10]

1 Ministry of Finance and Development Planning, "National Development Plan 7," 1991, p 3.
2 United Nations and Government of Botswana, "Botswana: Towards National prosperity—Common Country Assessment 2001," 2001, p 9.
3 Ministry of Finance and Development Planning, "National Development Plan 9," 2003, p 9.
4 UNDP, "Human Development Report 2002."
5 Ibid.
6 BWP or Pula is the currency in Botswana. Currently, 1 BWP equals approximately 18 USD.
7 Ministry of Finance and Development Planning, "National Development Plan 9," 2003, p 24.
8 Ministry of Finance and Development Planning, "A Review of Anti Poverty Initiatives in Botswana: Lessons from a National Poverty Reduction Strategy," 2002.
9 Government of Botswana, "Vision 2016—Towards Prosperity for All," 1997.
10 Ministry of Finance and Development Planning, "National Development Plan 9," 2003.

1.2 PURPOSE OF THE EVALUATION AND METHODOLOGY

The purpose of the evaluation was to assess UNDP's role and contribution to the achievement of key outcomes in governance and capacity building at the country level within the context of the Millennium Development Goals (MDGs) and the Declaration of Commitment. The evaluation assessed UNDP's role, including the role of the UN Resident Coordinator in handling HIV/AIDS challenges faced at the country level. It also examined the extent to which UNDP has its resources to bear in response to those challenges. In addition, the evaluation assessed the outcomes of UNDP's strategy, programmes and projects in addressing and mainstreaming HIV/AIDS at the country level through policy advice, knowledge management, coordination and leveraging of resources in collaboration with other development partners for the national response.

The national consultant held in-depth consultations with UNDP staff at the country office to gain familiarity with UNDP HIV/AIDS programmes and their linkages with other non-HIV/AIDS programmes. Consultations were also held with key UNDP partners in the government, bilateral donor agencies, civil society and public sector organizations supported by UNDP who contribute to the national response.

Extensive literature review was conducted based on available documents, both on HIV/AIDS and other UNDP programmes. Documents and reports from partner organizations, civil society organizations (CSOs) and government agencies that collaborate with UNDP were also reviewed.

Interviews were conducted with a wide range of stakeholders who had direct or indirect interaction with UNDP programmes. Respondents included government personnel at central and district levels, representatives of CSOs, development partners, and members of the private sector and UN agencies. Interviews were also conducted with representatives of District Multi-Sectoral AIDS Committees (DMSACs) in Francistown, Maun and Kweneng West districts. Interviews and focus group discussions were held with selected community members in Kweneng West and Shakawe who had participated in the Community Conversation Enhancement Programme.

Additional consultations were held with select stakeholders to validate information collected through the interviews and literature review, and a stakeholders' workshop was held at the end of the evaluation process to validate the preliminary findings. The inputs from participants of the validation workshop have been included in this report.

2. HIV/AIDS SITUATION

Botswana ranks second in the world for HIV/AIDS prevalence. Data based on Sentinel Surveillance Reports show that the prevalence rate has increased rapidly from 29 percent in 1999 to 37.4 percent in 2003 (see Table 1).[11] Prevalence rates ranged from 30.4 percent in Molepolole in the South to 50.3 percent in Selebi-Pikwe in the Eastern part of the country.[12] In 2004, the population-based Botswana AIDS Impact Study, revealed a prevalence rate of 17.1 percent for the general population, but this lower number does not reflect a lower prevalence rate for the country. Further analysis of the sexually active segment of the population reveals that prevalence rates are comparable to the Sentinel Surveillance Rate of 37.4 percent.

TABLE 1. HIV PREVALENCE RATES, 1999–2003

Year	Percent (%)
1999	29.0
2000	38.5
2001	36.2
2002	35.4
2003	37.4

Source: Sentinel Surveillance Reports.

Interviews with the National Aids Coordinating Agency (NACA) reveal that in 2003, the most affected age group was adults aged 25 to 29 years old. The agency also noted that infection rates in the 15 to 19-year-old age group have remained stable, while rates for older age groups continue to rise.

The 2002 National HIV/AIDS Report by NACA and the Ministry of Health (MoH) indicated that 258,000 adults between 15 and 49 years old were living with HIV/AIDS; 64 percent of them, or 164,000, were women. Approximately 110,000 individuals were reported to require antiretroviral therapy (ART), and by August 2004, the government provided ART to 23,000 people.[13] Ten thousand

11 UNAIDS, "AIDS Epidemic Update," December 2002.
12 NACA, "Sentinel Surveillance Report-2001."
13 ARV Programme, Presentation at the SADC meeting for National AIDS Coordinators July 2004

(10,000) people were receiving care and support under the Community Home Based Care (CHBC) Programme.

Stakeholders who participated in the interviews identified poverty, intergeneration sex, culture, gender inequalities, population mobility, urbanization, stigma and denial as some of the key factors that fuel the spread of HIV. The UN has estimated that 47 percent[14] of the general population live under the poverty datum line.

Interviews with the Prevention of Mother to Child Transmission (PMTCT) Programme indicate that an estimated 40 percent[15] of pregnant mothers infect their babies during pregnancy, through labour or breast feeding each year, with more than 25 HIV infected babies born every day. This translates, to approximately 7,000 to 9,000 infected children per year.[16] More than 10,000[17] children under the age of 15 years are estimated to be living with HIV/AIDS, and approximately 34,431[18] children are orphans due to HIV/AIDS. Estimates show that the orphan population will increase anywhere from 59,000 to 214,000[19] by the year 2010. In addition, infant mortality is projected to increase from 57 percent to 60 percent by 2005.

Before the emergence of HIV/AIDS, Botswana was close to eradicating tuberculosis (TB), but since the advent of HIV, there has been a resurgence of TB. Today, an estimated 60 percent[20] of the TB patients are co-infected with HIV, and TB remains a major killer of people living with HIV/AIDS (PLWHA).

According to the MoH, NACA, and the Ministry of Finance and Development Planning, HIV/AIDS is the greatest development challenge faced by Botswana today. UNDP concurs with this view. The socio-economic impact of HIV/AIDS is being felt in all sectors of society. According to the Central Office of Statistics, the epidemic is deepening levels of poverty by dissipating household incomes (as household resources are diverted to the care and support of HIV/AIDS patients), declining levels of savings, reducing investments, increasing the number of orphans, and increasing the cost of health care and labour.

Interviews with CSOs and DMSAC representatives indicate that the epidemic is robbing communities of their bread winners, leaders, and the knowledge and the skills necessary to sustain livelihoods. The epidemic is also threatening community and national food security. As a result of HIV/AIDS related deaths, the population of farm workers and agricultural professionals is shrinking, which is contributing to the decline in food production. The epidemic is also affecting and killing the most productive population age group, resulting in a negative impact on economic growth and productivity, leading to reduced capacity to utilize existing resources for development. Traditionally, Botswana has had a limited capacity to deliver public services, and the epidemic continues to undermine already limited capacity.

3. COUNTRY RESPONSE

3.1 NATIONAL RESPONSE

According to NACA and the MoH, the priority for the National HIV/AIDS response is to stop the occurrence of new infections, while simultaneously providing quality care and support for those already infected and mitigating the socio-economic impact of the epidemic. The initial response was a health-driven response, but the move toward a multisectoral approach is marked by the development of Medium Term Plan (MTP) II.

The national response has evolved through three phases. The first phase was the Short Term Plan of Action of 1987-1989, which focused on blood screening to prevent infections through blood transfusion. This was followed by the MTP I of 1989-1997, which focused on creating general public awareness on HIV/AIDS and using prevention strategies to promote abstinence, monogamy, and condom use.

The third phase included the MTP II of 1997-2002 and the National Strategic Framework of 2003-2009. While the first phase of the national response was characterized by multiple interventions that were

14 United Nations, "UNDAF 2003-2007," Botswana.
15 Interviews and literature review from PMTCT Programme, 2001.
16 Literature review PMTC Programme, 2001.
17 PMTCT proposal to Global Fund, 2002 (original draft).
18 Interviews with AIDS Coordinating Unit (E and E), Ministry of Local Government.
19 UNDP, Ministry of Finance and Ministry of Health, "Macro Economic Impacts Study on HIV/AIDS in Botswana."
20 NACA, "Sentinel Surveillance Report—2003."

largely uncoordinated, the third phase adopted a multisectoral and multi-level participatory approach, institutionalizing systematic and strategic coordination of interventions. UNDP's involvement in the National HIV/AIDS response started in 1997[21] through support to the AIDS/STD (Sexually Transmitted Disease) Unit of the MoH.

The following sections provide a synopsis of the key strategies, policies and programmes supported by the government of Botswana.

3.1.1 Policy

Policy responses to HIV/AIDS are guided by Vision 2016 and other development planning documents, such as the National Development Plan 9 and District and Urban Development Plans, which aim to bring the epidemic under control and achieve an AIDS-free generation by the year 2016. Vision 2016 also states that the government will ensure that all Batswana living with HIV/AIDS will be provided access to adequate care and support if a cure or vaccine is not found.

Interviews with CSOs and government officers reveal that at the beginning of the HIV/AIDS epidemic, the national responses relied heavily on the National Heath Policy, despite its inability to address the HIV/AIDS pandemic. The National Health Policy was developed before the emergence of HIV/AIDS, so the issue of AIDS was not addressed in the document. However, it was relied upon because the initial perception was that HIV/AIDS was primarily a health problem. This perception changed significantly during the implementation of the MTP II. UNDP played a major role in changing the perception of HIV/AIDS as a health issue to that of a development challenge that needed to be addressed by multiple sectors.

In 1993, the government launched the National HIV/AIDS Policy. The policy was the basis for future HIV/AIDS programming for both the public and private sectors. According to the CHBC Programme, the policy was reviewed in 1998 to incorporate and address home based care. Interviews with NACA indicate that the policy is currently under review again, to incorporate new issues such as ART, PMTCT, voluntary counselling and testing (VCT), routine testing, human rights and other issues.

21 UNDP Programme Support Document (PSD).

Individual sectors have developed and operationalized institutional or sector-based HIV/AIDS policies and guidelines on HIV/AIDS and the workplace. The Department of Personnel Services Management (DPSM) has developed a 'Public Service Code of Conduct on HIV/AIDS in the Workplace', while the Ministry of Labour and Home Affairs, with technical assistance from ILO is in the process of developing a National Policy on HIV/AIDS and Employment. UNDP provided short term technical expertise through consultancies to support these efforts. Other policy guidelines produced with UNDP support include Third Generation Antiretroviral (ARV) Guidelines and the CHBC Guidelines.

The Penal Code was revised in 1998 to prescribe more stringent penalties for rapists who knew their HIV positive status at the time of rape. Other laws and policies are in the process of being reviewed to address HIV/AIDS. The lead agency in the review process is Botswana Network of Ethics, Law and HIV/AIDS (BONELA), a non governmental organization (NGO) network that was formed with UNDP support. BONELA is working in collaboration with other stakeholders, including the Human Rights Sector of the National AIDS Council (NAC) to assist in policy development. Financial support for the review of the laws has been provided by the Global Fund to Fight AIDS, TB and Malaria (GFATM). UNDP provided technical and financial assistance during the preparation of the Botswana GFATM proposal.

3.1.2 Institutional arrangement and development

The government has established an integrated institutional framework to manage and implement the national response within the context of a multisectoral and multi-level approach. The adoption of this approach was to ensure efficiency and to provide opportunities for equal participation by all stakeholders at all levels of society with clearly defined roles and responsibilities.

The NAC, chaired by the State President is the highest policy and decision-making body on HIV/AIDS in the country. It meets four times a year to review the programmes implemented by different sectors. The NAC has established Sector Committees[22] that

22 The initial committees were composed of Men, Women, Sports and Recreation, Youth, Children, Education, Local Government, Finance, Labour, Agriculture, Law and Ethics, Trade and Industry, Wildlife and Tourism, and finally the sub committee on Health. The number and composition have also changed.

facilitate interventions, networking and collaboration at the sector level between Council meetings. The NACA serves as the secretariat of the NAC and is responsible for coordinating the multisectoral response. The MoH is responsible for the overall health-related response. However, the implementation of specific activities is coordinated by the Ministry of Local Government through the Primary Health Care Programme while, the multisectoral response is coordinated through the DMSAC.

NACA has strengthened Technical Advisory Committees that were initially established under MTP II to ensure that interventions meet and maintain standards. Currently, there are six Technical Advisory Committees: Clinic Management and Nursing Care; Counselling and Home Based Care; HIV and Development; Information, Education and Communication (IEC); Research and Surveillance; and the Botswana HIV/AIDS Response Information Management System (BHRIMS).

The Special Parliamentary Select Committee on HIV/AIDS was established in 1998 to ensure that HIV/AIDS issues remained on the national, social, political and economic agenda. The Committee meets twice a year and holds special sessions when the need arises. At the ministerial level, the Permanent Secretary Committee on HIV/AIDS was established to ensure sector collaboration and coordination. Individual ministries, government departments and some private sector institutions have recruited HIV/AIDS Coordinators at senior management positions to facilitate the mainstreaming of HIV/AIDS into their sector programmes.

The NAC Sector Committees were established to facilitate sector-specific programmes and interventions. The committees increased from 11 in 2001 to approximately 21 in 2005.

At the ministerial level, a Ministerial HIV/AIDS Task Force was formed to facilitate coordination, networking and information sharing. The Task Force is composed of representatives from the Ministry of Finance and Development Planning, MoH, Ministry of Local Government, Ministry of Education, and Ministry of Labour and Home Affairs.

At the district level, DMSACs and Village AIDS Committees (VACs) have been formed. In districts where United Nations Volunteer (UNV) Specialists were placed, DMSACs and VACs were found to be more active, compared to the other districts. Their role is to facilitate coordination and the implementation of HIV/AIDS interventions at district and community levels. District AIDS Coordinators have been appointed to coordinate district-level HIV/AIDS programmes. In some of the districts supported by UNDP, through the MoH, the Coordinators have assumed the functions and roles previously held by UNVs. DMSACs work in partnership and in collaboration with District Health Teams and the VACs.

CSOs have established networks that facilitate coordination and networking. These include Botswana Network of AIDS Service Organizations (BONASO), Botswana Network of People Living With HIV/AIDS (BONEPWA), BONELA, and Botswana Christian AIDS Intervention Programme. The private sector has formed its own network, the Botswana Business Coalition Against AIDS (BBCA). While there is not a network for traditional healers, the government is working towards improved coordination and networking with them.

During interviews, stakeholders acknowledged that UNDP played a key advocacy role in establishing some of the institutions and strengthening others in the areas of strategic orientation and leadership. However, despite these achievements, there is still a lack of clarity about the roles and responsibilities of some of these institutions.

3.1.3 Programme development

The national response programme is built around three broad activities: prevention of new infections; provision of comprehensive, quality care and support; and the mitigation of the socio-economic impact of HIV/AIDS. From 1997 to 2003, HIV/AIDS programmes were guided by the MTP II. The current programmes are closely aligned to the National Strategic Framework for HIV/AIDS 2003-2009. The programmes have evolved from being predominantly health based to being multisectoral interventions, with the exception of the interventions that are health-sector based. A decentralized and participatory implementation process has been adopted, creating new dynamics between stakeholders at national, district and community levels.

Sector-based responses have primarily targeted HIV/AIDS and the workplace, focusing on prevention,

creating awareness, education, promoting condom use, VCT, and care and support. Some private sector companies such as Barclays Bank and Debswana have started providing ART to their employees.

3.1.4 Preventing new infections

Between 1997 and 2003, most programmes focused on creating awareness and building a knowledge base on HIV/AIDS. This evaluation identified a variety of interventions, ranging from public meetings, seminars and workshops, skills training, and social mobilization to production and dissemination of materials such as pamphlets, videos, posters in both English and Setswana, drama, art, radio talk shows, and music aimed at creating awareness and educating the public about HIV/AIDS.

By 2000, more than 70 percent[23] of the general public was aware of HIV/AIDS and knew how they could protect themselves from infection. However, according to NACA and several other service providers, this high level awareness has not been translated into changes in behaviour.

By August 2004, the government, in partnership with other development partners, had established more than 16 VCT centres around the country. This has increased opportunities for community members to test for HIV. In addition, 10 Health Resource Centres were established at selected hospitals in the country. The Centres offer education, counselling and testing services.

The PMTCT Programme was launched in 1999 and has been rolled out across the country. While the services are within reach of most of the population, participation in the PMTCT Programme remains low. The government has increased advocacy, education and awareness programmes as part of the social mobilization to reach out to potential mothers and their spouses. By 2001, 2,245 women and 1,653 children had received AZT[24] and 1,595 infants were receiving infant formula for PMTCT. The programme hopes to increase participation from 28 percent to 75 percent through the implementation of National Development Plan 9 (NDP 9).

With regard to blood safety, a key focus has been to establish a sufficiently large pool of safe blood donors and a reliable transfusion service that guarantees safety. A total of 7,018 units of blood were donated by December 2001 with schools donating 61.5 percent, followed by disciplined forces (the army, police and prisons officers) at 11.7 percent, and health clinics at 10 percent.

The Teacher Capacity Building Programme and the Talk Back Programme co-supported by UNDP, African Comprehensive HIV/AIDS Partnerships (ACHAP), the Ministry of Education and Botswana Television are seen as good vehicles for building a 'safe blood pool' in schools, as more students become aware of HIV/AIDS and reduce risky behaviours. The Teacher Capacity Building Programme is modelled after a Brazilian initiative. UNDP facilitated a study tour to Brazil to provide an opportunity for the Botswana Programme Managers to learn from the Brazilian experience.

3.1.5 Care and support

Care and support for PLWHA is being offered through hospitals, clinics, day care centres, hospices and the CHBC (see Box 1). The CHBC Programme is considered to be the cornerstone of the care and support programme in the country. Between 1999 and 2002, the government provided more than BWP 40.6 million for home based care. The programme provides home nursing, home visits, PLWHA and family counselling, spiritual support, nutrition, material support, food basket and referral to other services.

UNDP has provided capacity building for CHBC by placing UNV Specialists through the MoH to conduct training in care, counselling and IEC in 16

BOX 1. ACHIEVEMENTS IN CARE AND SUPPORT

- Operational guidelines produced
- Training guide with modules developed
- CHBC assessment guide with discharge plan produced
- Directory of CHBC support groups produced
- Supported numerous IGAs
- Provided care related materials to homes with PLWHA
- Evaluation conducted
- Technical assistance provided to district and community level
- Staffing increased

23 Government of Botswana, "Botswana 2002 Second Generation HIV/AIDS Surveillance-Technical Report," November 2002.
24 Ministry of Health, Draft text for NDP 9, chapter 16.

districts. At the district level, UNVs have supported community based initiatives and were instrumental in the formation and strengthening of CHBC and PLWHA support groups. The UNVs also facilitated district HIV/AIDS situation analysis, which subsequently led four districts, South East, North East, Lobatse and Ngamiland, to develop and publish district HIV/AIDS Strategic Plans.

3.1.6 Research and surveillance

Since 1992, the government has monitored the rate of HIV/AIDS infection in some groups and areas, but it was not until 2002, that a national survey (the Sentinel Surveillance) was rolled out to cover all parts of the country. The prevalence rate based on the Sentinel Surveillance was estimated at 37.4 percent in 2003. While the Botswana AIDS Impact Study indicated a prevalence rate of 17.1 percent in 2004, as discussed earlier, that survey was based on the general population and not the sexually active segment, thus the Botswana AIDS Impact Study (BAIS) does not necessarily reflect a reduction in national prevalence of HIV/AIDS. The information generated from the surveys has been used for decision making to allocate resources for HIV/AIDS programmes. UNDP provided technical support for data collection, analysis and dissemination during both Sentinel Surveys and BAIS studies, through the AIDS/STD Unit of the MoH and through NACA.

3.1.7 Medical and clinical management

The emergence of HIV/AIDS led to the training of health workers and their orientation in clinical diagnosis and management of HIV/AIDS symptoms and opportunistic infections. Guidelines on ART have been developed to assist general practitioners and other clinicians in providing services. UNDP has supported district level workshops for Public Health Specialists and other health workers on ART.

UNDP, in collaboration with the MoH and the Bank of Botswana supported the feasibility study that was used as a basis for establishing the ART programme. The study also helped catalyze resource mobilization for the programme from other partners, particularly ACHAP. The ART programme was introduced to Botswana in 2001, and by 2004, more than 23,000 people were enrolled (out of approximately 110,000 who had been identified to need ART). The programme is currently being rolled out nationwide.

The government, in collaboration with the Harvard AIDS Institute, is researching an HIV vaccine and the most effective prophylactic therapy for HIV infected patients. As part of this initiative, the first National HIV Referral Laboratory was opened in 2002 in Gaborone. The laboratory has the capacity to conduct between 100 and 200 HIV tests a day and will continue to investigate the HIV-1 subtype C virus, which is responsible for AIDS in Botswana.

At the hospital level, the government continues to emphasize improving treatment for opportunistic infections, including sexually transmitted infections (STIs). Syndromic management of STIs and Isoniazid Preventive Therapy is being offered in all health facilities. Interviews with the doctor in charge of the STI programme at the MoH indicate that early treatment of STIs could contribute to the reduction of HIV by approximately 40 percent[25] in Botswana.

3.2 UNDP RESPONSE

Between 1997 and 2003, UNDP's involvement in HIV/AIDS in Botswana focused on capacity building in the areas of policy development, institutional strengthening, and the improvement of service delivery systems. Capacity building focused on central and district level institutions, disciplined forces, CSOs and applied research.

3.2.1 Capacity building at the central level

From 1997 to 2003, UNDP supported capacity building and strengthening of the AIDS/STD Unit of the MoH and was responsible for coordinating and managing the national HIV/AIDS response. It placed UNV Specialists in IEC, Counselling and CHBC to support the unit. The UNVs provided technical support in the development and implementation of training workshops and materials, and assisted in conducting situation analysis and baseline studies. UNVs were also involved in the AIDS/STD Unit programme development and assisted in developing operational guidelines, training manuals and conducting training at the district level. In addition, a UNV Specialist was placed with the AIDS/STD Unit to support CSOs in resource mobilization and organizational and programme development. Other UNVs were placed with BONEPWA and BONASO and helped them develop

25 Ministry of Health, "Botswana Country Paper on HIV/AIDS," December 2000, presented in Lusaka Bilateral meeting between government of Zambia and Botswana. Also, interviews with Public Health Specialists.

their strategic plans. Interviews with CSOs reveal that the UNVs were instrumental in strengthening the organization and governance of these organizations. However, the NGO networks expressed concerns about the withdrawal of these UNVs by UNDP. They felt it was done without an appropriate exit strategy, which has left the institutions without technical support and sustainability for future programmes.

UNDP assisted the MoH's AIDS/STD Unit in establishing the NACA and DMSAC, and in strengthening the leadership of the NAC. It also provided personnel and financial support to NACA for developing the National Strategic Framework for HIV/AIDS 2003-2009 and the National Operational Plan. UNDP posted a Policy Advisor to NACA to assist in accomplishing these tasks.

UNDP also provided support through the MoH to the Ministries of Agriculture, Labour and Home Affairs, Finance and Development Planning, and DPSM in mainstreaming HIV/AIDS and implementing HIV/AIDS workplace programmes. Technical support was later extended to other key ministries such as Local Government, Education, Trade, Wildlife and Environment. UNDP also supported capacity building for the Department of Women Affairs in the Ministry of Labour and Home Affairs to mainstream gender and HIV/AIDS. The Ministry of Labour has since produced an HIV/AIDS Policy, launched a workplace programme on HIV/AIDS, and has recruited departmental HIV/AIDS Coordinators. DPSM has developed the 'Botswana Public Service Code of Conduct on HIV/AIDS in the Workplace'.

The Ministry of Local Government, which is responsible for implementing primary health care, did not have adequate capacity to mainstream, coordinate and monitor HIV/AIDS interventions. As a result, UNDP in collaboration with the Swedish International Development Agency (SIDA) initiated a capacity building programme for the ministry. The HIV/AIDS Coordinating Unit was established and technical assistance was provided to conduct a situation analysis and develop a strategy for mainstreaming HIV/AIDS. A UNV Specialist was placed at the unit to provide continued technical assistance. With this assistance, the Unit was able to organize workshops for HIV/AIDS mainstreaming for district level personnel and develop an HIV/AIDS database. The database is currently being used by different government and private sector institutions.

UNDP Botswana and the Government of Botswana, in collaboration with UNDP Brazil and the government of Brazil, helped develop the South-to-South Cooperation on Teacher Capacity Building Programme on HIV/AIDS Prevention. The programme seeks to replicate the experiences of Brazil in the use of TV-based educational HIV/AIDS programming for schools. UNDP facilitated a study tour to Brazil for project staff. Interviews with teachers revealed that while the programme was effective, the timing and back-up services were poorly organized. In partnership with MoH and BOTUSA, UNDP also contributed to the establishment and funding of a toll free call centre, Ipoletse, to provide the public with information on HIV/AIDS and STIs.

UNDP has worked with the government, particularly the Ministry of Finance and Development Planning and the MoH, in order to strengthen capacity for research, facilitate knowledge management, and produce important publications. In 2000, UNDP supported the production of the first National Human Development Report, which focused on HIV/AIDS. In collaboration with the Ministry of Finance and Development Planning, six studies on the socio-economic impact of HIV/AIDS were conducted. UNDP provided technical assistance to the MoH to conduct and produce a study on best practices and HIV/AIDS. UNDP also provided technical and financial resources for the study of the socio-economic implications of violence against women in Botswana by the Women Affairs Department. A study on knowledge, attitudes and practices of teachers and students on HIV/AIDS was supported by UNDP in collaboration with ACHAP, and conducted by the Ministry of Education. In 2004, UNDP facilitated the research and compilation of the Botswana report on the MDGs, which was widely hailed as a success. The Ministry of Labour and Home Affairs was also supported in producing a guide on gender mainstreaming. Information obtained through the interviews and from literature review indicated that these publications have not only improved knowledge and understanding about HIV/AIDS, but also influenced decisions on programming and interventions on HIV/AIDS.

Since 2003, UNDP involvement in the national response is through the new Programme Support Document (PSD) Programme, which aims to strengthen capacity for gender sensitive multisectoral

response to HIV/AIDS. The new programme focuses on four areas: community conversation dialogues, leadership training, mainstreaming HIV/AIDS and gender, and teacher capacity building. UNDP has recruited 5 international UNVs and 15 national UNVs who will be posted to districts where UNDP is collaborating with the Ministry of Local Government to build and strengthen district level capacity for the implementation of HIV/AIDS programmes.

Regarding resource mobilization, contributions by UNDP include technical support during the preparation of the proposal to the GFATM, which helped Botswana secure USD 18.5 million. In addition, UNDP participates in the PEPFAR Steering Committee and Technical Working Group, which has led to increased funding for Botswana. UNDP has also facilitated resource mobilization from a wide range of sources, including UB40, ACHAP, DANIDA, Technical Cooperation Among Developing Countries (TCDC), and UN Foundation in support of various programmes.

3.2.2 Capacity building at the district level

UNDP provided technical support to 16 districts in the development of the district-based HIV/AIDS interventions and the establishment of the DMSACs. Ten of the districts conducted situation and response analysis and subsequently developed Two-Year Strategic Plans. The publication of the Strategic Plans was jointly supported by UNDP and SIDA.

In addition to placing a UNV Specialist in each of the districts, UNDP provided financial and technical assistance through the AIDS/STD Unit of the MoH to support the formation of the DMSACs, CHBC and PLWHA support groups.

As part of the process of disseminating best practices, UNDP supported the AIDS/STD Unit to conduct and document best practices in prevention, care and support. One of the best practices identified was the establishment of a Health Resource Centre at Athlone Hospital in Lobatse. The MoH embraced the concept and facilitated the establishment of similar Health Resource Centres in 10 selected district hospitals. The Health Resource Centres are accelerating the dissemination of HIV/AIDS information and the provision of VCT services.

3.2.3 Support to disciplined forces

UNDP provided technical assistance to the Botswana Defence Force, Police Force, and Prisons Services to mainstream HIV/AIDS into their respective forces. Interviews with representatives of the forces indicate that they have developed HIV/AIDS policies and workplace programmes and have appointed HIV/AIDS coordinators at senior staff levels. The Botswana Defence Force is offering ART at its medical facilities, the Police Force is incorporating HIV/AIDS into their training curriculum at the Police Training College, and the Prisons Services are offering HIV/AIDS education and awareness programmes to staff and inmates.

3.2.4 Support to civil society organizations

UNDP supported the AIDS/STD Unit in establishing two NGO networks, BONELA and the BONEPWA, and helped strengthen the institutional capacity of BONASO.

According to the NGO networks, UNDP provided financial, material and technical assistance to support organizational development, constituency building and expansion, programme development, additional resource mobilization, and strengthening of governance institutions. A UNV Specialist at the AIDS/STD Unit facilitated and coordinated capacity building and strengthening initiatives for CSOs, and two other UNVs were placed at BONASO and BONEPWA. Other areas of support include capacity building and strengthening for networking, monitoring and evaluation. Key personnel from the networks were trained in HIV/AIDS programming, mainstreaming and community mobilization.

Currently, BONELA is working on issues of law, ethics and human rights and is coordinating the NAC Sector Committee on Ethics, Law and Human Rights. It is also facilitating the review of all national laws to address HIV/AIDS issues. It is a collaborating partner with the Ministry of Labour and Home Affairs in the development of the National Policy on HIV/AIDS and Employment. BONEPWA is facilitating the work of PLWHA support groups in the country, and represents PLWHA in the NAC and other policy forums.

BONASO indicated that capacity building has enabled them to facilitate active participation of other CSOs in national and district level programming, for the implementation of activities towards the national response. BONASO also represents a large number of CSOs in the NAC and coordinates the Health and

Population NGO sector of the Botswana Council of NGOs.

At the community level, UNDP has provided direct support to Nkaikela Youth Group in Tlokweng to reach out to commercial sex workers with education, awareness and skills-building programmes. The programme is yielding results in the form of behaviour change among commercial sex workers and long distance truck drivers. Interviews with the group indicate increasing insistence on the use of condoms and early treatment of STIs. Other community based organizations (CBOs), that have received support from UNDP, include the Light and Courage Centre (Francistown), Itoseng Banana (Palapye) and Mothers Union (Mahalapye).

While the NGOs appreciated assistance from UNDP, they also expressed disenchantment with the abrupt withdrawal of support with the beginning of the new PSD. There was no exit strategy to enable the networks to prepare themselves for an environment without UNDP support. However, UNDP has continued to advocate strongly for NGO participation, capacity building, and financial and technical support, despite its withdrawal of direct support.

3.2.5 Strengthening capacity for applied research

According to the Ministry of Finance and Development Planning, UNDP support for applied research was primarily focused on the following: conducting a series of HIV/AIDS socio-economic, demographic and epidemiological studies; and strengthening research capacity and the competence of local institutions and individuals to undertake applied research.

UNDP supported initiatives to strengthen linkages between research, policy and programme development through the involvement of policy makers and programme developers.

UNDP has provided support to the following studies and reports:

- Sentinel surveillance, data analysis and production of these reports
- The Botswana HIV/AIDS Impact Studies (BAIS) in 2001 and 2005
- The 2000 Botswana Human Development Report—Towards an AIDS Free Generation, which provides strategic information and data that is being used for advocacy by government, development partners, the private sector and CSOs
- Research and documentation of best practices in prevention, care and support in Botswana
- A review and evaluation of HIV/AIDS related data for an expanded national response to the HIV/AIDS epidemic
- An impact assessment of HIV/AIDS on current and future populations and demographics
- An assessment of HIV/AIDS impact on the health sector
- Study on the impact of HIV/AIDS on macro-economic variables
- Study on the impact of HIV/AIDS on education
- Study on the socio-economic implications of violence against women in Botswana
- Knowledge, Attitudes and Practices of Teachers and Students on HIV/AIDS—Baseline Study Report, co-sponsored with ACHAP

The studies are being used in different ways by different stakeholders. They are widely quoted by programme development specialists in the public and private sectors, researchers and scholars. The information has also been used in the development of the National Strategic Framework for HIV/AIDS, the National Development Plan 9, and has informed the development of several HIV/AIDS workplace programmes for different sectors. The MoH has used a report on the impact of HIV/AIDS on the health sector to review the sector's human resources requirements and to develop its sector response to HIV/AIDS.

In collaboration with the Bank of Botswana and MoH, UNDP supported the first ART feasibility study that led to the development and launching of the ART Programme. Subsequently, Botswana became the first Sub-Saharan African country to provide free ART for its citizens. The report was also used to mobilize internal political, technical and financial support for the ART Programme. The UN Resident Coordinator played a key role in the advocacy work leading to the establishment of the ART Programme and funding by development partners, such as ACHAP.

3.2.6 Mainstreaming of HIV/AIDS and gender

As mentioned earlier in this report, mainstreaming of HIV/AIDS into other sectors started with the implementation of the MTP II in 1997. The concept was new and most sectors did not have the capacity and the skills to mainstream HIV/AIDS. In the beginning, UNDP provided technical assistance to

other sectors through the AIDS/STD Unit. UNDP worked in collaboration with the UNDP HIV/AIDS Regional Project in Pretoria to organize and conduct training workshops on HIV/AIDS mainstreaming. Additional support was provided through consultants who assisted the various sectors in conducting situation analysis and developing mainstreaming strategies.

Currently, most of the public sector institutions have developed sector-based HIV/AIDS policies, HIV/AIDS workplace programmes, and have appointed HIV/AIDS coordinators. A number of programmes such as peer education, counselling, and referrals for services are being implemented.

UNDP played a major role in institutionalizing the concept of HIV/AIDS mainstreaming, building the capacity for mainstreaming, and facilitating resource flows to support the process. However, while UNDP has made impressive progress in assisting other organizations in mainstreaming HIV/AIDS into their respective sector programmes, UNDP has not been able to mainstream HIV/AIDS into its own programmes, particularly the poverty reduction and environment programmes.

In gender mainstreaming, UNDP assisted the Women Affairs Department of the Ministry of Labour to strengthen gender mainstreaming and advocacy work to complement Government of Botswana efforts. This process led to the establishment of the Botswana National Women Council in 1999. A study of the socio-economic impact of violence against women was conducted in 1999, followed by a Gender Advocacy and Mobilization Strategy. The Department has developed and published a Guide in Gender Mainstreaming, with UNDP's support, but mainstreaming gender into programmes remains limited. It is a critical issue for subsequent review, given the disproportionate impact of HIV/AIDS on women.

3.3 DEVELOPMENT PARTNER RESPONSE

There are several development partners supporting Botswana, including UN agencies: UNDP, WHO, UNICEF, UNFPA, United Nations High Commissioner for Refugees, UNAIDS, UNV, and bilateral and private-sector donors. The UN agencies work through the UN Theme Group, which facilitates their collective participation and involvement in the national response. A Development Partners Forum was formed to bring together all development partners, including CSOs and donor agencies. The Country Coordinating Mechanism was formed in 2002 to meet the requirements for accessing the GFATM. The UN Resident Coordinator was instrumental in its formation and continues to oversee the coordination of these mechanisms.

The activities and programmes of the UN agencies are guided by the UN Development Assistance Framework (UNDAF) of 2003-2007. UNDAF has identified HIV/AIDS, poverty and environment as the three priority areas of action. The UN agencies' financial allocation towards health programmes, particularly HIV/AIDS, was estimated at USD 10,134,167 for 2003-2007. Most of the funding was allocated to core HIV/AIDS activities: prevention, care and support, and mitigation of the socio-economic impact of AIDS.

The collaboration between UNDP and other donors and development partners has revolved around institutional strengthening, systems development, knowledge management and improving the quality of service delivery.

While other UN agencies in Botswana and other development partners, such as ACHAP, BOTUSA, Botswana Harvard Partnership and Bristol Myers, have direct involvement in the actual design and implementation of specific programmes, the involvement of other donors revolves around financial support and policy advocacy. The UNDP Resident Coordinator has played a key role in facilitating collaboration, partnerships and joint initiatives. This has been achieved primarily through improved coordination through the UN Theme Group and the Development Partnership Forum.

UNDP has supported mainstreaming of HIV/AIDS in local government institutions in conjunction with other development partners. UNDP, in partnership with ACHAP, supported the Teacher Capacity Building and Talk Back Radio Programmes (UNDP funded the position of the Project Manager for the Talk Back Radio Programme). UNDP was the first to provide financial and technical support for a call centre that encouraged other donors to provide additional support and eventually provide funds to establish the VCT centres. Similarly, ACHAP was inspired by the results of the UNDP study on best

practices and used data from the study to inform its decision to support the establishment of Health Resource Centres in selected districts through the MoH.

As a result of UNDP's support to CSOs, the improved capacity of these organizations has enabled other development partners to forge stronger partnerships with NGOs. BONASO and BONEPWA are good examples of organizations that are currently being used to manage community HIV/AIDS initiatives such as small grants for community based organizations and support groups.

4. PROGRESS ON THE MILLENNIUM DEVELOPMENT GOALS

In September 2000, Botswana was one of the 189 nations that adopted the Millennium Declaration and the eight MDGs. By 2004, Botswana had prepared and submitted its first Status Report for 2004 by the UN deadline.

The process of preparing the MDG report started in September 2003 and was completed in June 2004 with support from UN Resident Coordinator. The process was participatory in nature and involved more than 150 people representing a large variety of stakeholders. A high-powered Steering Committee was established to oversee the process, with the support of a Technical Working Group composed of 45 people. The UN agencies participated through the UN Task Force. The Resident Coordinator facilitated resource mobilization, technical assistance, and mobilized other UN agencies to provide specialized input and support to the Technical Working Group.

The commitment of Botswana to the MDG was based on the premise that the MDG goals complemented its own goals as articulated in Vision 2016, which followed the five national principles of democracy, development, self reliance, unity and respect for humanity/being human. This also took into consideration the fact that Botswana's fight against poverty was dependent on improving access to quality health care and education, and the sustainable utilization of natural resources.

Since the MDGs were launched, Botswana has made significant efforts towards achieving its MDG targets and goals. In 2003, the UN Economic Commission for Africa rated Botswana first in its Expanded Policy Support Index, which measures performance on macro economic policies, poverty reduction policies and institution building.

Botswana has achieved universal access to 10 years basic education and reduced gender disparity at all levels of education. HIV/AIDS statistics indicate that infections are levelling off among the 15 to 19-years-olds, and there is an increase among the number of people who wish to determine their HIV status. By the end of 2003, more than 80,000 people had used VCT centres, and by August 2004, 23,000 people had enrolled in the ART Programme. An additional 131 PLWHA and CHBC support groups had been formed.[26]

In 2004, Botswana conducted its first population-based HIV study, which indicated a 17.1 percent prevalence rate. Botswana has indicated that it hopes to halt and reverse the incidence of HIV by 2016, especially among young people, and reduce by 50 percent the number of infants born to HIV infected mothers by 2006.

4.1 COMBATING HIV/AIDS, MALARIA AND OTHER DISEASES

Botswana has demonstrated a serious commitment to responding to the MDG Goal 6—Combating HIV/AIDS, Malaria, and other Diseases, through policy development, resource allocation and programme development. The National Strategic Framework for HIV/AIDS for 2003-2009 was developed in 2003 and the National HIV/AIDS Policy was revised. Isoniazid Preventive Therapy was introduced in 2000, and the government, in collaboration with BOTUSA and ACHAP, also established VCT centres and introduced ART in 2002.

Several strategic programmes, including behaviour change interventions, PMTCT, safe blood, VCT, ART, CHBC and orphan care have been established and are functional in 90 percent of the country.[27] The level of awareness about HIV/AIDS had increased to more than 95 percent among the general population by 2003.

26 Interview with BONEPWA.
27 Various programme reports to GFATM.

4.2 POVERTY REDUCTION INITIATIVES

Poverty has been singled out as a major contributor to HIV/AIDS vulnerability, thus success in combating HIV/AIDS remains a great challenge, as 47 percent of the population still lives below the poverty line. The government has established several programmes for poverty reduction. The key strategies are the National Poverty Reduction Strategy that was released in 2003, the revised National Policy for Rural Development of 2002, and the Destitute Policy, which was revised in 2000. Several programmes that were developed prior to the adoption of the MDG are still being supported and expanded to reach out to more people. UNDP, in collaboration with the government has finalized a new PSD for poverty reduction.

Key strategies in poverty reduction include people's empowerment through health, education, skills development, increased opportunities for employment through job creation, and programmes for expanded social welfare.

Some of the interventions have started yielding results. By 2001, Botswana had reduced unemployment to 19.3 percent. By 2002, under-5 malnutrition, which was adopted as the proxy for malnutrition in the MDG report, was reduced to 6.5 percent. There is a strong likelihood that the country could reduce poverty by 50 percent by 2015, if the current policy environment and programme support prevail.

Since its launch, the MDG Report has served as a tool to generate dialogue on the current development situation and critical issues in Botswana. The dialogue has helped to maintain poverty reduction and the fight against HIV/AIDS on the social and political agendas.

5. OUTCOME OF UNDP CONTRIBUTIONS AND SUPPORT

UNDP support has primarily focused on building and strengthening the capacity of government ministries and CSOs, particularly in the areas of HIV/AIDS programming and governance, mainstreaming and service delivery. Several outcomes have been associated with UNDP's contribution and support for the national response to HIV/AIDS in Botswana.

5.1 CAPACITY DEVELOPMENT

The improved capacity enabled the AIDS/STD Unit to accelerate the implementation of the MTP II Strategic Plan. In addition, the AIDS/STD Unit was able to coordinate the national response in a more focused and effective manner. Because of UNDP's support and strengthened capacity, the unit was able to mobilize other sectors. The number of public-sector institutions that were engaged in the national response increased from 3 to 9 ministries between 1998 and 2000.

Sentinel surveillance was conducted annually and the number of sites increased. Training materials in counselling, home based care and IEC were produced and disseminated. Through an expanded IEC programme, the awareness of HIV/AIDS among the general population increased to more than 70 percent[28] in 2000 and reached 95 percent[29] in 2004, resulting in an increase in the number of people seeking treatment. The Home Based Care Programme was expanded to cover the entire country, which increased the availability of care and support services to PLWHA.

As a result of increased capacity building of the AIDS/STD Unit, the unit was also able to provide technical assistance to other government ministries, the private sector and CSOs. The Unit trained HIV/AIDS counsellors, peer educators and community mobilizers. Several institutions have subsequently established HIV/AIDS workplace programmes, and the quality of these programmes is improving. Some public sector institutions have reported a decline in absenteeism and increases in the use of condoms, indicating that these programmes are reducing the impact of AIDS and/or changing behaviour.

Through MoH, UNDP assisted other Ministries such as Agriculture, Labour and Home Affairs, Finance and Development Planning, Education, Trade, Wildlife and Environment and DPSM to Mainstream HIV/AIDS. Mainstreaming of HIV/AIDS has increased awareness, knowledge and understanding of HIV/AIDS, significantly. The number of people seeking VCT and the number of people involved in HIV/AIDS related stigma-

28 Botswana 2002, Second Generation HIV/AIDS Surveillance—Technical Report

29 Interviews with Programme Planning Manager, NACA and review of Sentinel Surveillance Reports.

reduction campaigns have also increased. According to interviews with HIV/AIDS coordinators in different sectors, including NACA, the increased level of awareness has not translated into desired behavioural change. However, focus group discussions with community participants indicate that people are becoming concerned about AIDS and changing their behaviour. In Maun and Gaborone for example, some community members were demanding the use of condoms, even with regular partners.

UNDP capacity building in ministries has also yielded significant results. The Ministry of Local Government has established an AIDS Coordinating Unit, which helped to mainstream HIV/AIDS in local authorities. At the district level, development planners are demanding development projects to indicate how they will address HIV/AIDS in their programmes. The Ministry of Labour and Home Affairs has mainstreamed HIV/AIDS and gender through the Women Affairs Department and has produced guidelines on gender and HIV/AIDS mainstreaming that are currently being used not only by the Ministry but also by other development agencies. The DPSM has developed the Botswana Public Service Code of Conduct on HIV/AIDS in the Workplace, which has improved the management of HIV/AIDS related cases in labour settings. The Ministry of Finance, in collaboration with the AIDS/STD Unit of the MoH, facilitated six studies on the socio-economic impact of HIV/AIDS in Botswana, which have not only increased understanding and knowledge about HIV/AIDS but also have been used to expand and improve programmes to mitigate the impact of HIV/AIDS, such as counselling and the provision of ART.

Capacity building in 16 districts has improved ability to develop, coordinate and implement multisectoral HIV/AIDS programmes, resulting in a more efficient response at district and community levels. Ten districts have conducted situation and response analysis on HIV/AIDS and have developed district-specific strategic plans. District and Village Multi-sectoral Committees have been established and HIV/AIDS Coordinators appointed. Improved coordination and community mobilization has contributed to the formation of support groups for PLWHA and CHBC. This has increased availability and access to care and support services. UNDP has continued to support the placement of UNV specialists at community level to support VACs and other HIV/AIDS community based initiatives.

UNDP assistance to the disciplined forces has resulted in the forces developing HIV/AIDS policies, workplace programmes, and appointing HIV/AIDS Coordinators. The Botswana Defence Force is offering ART in its medical facilities, the Police Force is incorporating HIV/AIDS in the training curriculum at the Police Training College, and Prisons Services is offering HIV/AIDS education and awareness programmes to both inmates and prison officers. Interviews with HIV/AIDS Programme Coordinators within the disciplined forces reveal that improved capacity for service delivery has contributed to increased awareness, knowledge of HIV/AIDS, and access to care and support.

UNDP has supported the participation of CSOs and PLWHA in the design and implementation of the national response. UNDP supported three networks, BONASO, BONELA, and BONEPWA, in organizational development and capacity building. A representative of one network said "without UNDP's initial support, we would not be here." In turn, these NGO networks have built capacity of CBOs, other small NGOs, and support groups, through skills training, especially for those organizations in semi-urban and rural areas. Many of these organizations are now providing quality services such as counselling, adherence to treatment monitoring, and nutrition, and are increasingly reaching out to rural communities members, including in and out of school youth with information for behaviour change.

As a result of the improved capacity of these NGO networks, and the social mobilization of their constituencies and communities, more PLWHA are now involved in HIV/AIDS interventions at community, district and national level. The increased visibility of CSOs has contributed to the national response, significantly. PLWHA are now represented in the NAC and in almost all sector committees. The level of awareness on human rights, ethics and law has improved. This can be measured by the number of human rights and ethical challenges on workplace discrimination being brought forward by CSOs and individuals. BONELA's capacity has improved to a level where the NAC feels comfortable to delegate the coordination and review of laws to the organization. NGOs are also collaborating with Ministry of Labour and Home Affairs to develop the National Policy on HIV/AIDS and Employment.

The support of UNDP to CBOs such as Nkaikela Youth Group in Tlokweng has enabled them to improve and broaden their reach to commercial sex workers with education, awareness and skills-building programmes. Apart from empowering the individual commercial sex worker with skills and knowledge to prevent HIV and STIs, long distance truck drivers who depend on commercial sex workers for casual sex are also benefiting indirectly from the programmes. Interviews with some truck drivers reveal that commercial sex workers are consistently demanding the use of condoms and are seeking early treatment for STIs.

Other CBOs that have been supported by UNDP and are providing care and support to orphans and PLWHA are the Light and Courage Centre in Francistown and the Itoseng Banana in Palapye. Light and Courage Centre is currently providing care and support to more than 20 PLWHA and 43 orphans. The centre is being used as a model for implementing similar programmes.

In the area of applied research, UNDP has focused on building and strengthening institutional capacity to conduct and use research data in planning and decision making, and link the data to policy and programme development. A key outcome of the applied research initiatives is the increased knowledge and understanding of the socio-economic impact of HIV/AIDS by different sectors. This has resulted in the review of existing policies, programmes and activities to incorporate strategies to mitigate the socio-economic impact of the disease. According to the MOH and NACA, the study on Impacts of HIV/AIDS on the Health Sector has informed the review of human resources requirements in the health sector and the study on the Review and Evaluation of HIV/AIDS Related Data for an Expanded National Response has informed the strategic orientation of BHRIMS. The 2000 Botswana Human Development Report; the Best Practices Report in Prevention, Care and Support; and Botswana's MDG Report (which were facilitated by UNDP) are being used by different stakeholders for reference, advocacy and as a source of information for planning.

In strengthening community capacity, UNDP supported training on Community Capacity Enhancement. The programme is operational in five districts, North East, Okavango, Kgalagadi North, Kweneng West and Gaborone. More than 88 people have been trained. Interviews have shown that their perceptions about HIV/AIDS, particularly perceptions towards PLWHA, are changing. One of the major outcomes is personal appreciation of the problems associated with HIV/AIDS and the internalization of the degree of personal risks and vulnerability. The acknowledgement that anyone can be infected is helping people realize the impact of stigma and the need to address it. While it is too early to evaluate the impact of the programme, it is evident that the training is contributing towards behaviour change.

5.2 LEADERSHIP FOR DEVELOPMENT

Prior to the involvement and leadership role of UNDP in HIV/AIDS work in Botswana, most stakeholders depended on the initiatives and leadership of the MoH. While the Ministry did its best, given the circumstance at the time, UNDP contributed to the transformation of leadership in the HIV/AIDS arena and influenced the way the Government of Botswana currently responds to HIV/AIDS.

UNDP capacity building of the AIDS/STD Unit repositioned the Unit to provide a more effective leadership role in changing the HIV/AIDS environment. The continuous support provided by UNDP contributed to eventual upgrading of the Unit to a full fledged department for addressing HIV/AIDS and STI issues for the health sector and handling the ART and PMTCT Programmes. With increased advocacy support from UNDP, the Unit spearheaded the mainstreaming of HIV/AIDS in public and private sector institutions, negotiations for increased budget allocation for HIV/AIDS work, and the strategic repositioning of HIV/AIDS as a priority social and political agenda. The Government of Botswana declared HIV/AIDS a national emergency and increased the budget for HIV/AIDS.

The trickle down effect of the UNDP and the AIDS/STD Unit's influence can be seen in the number of community leaders who are increasingly participating in community based HIV/AIDS programmes. There are also an increasing number of political leaders, including councillors and elected Members of Parliament, calling on their constituencies to take a more active role to stop the spread of HIV/AIDS and to provide quality care to those

already infected. Today, HIV/AIDS features prominently in most traditional, community and religious leadership agenda. UNDP advocacy work and the involvement of leaders have helped to change the public perception of HIV/AIDS from being perceived as a health problem to a development challenge.

At the institutional level, UNDP played a catalytic role in advocating for the strengthening of the leadership of the NAC and the transformation of NACA to a more effective multisectoral coordinating agency. NACA has since moved to the Office of the State President and has acquired more institutional authority for coordinating the National Multi-Sectoral Response. The Council is now chaired by the State President, while the position of the National Coordinator of NACA was elevated to the level of Permanent Secretary. At the district level, District Commissioners and Council Secretaries were appointed as the co-chairs of DMSAC, providing the committees a strengthened authority base.

Following a UNDP facilitated training workshop on HIV/AIDS and Development in 1999 for members of parliament, the parliamentarians formed the Special Parliamentary Select Committee on HIV/AIDS. Since the formation of the Committee, several members of parliament, including the State President have voluntarily undertaken HIV tests. This was a strategic move by parliamentarians to encourage other people to test by serving as role models. While it is difficult to correlate the current increase in the number of people who are testing, evidence from VCT records indicate substantive increases after the State President's test.

Membership of NGOs and organizations of PLWHA in the NAC and other country level coordinating mechanisms has increased from less than 15 percent to more than 35 percent. The involvement of PLWHA in national events, public forums, and their willingness to acknowledge their HIV status publicly has contributed to the fight against the stigma and discrimination associated with HIV/AIDS. The empowerment of individual PLWHA and leadership training has facilitated more PLWHA to declare their status in public and serve as role models. Increased awareness, positive living support, improved knowledge of human rights, and leadership training have contributed to an increasing number of PLWHA coming out. In 1999, 10 public figures had revealed that they were HIV positive. That number was more than 25 in 2003. Interviews with PLWHA and their support groups reveal that more continue to share their status with immediate caregivers and close relatives.

The current leadership training programme has provided training for approximately 120 people drawn from government, the private sector and CSOs. Interviews with some of the trainees indicate that the programme helped them identify their specific roles and increased their moral obligation towards the national response to HIV/AIDS, particularly in mainstreaming HIV/AIDS and gender. The trained staff also stated that the training has improved their ability to delegate work, provide organizational development leadership, and contributed to their personal growth. Consultations and networking among stakeholders have also improved, due to the increase in information exchange.

5.3 GOVERNANCE

The development of the National Policy on HIV/AIDS and subsequent development of the Strategic Framework for HIV/AIDS have improved governance issues around HIV/AIDS, assisting in defining the roles and responsibilities of different stakeholders. UNDP has made significant contributions in this area, with its publication of the Botswana MDG Report and its efforts in institutional capacity building. Different stakeholders are able to clearly identify their role in the war against HIV/AIDS.

UNDP has successfully advocated a participatory, decentralized approach to the management and implementation of the national response. This has resulted in greater involvement of CSOs, local authorities, and private sector institutions in decision and policy making. Its advocacy role has contributed to the establishment of new interventions and programmes such as VCT, routine testing at health facilities, PMTCT, and provision of ART. Ownership of programmes is gradually being recognized by communities, and UNDP is strengthening this process through its Community Capacity Enhancement Programme. CSOs, NGOs and CBOs are increasingly supporting the involvement of PLWHA in their governance structures and PLWHA are assuming leadership and management roles at the national and community levels. The process has enhanced the voices of PLWHA, especially those of women.

The government and other stakeholders have also made a deliberate decision to support the mainstreaming of HIV/AIDS and gender into all development initiatives, building on the knowledge and capacity that already exist within the institutions that have been supported by UNDP. Review of institutional based programmes indicates that efforts are being made to mainstream HIV/AIDS and gender into all aspects of development programmes.

From a national point of view, improved institutional arrangement has increased efficiency in service delivery management. More consultations are being held with implementing partners and the decision making process has become more participatory, involving more stakeholders. UNDP has continued to support the expansion of the UN Theme Group and the establishment of the Development Partners Forum, and this has led to improved consultation and decision making among partners. At the request of the Government of Botswana and other development partners, the UN Resident Coordinator has recently developed a discussion paper on how to improve coordination and decision making around HIV/AIDS planning and programme development.

At the community level, community groups have been empowered to determine how they want to address HIV/AIDS and with whom they want to partner. However, due to lack of skills in management and governance, community based programmes seem to have more challenges at the district and national levels. Interviews with community leaders who have participated in the Community Capacity Enhancement Programmes indicate that the role and contribution of women in care and support is increasingly being recognized and appreciated. Women are also making decisions to undertake VCT, PMTCT, and Isoniazid Preventive Therapy and are encouraging their spouses to join. Eleven of the women interviewed in Maun and Gaborone districts, where UNDP had provided technical support, indicate that they have managed to convince their husbands to use condoms all the time and seek early diagnosis and treatment for STIs. This is an indication of the degree of empowerment at the personal level.

Due to UNDP advocacy and support, Botswana continues to try and meet its international commitment to HIV/AIDS and has become a signatory to all the major global declarations on HIV/AIDS and Gender, including the Abuja Declaration, UNGASS Commitment, Maseru Declarations, and CEDAW and others. Botswana is also making efforts to meet its other international obligations.

5.4 PARTNERSHIP COORDINATION

UNDP was among the first UN agencies to partner with the Government of Botswana to address the challenges of HIV/AIDS. Through the UN Theme Group, the Resident Coordinator has managed to bring together a number of other agencies to develop a common approach for UN support to the government, while maintaining their unique technical roles and responsibilities.

The current UN joint response to HIV/AIDS is articulated in the UNDAF 2003-2007. This was developed in 2002, with attempts to create linkages between HIV/AIDS, poverty and environment by addressing cross cutting issues such as governance, gender equality, human resource development, capacity building, with the involvement and strategic participation of key stakeholders and sectors.

UNDP played a catalytic role in the formation of the Partnership Forum that brought together a number of development partners, including the private sector and CSOs that are actively engaged in the war against HIV/AIDS. The forum has improved coordination and information sharing, and facilitated the identification of common areas for collaboration and partnerships. It is anticipated that the Forum will also improve the process of decision making for resource allocation in support of the national HIV/AIDS response.

Through improved coordination of development partners, the government was able to access and use technical expertise and strategic information in the development of the proposal for the GFATM and the National Strategic Framework for HIV/AIDS. UNDP provided funding for the consultants, while other UN agencies and development partners seconded technical personnel to work with the respective teams. Through the Theme Group, UNDP provided support to the government in developing the GFATM proposals that eventually led to USD 18.5 million in funding. The success of the implementation of the MTP II was partly due to UNDP's support, which encouraged other donors such as ACHAP, Centers for Disease Control, SIDA, the European Union and others to come

forward and support the national response. Through the efforts of the Resident Coordinator, UN agencies made an estimated USD 10,134,167 financial allocation for HIV/AIDS for 2003-2007. UNDP's role facilitated the securing of additional funding from other donors such as the UN Foundation, ACHAP, UB40, SIDA, and the Danish government.

The UN Resident Coordinator has continued to lobby for increased financial and technical support to Botswana through the Development Partners Forum at a time when donors are leaving the country because they assume that Botswana is capable of funding its own programmes. UNDP efforts have yielded some results, because as some donors leave, others are coming in or returning, and the ones who stayed have increased their funding levels for HIV/AIDS programmes.

The recognition of the critical role of NGOs and their contribution in the war against HIV/AIDS by government and other development partners has led to more resource allocations to the sector. Interviews with NACA indicated that more than 65 percent of the USD 18.5 million grant will be channelled through NGOs and CBOs. BONELA has been assigned to provide the secretariat for the Human Rights, Ethics and Law Sector of the NAC. BONASO now represents CSOs in National Committees contributing to several policy decisions on HIV/AIDs. More than 33.3 percent of the membership of the National IEC/Behaviour Change Communication Board is composed of CSOs.

5.5 MITIGATION OF HIV/AIDS AND POVERTY ERADICATION

UNDP, in collaboration with the MoH and Bank of Botswana, supported the first feasibility study on ART in Botswana. This study formed the basis for the introduction of the free ART Programme and PMTCT for all pregnant women. More than 44,000 people were reported to be receiving ART in 2005. Their quality of life has improved and some have resumed normal lives.

The introduction of ART has contributed to the gradual breakdown of the culture of silence among PLWHA. More people have come forward to enrol in the ART Programme, and evidence from the Programme indicates that more people are declaring their HIV status with close family members and friends, as a result of ART. In addition, the AIDS/STD Unit, with technical assistance from UNVs, conducted training workshops on pre and post testing for HIV and supportive counselling for PLWHA, caregivers and orphans. While the outcomes have been slow in being realized, evidence indicates that PLWHA are publicly engaging in advocacy efforts to reduce stigma and discrimination by speaking out about their HIV/AIDS status in communities and schools.

Other support services for PLWHA and orphans, such as food baskets have been introduced. These baskets improve the nutrition level among beneficiaries, and in some cases, fill the gap created by food insecurity at the household level. Other initiatives include the development and support for income generating activities, increased availability and access to syndromic management of STIs, and treatment of opportunistic infections, including TB. UNDP played a catalytic role, through the UN Theme Group, in mobilizing other UN agencies to respond with technical assistance in support of these initiatives.

5.6 MAINSTREAMING OF GENDER AND HIV/AIDS

UNDP support to gender mainstreaming has sustained gender issues on both the social and political agenda. The government has increasingly demonstrated its commitment and political will to gender mainstreaming. The following outcomes have been achieved:

- Botswana National Council on Women was established in 1999.
- The Gender Advocacy and Social Mobilization Strategy was developed in 1999.
- A Study on the socio-economic impacts of violence against women was completed and disseminated in 1999.
- Gender focal points persons for various ministries were identified in 2000.
- A 'Step by Step Guide to Gender Mainstreaming' was published in 2002 to assist the different stakeholders in gender mainstreaming.
- Study tours were conducted in the region.
- Support was provided for the commemoration of Sixteen Days of Activism on Violence against Women and the International Women's Day.
- A disaggregated gender database for senior management positions in the public and private sectors was developed.

- UNDP has supported an advocacy campaign that led to the development of the National Policy on Women and Development in 1996 and the ratification of the Convention on the Elimination of all forms of Discrimination against Women in 1997. The government is committed to developing the National Gender Policy during the period of NDP 9.

One of the key outcomes of gender and HIV/AIDS mainstreaming has been the elevation of the knowledge base, demonstrating the relationship between gender, broader development issues, and the impact of HIV/AIDS on development. UNDP may not have initiated the mainstreaming programme, but its support has accelerated the implementation process.

UNDP and UNV helped build capacity for gender mainstreaming at the Women Affairs Department and in selected NGOs that work on gender and development through training on gender and development, gender mainstreaming, and gender-based IEC materials and programmes. Women were empowered through training, access to information and exposure to best practices through study tours. This has enabled some of them to participate more actively and effectively in decision making, and to assume leadership roles in their organizations and in the political arena.

5.7 MILLENNIUM DEVELOPMENT GOALS

The first Botswana Status Report towards the achievement of the MDG was released in August 2004 and has been presented to the UN Secretary General. Botswana was able to mobilize a variety of stakeholders involving more than 150 people. The UN Resident Coordinator played a key role in the process by facilitating resource mobilization, technical assistance and mobilizing other UN agencies to provide specialized inputs and support to the Technical Working Groups.

While it is still too early to measure the performance of Botswana towards achieving the MDGs, Botswana has made significant progress in several areas:

- Universal access to 10 years of basic education has been achieved.
- Gender disparity at all educational levels has been reduced.
- The 2003 HIV/AIDS Surveillance Report indicates a levelling of infections among 15 to 19-year-old youths.
- By the end of 2003, 80,000 people had used VCT centres.
- By 2005, more than 40,000 people had enrolled in the ART Programme.
- In 2004, a population-based HIV survey was conducted, indicating a national prevalence rate of 17.1 percent.
- Policies and strategic plans have been developed to guide the implementation of the National HIV/AIDS Response including: the National Strategic Framework for HIV/AIDS of 2003, the Revised National HIV/AIDS Policy of 2004, the Isoniazid Preventive Therapy of 2000, ART in 2002, and VCT.
- Several strategic programmes, including behaviour change interventions, PMTCT, safe blood, VCT, ART, CHBC, routine testing and orphan care have been established and are functional in almost 90 percent of the country.[30]
- The level of awareness on HIV/AIDS has increased to more than 95 percent[31] among the general population.
- Poverty reduction policies and programmes have been developed and are operational. The National Poverty Reduction Strategy was released in 2003, the National Policy for Rural Development was revised in 2002, and the Destitute Policy in 2000 was revised. Several programmes that were developed prior to the adoption of the MDG are still being supported and expanded. Key strategies in poverty reduction include empowering people through healthcare, education, and skills development; increasing opportunities for employment and job creation; and expanding, improving, and increasing accessibility to social welfare.
- By 2001, Botswana had reduced unemployment to 19.3 percent, and by 2002, under-5 malnutrition, which is adopted as the proxy for malnutrition in the MDG Report, was estimated at 6.5 percent.
- Botswana projects that poverty will be reduced by 50 percent by 2015, given the current strong policy environment and programme support.

30 Interviews with Chief Health Officer AIDS/STD Unit, Ministry of Health.
31 Interview with Programme Planning Manager, NACA.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

The following conclusions are based on the analysis of information collected through interviews, focus group discussions, and literature review. The overall picture shows that technical support from UNDP accelerated the implementation of the MTP II. The MTP II set the stage for a multisectoral response and galvanized political and community support and participation. The focus on policy development, capacity building, and improvement of service delivery was strategic and helped the MoH to strategically reposition itself through the AIDS/STD Unit to meet the demand for technical assistance from public and private sector institutions, at the national, district and community levels.

The role of UNDP in the repositioning of the AIDS/STD Unit was catalytic and facilitative. UNDP achieved this outcome with the help of both the UN Resident Coordinator and through its regular country programme assistance. The Resident Coordinator was able to mobilize other UN agencies and development partners to increase support and collaboration with the government and CSOs in the implementation of MTP II. Through its regular programmes, specific areas of support were identified and articulated in the PSD. Partnerships were forged with key government ministries, departments and CSOs.

6.1.1 Policy development

UNDP supported the operationalization and review of the National HIV/AIDS Policy, the development of the National Strategic Framework of 2003-2009, and mainstreaming of HIV/AIDS and gender into the programmes of most public sector institutions.

UNDP's advocacy initiatives helped form the NACA and its subsequent relocation to the Office of the President, with the objective of giving it the appropriate political status to effectively coordinate the multisectoral response. In addition, its advocacy initiatives contributed to the State President's acceptance to chair the NAC.

At the sector level, UNDP worked with key stakeholders to develop sector policies and HIV/AIDS workplace programmes. Almost 95 percent of all public sector institutions are currently implementing HIV/AIDS workplace programmes. While it is difficult to measure the current impact of sector-based HIV/AIDS policies, some respondents felt that the policies were too many, uncoordinated and had little impact. However, none of these sectors have measured the effectiveness of their sector policies and HIV/AIDS workplace programmes.

6.1.2 Capacity building

Lack of skilled manpower and efficient operational systems have been a major constraint in the implementation of the National HIV/AIDS Response. UNDP supported capacity building through technical support, human resource development, and the improvement of operational and management systems. Technical expertise was provided in the form of specialists, consultants and placement of UNV Specialists in central government departments, select districts and CSOs. Financial support was provided to ensure the implementation of activities at the national, district and community levels.

At the central level, capacity was built at the Ministries of Health, Labour and Home Affairs, Agriculture, Finance and Development Planning, Agriculture, Department of Personnel Management services, and the Disciplined Forces, Defence, Police and Prisons. Capacity was also built at the three NGO networks, BONASO, BONEPWA and BONELA.

At the district level, capacity building primarily focused on the establishment of the DMSAC and VAC applied research for situation and response analysis, and the development of action plans to cover prevention, care and support, human rights, and the mitigation of the socio-economic impact of HIV/AIDS.

Technical and financial support to the MoH's AIDS/STD Unit and NGO networks was terminated with the launching of the new PSD. This is viewed by some stakeholders as an inappropriate strategic move for the implementation of HIV/AIDS programmes in Botswana. Since the multi-sectoral response's key initiatives are health-based and community oriented, continued partnership between the MoH and the NGO networks is perceived as important to reducing the impact of AIDS on communities. Termination of these partnerships is premature and is the result of

improper planning and development of exit strategies for UNDP support to civil society.

6.1.3 Leadership

UNDP has supported leadership development for the public sector and CSOs through training workshops, study tours, and exposure to best practices. As a result, several political and community leaders have become increasingly vocal on issues of HIV/AIDS and are serving as role models. The State President has received several awards for providing strategic political leadership in the development and implementation of HIV/AIDS programmes. Similarly, other public figures, including PLWHA, have also won awards both locally and internationally in support of their commitment to the fight against HIV/AIDS. The leadership programme has enabled the beneficiaries to sustain HIV/AIDS issues on the social and political agendas of the country.

At the operational level, Programme Managers are increasingly providing sound leadership, resulting in improved collaboration among the key stakeholders who are actively involved in HIV/AIDS activities. Several institutions have been formed that are spearheading the leadership process. These include the Parliamentary Select Committee on HIV/AIDS and the Permanent Secretaries Committee on HIV/AIDS.

At the community level, community leaders are being empowered to play visible roles in community based interventions, particularly in providing opportunities for people to develop their own programmes.

6.1.4 Governance

UNDP assisted in the development and implementation of a participatory and decentralized approach to the National Response. This approach has created more opportunities for people at all levels to get involved in HIV/AIDS activities. Governance structures for HIV/AIDS have been developed and are operational at all levels: NACA, DMSACs, VACs and support groups. The National Policy on HIV/AIDS and the National Strategic Framework for HIV/AIDS provides policy guidelines to these coordinating and implementing institutions.

CSOs have also set up their own network with support for UNDP and other partners. These have improved coordination, and increased outreach and coverage. Of particular interest is the increasing involvement and participation of PLWHA.

At the individual level, empowerment through increased awareness and knowledge has contributed to the commitment by individuals to take responsibility for their sexual behaviour, determine their HIV status and therefore determine their own destiny.

UNDP has encouraged and supported Botswana to meet its international HIV/AIDS and gender related obligations. Botswana has ratified and is signatory to several international agreements and conventions.

6.1.5 Partnership coordination

UNDP played a key role in facilitating partnership coordination through the UN Theme Group and the Development Partners Forum. More development partners are identifying collaborative areas and some have initiated joint HIV/AIDS projects.

Through UNDAF, Botswana has benefited from increased resource flows and technical assistance in various areas. Some of the more recent partnership initiatives include the ART and PMTCT programmes, VCT, the development of BHRIMS, and the development of the Botswana MDG 2004 Report.

The Botswana GFATM initiative was another area that UNDP assisted in partnership building and coordination. Eventually, Botswana was awarded USD 18 million for HIV/AIDS programmes. UNDP also played a strategic role in coordinating resource mobilization from a variety of partners, including ACHAP, Merck Foundation, the UN Foundation, UB 40, the Danish Development Agency and PEPFAR.

Despite increased awareness and governance skills, the management of partnership arrangements remains a great challenge, particularly at the community level, where community agenda may differ from national or development partner agenda.

6.1.6 Mitigating the socio-economic impact of HIV/AIDS

UNDP was not directly involved in the mitigation of socio-economic impacts of HIV/AIDS. However, UNDP worked with different ministries, departments and CSOs in developing strategies to address these challenges.

One key area of UNDP contribution was the support given to various sectors to undertake socio-economic studies on HIV/AIDS. The studies have improved

the knowledge base and facilitated better understanding and planning for HIV/AIDS interventions. The MoH is reviewing its manpower requirements based on the impact study.

Other UNDP initiatives include the contribution to the establishment of counselling services in the public health facilities and centres operated by CSOs; support to NGOs to build the capacity of PLWHA and CHBC support groups for income generating activities; implementing the PLWHA and orphans' food baskets through the AIDS STD Unit with the help of UNVs; the feasibility study that eventually facilitated the establishment of the ART Programme; and the training of counsellors to provide supportive counselling by UNVs.

6.1.7 Mainstreaming of gender and HIV/AIDS

UNDP provided technical support to different sectors for mainstreaming HIV/AIDS. Many sectors have been working with the UNDP Regional HIV/AIDS Programme based in South Africa to provide training for developing strategies for mainstreaming HIV/AIDS. Some sectors have demonstrated political will and commitment to the process. As a result, several sectors have developed their sector HIV/AIDS policies and workplace programmes, and have appointed either HIV/AIDS Coordinators or focal points. HIV/AIDS activities are increasingly being reflected in the sector programmes and financial resources are being allocated for these activities.

Similarly, UNDP has supported the Women Affairs Department of the Ministry of Labour and Home Affairs in mainstreaming gender into their development work. One of the major outcomes of this process has been the establishment of the National Council for Women in 1999 and the appointment of Gender Focal Points in different public sector institutions. Skills in gender planning and mainstreaming have been developed through training.

6.1.8 Millennium Development Goals

The first Botswana MDG report was developed and published in 2004 with support from UNDP. It is evident that Botswana is on course for achieving its MDG commitments. By the time the report was submitted in August 2004, Botswana indicated that it had already achieved some of its goals. For example, Botswana had achieved universal access to 10 years of basic education and had reduced gender disparity at all educational levels. Prevalence rates for AIDS had started levelling off for 15 to19-year-old youths. By 2001, unemployment had been reduced to 19.3 percent. The existing trends indicate that Botswana is likely to achieve the targets set in its MDG report. UNDP has contributed to these achievements through collaborative efforts with different partners.

6.1.9 Mainstreaming HIV/AIDS in UNDP country programmes

UNDP's efforts in mainstreaming HIV/AIDS into public and private sector programmes can be easily identified. However, while these efforts are yielding good results, there is no evidence of UNDP mainstreaming HIV/AIDS into its own poverty reduction and environment programmes.

Mainstreaming HIV/AIDS has not been a criteria or condition for approval of other programmes such as the Global Environment Fund. The design of the programmes does not reflect consideration for HIV/AIDS in core components, financing or related policies. In addition, there is no evidence in any of the reports reviewed that a UNDP workplace programme is being implemented for its staff and family members. UNDP corporate office has developed policy guidelines on how to manage HIV/AIDS within its institution, but these policies do not seem to have been implemented.

6.2 RECOMMENDATIONS

The following recommendations are based on the findings of the evaluation. They are presented according to outcome theme areas for ease of reference.

6.2.1 Policy development

- A review of the impact of existing sector policies and their continued relevance should be conducted. The review should attempt to harmonize the policies' overall strategic approach and orientation and align them to the National HIV/AIDS Policy, relevant legal instruments, and in the case of government, the conditions of service for public servants.
- Provide technical support to NACA to finalize the review of the National HIV/AIDS Policy.
- Assist in the development of guidelines for sectors in developing their own sectoral policies. Such guidelines should be clear on what should be contained in any sector policy on HIV/AIDS.

6.2.2 Capacity building

- Build and strengthen capacity in applied research, monitoring and evaluation, especially in the three key institutions of NACA, MoH and Ministry of Local Government.
- Facilitate programme integration to avoid vertical interventions of HIV/AIDS.
- Continue support for capacity building of CSOs, especially NGO networks, in order to ensure their continued ability to deliver effective programmes. In this regard, UNDP should develop an appropriate exit strategy for its support to NGOs and government ministries.
- Train programme managers on the use of research information and data in programme planning and in decision making.

6.2.3 Leadership development

- The current Leadership Development Programme should be rolled out nationally, phase by phase. The criteria for the selection of participants should be reviewed and improved. A follow up strategy for backstopping trainees should be developed. This should also apply to the Community Capacity Enhancement Programme.
- Lead by example by developing and implementing the 'We Care' HIV/AIDS workplace programmes for UNDP staff and other resident UN agency employees and their family members.

6.2.4 Governance

- Strengthen coordination and information sharing between partners and programmes.
- Facilitate the clarification of roles of different partners to ensure efficiency.
- Conduct more training on governance as related to HIV/AIDS programmes and institutions.
- Develop exit strategies to ensure smooth transition and sustainability of programmes.
- Avoid creating a dependence syndrome among partners, especially NGOs and CBOs by ensuring that sustainability mechanisms are included in the planning and development of programmes.

6.2.5 Partnership coordination

- Strengthen the effectiveness of the Development Partners Forum in coordinating new developments, partnership building and consultations, and build linkages with the Country Coordinating Mechanism.
- Minimize UNDP's implementing role but build capacity among key partners for the implementation of the national response.

6.2.6 Mitigating socio-economic impacts of HIV/AIDS

- Strengthen the capacity of organizations, especially organizations of PLWHA, to assist them in developing viable income-generating activities.
- Strengthen the expansion of counselling services, especially at community level.

6.2.7 Mainstreaming of gender and HIV/AIDS

- Strengthen, expand and roll out UNDP's capacity building programme for mainstreaming HIV/AIDS into public institutions and NGOs. This process should also include training on the concept of mainstreaming to create better understanding of the process for developing, implementing and monitoring the process.

6.2.8 Mainstreaming of HIV/AIDS in other UNDP programmes

- Make a serious effort to mainstream HIV/AIDS into UNDP's own programmes, particularly the poverty reduction, environment and governance programmes.

ANNEX 1. ACRONYMS AND ABBREVIATIONS

ACHAP	African Comprehensive HIV/AIDS Partnerships
ART	Antiretroviral Therapy
BHRIMS	Botswana HIV/AIDS Response Information Management System
BONASO	Botswana Network of AIDS Service Organizations
BONELA	Botswana Network of Ethics, Law and HIV/AIDS
BONEPWA	Botswana Network of People Living With HIV/AIDS
CBO	Community Based Organization
CHBC	Community Home Based Care
CSO	Civil Society Organization
DMSAC	District Multi-Sectoral AIDS Committees
DPSM	Department of Personnel Services Management
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, TB and Malaria
IEC	Information, Education and Communication
MDG	Millennium Development Goal
MoH	Ministry of Health
MTP	Medium Term Plan
NAC	National AIDS Council
NACA	National AIDS Coordinating Agency
NGO	Non Governmental Organization
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PSD	Programme Support Document
SIDA	Swedish International Development Agency
STD	Sexually Transmitted Diseases
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNV	United Nations Volunteer
VAC	Village AIDS Committee
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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ANNEX 3. PEOPLE INTERVIEWED

GOVERNMENT OF BOTSWANA

T. Baakile, Ministry of Finance and Development Planning
Festina Bakwena, PS Ministry of Education
E. Batshu, Botswana Police Community Service
Matheas Chakalisa, PS Ministry of Agriculture
Matong Matong, Botswana Defense Force
Anna Majelantle, Government Statistician, Central Statistics Office
Dr. Patson Mazonde, Acting PS, Ministry of Health
Ms. Mazonde, DAC, Hukuntsi Sub District
Tapiwa Moloisi, NACA
Kushata Mosienyane, Ministry of Labour and Home Affairs
Monica Tselayakgosi, National Coordinator, NACA

UNDP

Leonard Dikobe, Environmental Programme Manager
Rose Mandevu, Coordinator, Teacher Building Capacity
Lydia Matebesi, Team Leader , HIV/AIDS and Gender Programme
Sennye Obuseng, Poverty Programme Manager
Patrick Tema, HIV/AIDS Programme

UN SYSTEM

Dr. Kwame Ampomah, Country AIDS Coordinator UNAIDS
Moses Keetile, UNFPA

BILATERAL DONORS

Annika Jagander, Ambassador, Embassy of Sweden
Dr. Ndiki Ngcongco, HIV/AIDS Specialist, World Health Organization

NGOs AND CIVIL SOCIETY

V.M. Gunda, Coordinator, Women NGO Coalition
Bikini Leburu, Health/Welfare Coordinator, Barclays Bank of Botswana
Geoffrey Makolo, Coordinator Botswana Business Coalition Against AIDS
Mr. Mantlhe, Project Leader—ACHAP, Gaborone
M. G. Matenanga, Tribal Administration Gumare
Beauty Mogasha, Coordinator, Nkaikela Youth Group
Daniel Motsatsing, Coordinator, BONASO
Elisha S. Mouti, ACS—Okavango
Milikani Ndaba, BONELA
David Ngele, Coordinator, BONEPWA
Dr. K. Ntsatsi, Coordinator, Botswana Christian AIDS Intervention Programme
Dr. Prega Ramsamy, Executive Secretary SADC, Gaborone
Monica Smith, BOTUSA, Gaborone

ETHIOPIA COUNTRY STUDY

HIV/AIDS

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

By Yayehyrad Kitaw

The author thanks the UNDP Country Office Ethiopia for the invaluable help it provided.

ETHIOPIA

CONTENTS ETHIOPIA COUNTRY STUDY

Boxes, tables and figures

1. INTRODUCTION

1.1 INTRODUCTION

This report presents the results of an outcome evaluation of UNDP's role and contributions to the HIV/AIDS response in Ethiopia. The evaluation was undertaken for UNDP's Evaluation Office as an independent evaluation of significant changes that may have occurred as a result of UNDP's assistance in the fight against HIV/AIDS in Southern Africa and Ethiopia. The focus of the evaluation was the period from 1999 to 2004 at the country level but would also address some of UNDP's impact at the regional and sub-regional levels.

The purpose of the evaluation was to assess, within the context of the Millennium Development Goals (MDGs) and the Declaration of Commitment, UNDP's achievements in support of the HIV/AIDS response through its engagements with policy, institutions and communities. The evaluation was to learn from the experience of citizen groups and other stakeholders. The evaluation aimed to be strategic in character, concentrating on UNDP's roles and contributions. The focus was on outcomes and changes achieved, rather than on activities and processes of individual projects.

The analysis was not limited to specific HIV/AIDS activities. Other UNDP programmes were considered that may have mainstreamed HIV/AIDS into their activities, coincidentally addressed key factors that affected HIV/AIDS susceptibility and vulnerability, or even undermine an effective response to HIV/AIDS.

1.2 METHODOLOGY

The evaluation was carried out in November 2004 by a national consultant with support from an international consultant. The national consultant reviewed UNDP documents and other relevant literature (see Annex 2) and used interview guidelines prepared for the evaluation. The consultant then carried out interviews and group discussions with UNDP Ethiopia and other relevant stakeholders (see Annex 3). The interview and discussions programme was designed as a groundbreaker and to avoid duplication with the activities of the international consultant.

Based on the interviews and documents reviewed, the national consultant prepared a draft country report that served as an introduction and background document for a five-day visit by the international consultant in December 2004. During the visit, the consultants held a series of interviews and group discussions with the UNDP country office (CO) and selected stakeholders, which tried to avoid duplication with previous interviews. The consultants visited the Southern Nations, Nationalities and Peoples Region (SNNPR) where they interviewed key informants and observed and held discussions with two community conversation (CC) groups in Alaba Special Woreda. They also visited a Leadership Development Programme (LDP) training session and interviewed stakeholders there. Preliminary findings were presented to a stakeholder workshop for discussion and validation.

2. COUNTRY BACKGROUND AND HIV/AIDS SITUATION

2.1 COUNTRY DEVELOPMENT CONTEXT AND PRIORITIES

Ethiopia is a large country of 1.1 million square kilometres that spans tropical, arid and temperate mountainous areas. The population is more than 70 million people—the third largest in Africa—and is growing at approximately 2.6 percent per annum. Approximately 46.5 percent of the population is younger than 15 years of age. The overwhelming majority of the population lives in rural areas (87 percent as of 1994), but the urban population is growing rapidly at about 4 percent per year. Most of the population is Christian (60 percent) or Muslim (34 percent). Smallholder agriculture is the backbone of the economy, making up approximately 48 percent of the gross domestic product (GDP), 85 percent of employment and 90 percent of export earnings in the mid 1990s.

The HIV/AIDS Programme in Ethiopia must be viewed against a background of dire poverty and profound health and development challenges (see Table 1). In 2002, Ethiopia's human development index ranking was 170. Ethiopia is one of the poorest countries in the world, with GDP per capita of USD 810 (purchasing power parity 2001) and with approximately 45 percent of people living below the absolute poverty level of USD 100 per annum. Severe drought and famine strike periodically and an increasing number of areas are chronically food insecure. In 2003, more than 12 million people were on food assistance. The infant mortality rate of 113

TABLE 1. DEMOGRAPHIC, HEALTH AND DEVELOPMENT PROFILE FOR ETHIOPIA: 1996-1997, 2001-2002 AND PLANNED FOR 2015

Indicators	Circa 1996-1997	Circa 2001-2002	Estimated 2015
Estimated population (millions)	58.3	67.2	90
Rural population (% of total population)	NA	84.5	NA
Population growth rate (%)	2.9	2.6*	2
Infant mortality (per 1,000 live births)	110-128	116*	50
Maternal mortality ratio (per 100,000 live births)	500-700	871	300
Life expectancy at birth (years)	52	45.5*	64
Daily calorie supply per capita	NA	1,610*	NA
Underweight children under age 5 (%)	NA	47	NA
Malaria (number of cases per 100,000 people)	NA	556*	NA
TB (number of cases per 100,000 people)	NA	179*	NA
Physicians (per 100,000 people)	2.6	1.7-2.8	6.8
Population with access to health services (%)	45-53	62	90
Population with access to improved-water (%)	NA	24*	NA
Population with access to adequate sanitation (%)	NA	15*	NA
Contraceptive coverage (%)	8	14.6	40
Immunization coverage (%)	67	55	90
Number of hospitals	89	115	NA
Number of health centres	246	412	3,161
Number of health posts	2,291	3,763	15,805
Number of nurses	3,114	12,823	38,940
Government health expenditure per capita (USD)	1.04	1.04	NA
Government health expenditure (% of GDP)	2.7	NA	NA
GDP per capita PPP 2001 (USD)	NA	810*	NA
Literacy rate (%)	27.3	29.4	NA
Gross enrollment rate in elementary school, ages 7-14 yrs (%)	30.1	61.6	NA

Sources: Adapted from UNDP 2003 (indicated by *) and Ministry of Health 2003.
NA indicates data not available.

per 1,000 is one of the highest in the world. Levels of literacy and primary school enrolment are low.

The health status of Ethiopia's population is characterized by diseases of poverty, including infections and malnutrition. Access to safe water, sanitation and health services is very limited. Modern health services formally cover approximately 60 percent of the population, but accessibility is very low—especially in rural, nomadic pastoralist and fringe areas. Poor quality of health services is also an important cause of low utilization and much of the population uses traditional medicine.

Ethiopian women face cultural influences and poverty that disproportionately affect them and make them vulnerable to HIV/AIDS. There is socially condoned violence against girls and women, such as female genital mutilation, early and forced marriage, abduction, rape and domestic violence. The division of labour places girls and women under stress and gives them little time for personal development or health care. Women are further disadvantaged by intra-household food distribution and nutritional taboos. Sexuality is a taboo subject. Discussion of sex, even among sexual partners or peer groups, is very limited. Divorce and remarriage are very frequent, especially in the Northern highlands. People in these areas, and in communities where polygamy is the norm, have multiple marital partners. Extramarital relationships are frowned upon but are not infrequent.

A recent assessment of MDGs[1] indicates that reversing the spread of HIV/AIDS is a major preoccupation. The government has retuned its strategic framework and was trying to reduce new infections by 25 percent by 2005.

2.2 POLITICAL SITUATION AND REFORMS

Ethiopia has a long history of wars and internal regional/civil conflicts. In the last 50 years alone, a number of internecine wars, repeated wars with Somalia and, more recently, with Eritrea have impacted health and development.

Since the new government came to power in 1991, Ethiopia has been in the process of thorough political reforms towards pluralism in politics and decentralization and democracy in governance. The new constitution (introduced in 1995) guarantees extensive human and political rights. There are nine regional states, structured essentially on ethno-linguistic lines, and two autonomous city administrations. The government is highly decentralized, with extensive powers for regions and the 560 *woreda*-level governments. Reforms are intended to facilitate focus on grassroots problems and more responsive and responsible governance.

The government has formulated an agriculture-led, market-driven economic policy and strategy. This emphasizes the role of the private sector, reducing economic distortions and redirecting the role of the state (dominant in the previous regime) to a regulatory one.

To improve the health status of the population, the government is giving priority to the prevention and control of communicable disease with active community participation. A new category of women health workers, Health Extension Agents, will be trained and deployed. There will be two in each *kebele*.[2]

2.3 HIV/AIDS SITUATION[3]

HIV infection in Ethiopia is acquired predominantly through heterosexual contact and peri-natal transmission from mother to child. Ethiopia's first cases of HIV infection and AIDS were detected in 1984 and 1986 respectively. HIV infection levels for urban areas rose sharply from the early 1980s to mid 1990s, but have leveled for the last seven years. There is a constant but slowing rise in rural areas.

At the national level, this translates into a continuous rise in prevalence, with signs of leveling at a relatively low level. According to the Ministry of Health (MOH), the national HIV prevalence rate in 2003 among pregnant women was 6.6 percent (4.1 percent rural, 12 percent urban) and 4.2 percent in 2004. The highest burden nationwide in 2003 was in the age group 15 to 24 years, where 8.6 percent of the overall population was infected, although urban women aged 25 to 29 years had an infection rate of 12.5 percent. Women are generally infected at a younger age than men.

The number of people living with HIV/AIDS in 2003 was approximately 2.2 million, of which close to 100,000 were people less than 15 years old. The estimated new HIV/AIDS cases in the adult population in 2003 were approximately 98,000. This number has been projected to increase to approximately 300,000 in 2010.

The number of HIV/AIDS-related orphans in Ethiopia is currently estimated to be 1.2 million. This figure is projected to increase to approximately 2.5 million in 2014.

3. COUNTRY RESPONSE

3.1 NATIONAL RESPONSE

In 1985, Ethiopia established a National Task Force for the prevention and control of HIV/AIDS. This was followed in 1987 by the establishment in the MOH of the Department of AIDS Control, which was responsible for directing and coordinating the implementation of the National AIDS Control Programme. The MOH, in collaboration with the Global Programme for AIDS, developed and implemented two HIV/AIDS programmes under the first (1987-1990) and the second (1992-1996) medium-term plans. These covered information, education and communication; condom promotion; surveillance; patient care; and expansion of HIV testing laboratories in different health institutions. However, the interventions had little impact on the

1 Ministry of Finance and Economic Development, "MDGs Report: Challenges and Prospects for Ethiopia," March 2004.
2 A *kebele* is the lowest administrative unit, at community level below the woreda with approximately 5,000 people (range less than 2000 to over 10,000).
3 Information in this section is based on MOH data from 2003 and 2004 and Yayehyirad Kitaw et al, "The Health Care System and HIV Epidemic in Ethiopia," In Beck et al (eds), Oxford University Press, in press, 2004.

growth of the epidemic. Moreover, coordination of programme activities among stakeholders was limited.

The response to the epidemic has gained momentum in recent years. Major efforts have been made by the government, non-governmental organizations (NGOs), the private sector and donors to put in place policies, strategies, systems and institutions required for the national response to HIV/AIDS. With the HIV/AIDS epidemic worsening, in 1998, the MOH drafted a National HIV/AIDS Policy and Strategy in consultation with various stakeholders. The policy provided an enabling environment for a multisectoral approach in response to the epidemic. The MOH and the Regional Health Bureaus formulated HIV/AIDS Strategic Plans for 2000-2004 for all regions and city administrations. The National AIDS Priority Strategies for 2001-2005 have provided a national strategic framework for implementation of the Ethiopian Multisectoral HIV/AIDS Project (EMSAP). Priority intervention areas of the strategic framework include:

- Information, education and communication, and behavioural change communication
- Condom promotion and distribution
- Voluntary counseling and testing services
- Management of sexually transmitted diseases
- Blood safety and universal precautions
- Prevention of mother-to-child transmission of HIV infection
- Care and support of people living with HIV/AIDS (PLWHA)
- Human rights legislation
- Surveillance and research

During the last two years, antiretroviral therapy has become one of the priority programme areas. There is concern that the focus on antiretroviral therapy is crowding out actions in areas such as prevention and control.

There have been both continuities and important changes in HIV/AIDS structures and roles. A National AIDS Prevention and Control Council was established in 2000. This is headed by the President and has representation from sector ministries, regional states, NGOs, religious bodies and other civil society organizations (CSOs) including associations of PLWHA. The council approves and oversees the implementation of the federal and regional plans and budgets, and monitors performance. A National HIV/AIDS Prevention and Control Secretariat was also established under the Prime Minister's Office to coordinate and facilitate the country's response, with similar structures at regional and lower administrative levels.

In 2002, the National HIV/AIDS Prevention and Control Secretariat was restructured and renamed the HIV/AIDS Prevention and Control Office (HAPCO). Regional HAPCOs (RHAPCOs) were also established. In 2004, after a period of some uncertainty, HAPCO was placed under the MOH. While it is too early to make a reasonable assessment of the implications of this move, there are some concerns among stakeholders that this might curtail intersectoral responses. RHAPCOs had been developing institutional and human resource capacity, and it is uncertain how the current change will translate at regional and woreda levels.

The importance of civil society has been increasingly recognized, as evidenced by its participation in the National AIDS Prevention and Control Council and various planning processes. There are some 170 local and international NGOs involved in HIV/AIDS. CSOs are playing a pioneering role in behavioural change communication/advocacy, fighting silence, denial and stigma and in the care for PLWHA. Relations with the government are improving, but both sides tend still to have some mistrust and skepticism of each others' initiatives.

The national effort has resulted in some important developments. Ability to coordinate and drive the national response has previously been limited, but establishment and recent clarification of mandates around the HAPCO system should enhance ability to act. Capacity building of the government and CSOs for multisectoral response has progressed. Awareness raising seems to have borne fruit as the Demographic and Health Survey 2000 showed high awareness levels, even in remote rural areas. The effort to increase access to care and support has also shown progress.

3.2 DEVELOPMENT PARTNER RESPONSE

A large number of agencies is involved in HIV/AIDS response in Ethiopia. All UN agencies, in one form or another, contribute to the response, and the World Bank, through the EMSAP project, has had a major role. A number of bilateral agencies

including USAID, Swedish International Development Cooperation Agency (SIDA), Norwegian Agency for International Development (NORAD), Irish Aid and German Agency for Technical Cooperation (GTZ) provide support. UN agencies and the World Bank participate in a range of aspects of prevention and control—mostly information, education, and communication, behavioural change communication, and advocacy—funding activities both through the government and NGOs. Lately, prevention of mother to child transmission has been introduced with UNICEF in the lead. More recently, President Bush's Emergency Plan for AIDS Research (PEPFAR) has played an important role in increasing focus on antiretroviral therapy. Particularly large contributions to funding have come through EMSAP and, more recently, from the Global Fund to Fight AIDS, TB and Malaria (GFATM) and PEPFAR.

HAPCO is the main coordinator of donor HIV/AIDS activities. Most donors have provided funding through HAPCO, although there are other channels. Approximately Ethiopian Birr (ETB) 428 million (USD 50 million) was expended through HAPCO in 2003-2004, of which approximately 3 percent was from UNDP (see Table 2). Some partners, including UNDP, that have not always funded through HAPCO, may start to use this channel more now that HAPCO's position is more clearly defined.

3.3 UNDP RESPONSE

UNDP programmes and approaches in Ethiopia are intended to be interrelated and to reinforce each other. All components contribute to UNDP's general effort to create an environment where sustainable human development can occur and to reduce poverty (see Table 3). In its most recent projects, UNDP has introduced new approaches including methodologies used in LDP and in mainstreaming. It has also introduced multi-executing modalities.

UNDP funding for HIV/AIDS activities is shown in Table 4. There has been a substantial rise in UNDP funding of HIV/AIDS during the past four years, but the scale of its funding is relatively small.

TABLE 2. BUDGETS FOR HIV/AIDS THROUGH HAPCO FOR 2003-2004 (1996 ETHIOPIAN CALENDAR) AND 2004-2005 (1997 ETHIOPIAN CALENDAR), IN ETB THOUSANDS

Source	2003-2004 Actual		2004-2005 Planned	
	Amount	Percentage	Amount	Percentage
Government	13,798	3.2	17,462	2.8
World Bank	181,065	42.3	251,723	40
GFATM	183,566	42.9	321,600	51.1
Action-AID	14,131	3.3	13,837	2.2
UNICEF	12,502	2.9	11,757	1.9
UNDP	12,141	2.8	10,320	1.6
Ireland	11,075	2.6	3,257	0.5
Total	**428,278**	**100**	**629,956**	**100**

Source: HAPCO (December 2004)

TABLE 3. UNDP THEMATIC PRIORITIES IN ETHIOPIA 1997-2006

CCF-1: 1997-2001	CCF-2: 2001-2006	UNDAF: 2002-2004
1. Capacity development for public policy and management 2. Agricultural development 3. Education and health sector programmes 4. Water resource development and utilization 5. Economic recovery and reconstruction	1. Good governance 2. Special pro-poor initiatives, including ICT for development 3. Sustainable environment management and water resources development	1. Sustained economic growth 2. Productive employment 3. Food security and sustainable agricultural development 4. Access to basic social services 5. Good governance 6. HIV/AIDS and development

Note: CCF indicates country cooperation framework; UNDAF, United Nations Development Assistance Framework.

TABLE 4. ANNUAL UNDP PROGRAMME SPEND ON HIV/AIDS IN ETHIOPIA

Year	HIV/AIDS Amount (USD)	Share of Total UNDP Programme (%)
2002	353,350	3
2003	907,908	9
2004	1,000,628	6
2005 (planned)	2,044,350	15

Source: UNDP Ethiopia.

However, the relatively large resources of other programmes may be able to play a role in the national response through HIV/AIDS mainstreaming.[4]

Prior to 2002, UNDP focused on poverty reduction, reconstruction and institutional development and had no specific HIV/AIDS programme. The focus of this evaluation has been on the two projects/programmes that specifically target HIV/AIDS, namely the Support to Project Planning Development (SPPD) on HIV/AIDS and Development and the subsequent HIV/AIDS and Development Project. However, since HIV/AIDS is multi-factorial, a number of UNDP projects could directly or indirectly affect outcomes related to it, through addressing issues such as poverty, food security, governance, capacity building, gender and coordination. A summary of relevant, planned programme outcomes is given in Annex 4.

The SPPD on HIV/AIDS and Development (Project ETH/01/011/A/51) of 2001-2002 was conceived to prepare the ground for the full HIV/AIDS and Development Project. The initial phase identified target areas, project components, potential partners and funding sources. It then laid the foundation for implementation of project components including: mainstreaming HIV/AIDS and gender into the Poverty Reduction Strategy Paper (PRSP) and other government and UNDP programmes; capacity development in government sectors, civil society and national and regional AIDS councils; and gender dimensions of the response to the pandemic.

The HIV/AIDS and Development Project (Project ETH/02/011/01/99/A) supports Ethiopia in the implementation of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment, adopted in June 2001. Its central pillar is the development and enhancement of innovative leadership to support the national response, which is driven by the government of Ethiopia and civil society. A major thrust of the Programme has been to increase understanding of the epidemic and to address, at all levels, the underlying causes of it—including attitudes and mindsets in relation to HIV/AIDS and PLWHA. The project has the following five components, which have often coordinated and supported each other to take advantage of synergy and comprehensive approaches.

1. HIV/AIDS development planning
2. Leadership and capacity development for social mobilization and transformation
3. Human rights
4. Communication advocacy
5. Mainstreaming HIV/AIDS into UNDP supported programmes under CCF-II

3.3.1 HIV/AIDS and development planning

UNDP supports the development of the capacity required in order to mainstream HIV/AIDS into development planning processes for a sustainable, multisectoral response that incorporates prevention, impact mitigation and underlying causes of the epidemic, including gender issues. Activities include capacity development for planning and generating information on the impact of HIV/AIDS and the gender, socio-cultural and economic dimensions of the epidemic.

3.3.2 Leadership and capacity development for social mobilization and transformation

This is designed to strengthen Ethiopia's leadership on HIV/AIDS at all levels, including politicians, policy makers, officials, the private sector and CSOs (which comprise of religious organizations, women's groups, youth, PLWHA and research institutions). It emphasizes strengthening women leadership, networking among stakeholders, and the links between HIV, gender and development.

The Leadership for Results (L4R) Programme was introduced by UNDP in 2002. It builds on UNDP's previous involvement in leadership and governance, but uses new methods and tools to change behaviour and attitudes in order to create a core of committed individuals who can provide leadership in their organizations and communities. The programme uses a set of synergistic interventions

4 Between 1999 and 2003, USD 201,251 was spent on HIV/AIDS diagnostic and screening services.

FIGURE 1. THE LEADERSHIP FOR RESULTS (L4R) PROGRAMME

(see Figure 1) and multiple entry points to fit the differing needs in differing settings and stages of the response to HIV/AIDS.

The main elements of L4R as illustrated in Figure 1 include:

- LDP—The LDP trains select individuals from national, regional and, in some cases, *woreda* level governmental and non-governmental institutions for a new kind of leadership role. As part of a nine-month training process, LDP includes identification of 'break-through projects and innovative initiatives' that individuals will undertake in their own institutions.
- Community Capacity Enhancement Approach—This uses CCs to allow for changed and informed community decision making by creating opportunities for regular, open discussion of

BOX 1. COMMUNITY CONVERSATIONS IN ALABA AND YABELO

Alaba is a rural *woreda* in SNNPR, 85 kilometres from the regional capital. It has an estimated population of 197,000 people—almost all Moslem—in 79 *kebeles*. The community is relatively well organized under a clan system, the *Ogetie*. This has a historical, cultural and religious base, and takes an active part in settling disputes among families and clans. Key institutions, such as the mosque and associations for mutual aid, fall under its supervision. Traditional practices such as female genital mutilation and marriage by abduction are prevalent.

A community conversation (CC) pilot was started in Alaba in July 2002 by UNDP and the Kembata Women Self-Help Centre, with involvement of regional AIDS councils and non-governmental organizations (NGOs) in the launch process. CCs are held every two weeks at selected focal points for two to three hours, and many participants walk far to reach them. Participants have included youth, traditional leaders and traditional medicine practitioners. Participation of women is encouraged and is a prominent feature of CCs. Community-selected facilitators are given a monthly honorarium of ETB 100-125. Participants are provided with exercise book and pens.

CC was introduced in 10 focal points, with 32 facilitators and approximately 50 regular community members participating per point. Recent reports show that there are now approximately 51 focal points, 200 facilitators and 2,550 community participants in the Alaba project. With resonance effect, the total number of participants is estimated at 12,000.

The Yabelo project started in 2003, with 30 facilitators for 8 centres and 50 participants per centre. The centres are in or within 40 kilometres of Yabello town. Selection of facilitators was adapted to accommodate low levels of education in the area. The partner NGO (BRUDA) and facilitators identified participants, focusing on those who could promote change in the communities such as active youth, women, *Geda* (clan leaders), religious leaders and other community leaders. In 2003, 30 *Geda* were trained in HIV/AIDS and CC. CC meetings are held regularly every 15 days for a minimum of 3 hours and attendance is, reportedly, very high. Facilitators hold regular planning and evaluation meetings, facilitate CCs and receive ETB 300 per month.

The Yabelo CCs have registered a number of tangible outcomes. Involvement of *Geda* leaders has been seen as critical for changes to take root. After they discussed 'burning' issues identified by the communities such as *Jala Jalto* (multiple sexual partnership) and abduction, they raised them at their law-making meeting (*Gumi Gayo*), which decided on specific punishments for harmful traditional practices such as abduction and rape, multiple sexual partnerships and widow inheritance.

A development in both sites is joint quarterly meetings of all CC participants. This was a result of expressed needs for consultation and coordination, as CC often led to issues and/or measures beyond each focal point.

Requirements for external funding for participation in CC and quarterly meetings have varied between sites. Travel distances of participants often influence needs for funding of basic activities. In some cases, CC groups have proposed or undertaken fundraising from participants.

situations, values and behaviours related to HIV/AIDS. The first CC projects were started in the *woredas* of Alaba (in SNNPR) in 2002 and in Yabelo (Oromia Region) in 2003 (see Box 1). A number of other CC projects have recently been initiated, and UNDP Ethiopia has been developing a CC implementation guideline for wider use.

- Arts and Media for Social Transformation—This component of L4R has used guidelines developed by UNDP with support from UNAIDS and Pact.[5] The component has targeted the communication capacity of mass media, local media and religious groups. It is intended to create a conducive socio-cultural environment for tackling HIV/AIDS, including use of media to enhance the resonance effect of the CC and LDP by disseminating lessons and outcomes from those initiatives. Undertakings, in addition to those mentioned in LDP and mainstreaming (see Section 3.3.5), include: training and workshops for media; involving media leaders in LDP; and the development of the Future 500 campaign, which aims to identify and provide media coverage to promote positive role-models drawn from ordinary people.

3.3.3 Human rights

The programme sees promotion of human rights as an essential part of the response to HIV/AIDS. UNDP aims to strengthen national and regional legislative frameworks to protect PLWHA and people affected by the epidemic, as well as the rights of women and girls in general. In addition, it supports and develops the capacity of human rights, women's and organizations of PLWHA in Ethiopia, and advocates for a rights-based and gender-sensitive approach to HIV/AIDS.

3.3.4 Communication and advocacy

The UNDP programme hopes to build an enabling environment through cultivation of new leadership and to infuse a sense of urgency about addressing HIV/AIDS. A specific emphasis has been on strengthening and developing the capacity of the Ethiopian media, including collaboration with and support to the Ministry of Information and facilitation of the Ethiopian Coalition of Women against HIV/AIDS.

3.3.5 Mainstreaming HIV/AIDS into UNDP supported programmes under CCF-II

This supports mainstreaming HIV/AIDS and gender into UNDP supported programmes such as the Civil Service Reform Programme.[6] The intention of the mainstreaming component is to integrate HIV/AIDS into Ethiopia's national, sectoral and regional planning; the decentralization process; and workplace interventions. The mainstreaming process was launched through the SPPD and reinforced in the HIV/AIDS and Development Project.

One thrust of this component has been to build the capacity of the Ethiopian government, civil society and the private sector to integrate HIV/AIDS into the development planning process. This has included developing capacity to revise policies, strategies and budgets in order to integrate HIV/AIDS in selected institutions. Other aspects include increasing understanding of the root causes of HIV/AIDS, dialogue to integrate HIV/AIDS into the Development and Poverty Reduction Strategic Programme and other macro-economic instruments, and establishment of workplace HIV/AIDS programmes.

A second main thrust has been to develop capacity of UNDP programme management, government and civil society counterparts to integrate HIV/AIDS into UNDP-supported interventions. This has targeted improving UNDP Ethiopia programme management, as well as increased commitment and support of government, civil society and the private sector, to integrate HIV/AIDS in their programmes. Another key aspect has been to raise UNDP staff awareness of HIV/AIDS and to support affected and infected staff.

5 Pact is a networked global organization that builds the capacity of local leaders and organizations to meet pressing social needs in dozens of countries around the world.

6 The concurrent UNDP capacity building programme has included a number of projects (e.g ETH/02/019/A/01/99, ETH/02/020) to build capacity in support of government's major national Civil Service Reform Programme. Since 2001, there has been particular attention paid to capacity building at regional, *woreda* and *kebele* levels and systematically developing capacities of communities. UNDP support includes: formulation of national capacity development policy; strengthening capacity building in NGO and civil society; support to the Civil Service Reform Programme (with UNDP focusing on four remote, under-developed emerging regions in border areas); and decentralization with emphasis on the constraints in public services delivery.

4. OUTCOME OF UNDP CONTRIBUTIONS AND SUPPORT

HIV/AIDS-related outcomes of UNDP initiatives in Ethiopia should be seen in the light of two important aspects of the evaluation.

- There was a short period between the start of many of the programme components and the evaluation. Therefore, interventions had limited time to fully manifest their potential and possible challenges.
- The evaluation only reviewed the period to the end of 2004. In several of the areas covered by the report, important developments began in 2005, particularly in relation to scaling up, sustainability, and monitoring and evaluation. The evaluation could not fully assess these at the time and may not fully reflect the learning from them.

Nevertheless, a number of important outcomes of UNDP work was noted, as well as some strategic issues that are likely to have ongoing importance for UNDP work in Ethiopia and elsewhere.[7]

4.1 GOVERNANCE

Governance has been a major focus of UNDP activity in Ethiopia for some time. UNDP's involvement is considered to have led to changes in several dimensions of governance related to HIV/AIDS.

4.1.1 Participation and inclusiveness

UNDP has contributed to improvements in inclusiveness of processes and thus broad-based national ownership of recent HIV/AIDS-related policy, strategy and programmes. While the government has clearly been at the helm of the development of most policy and strategy programmes, UNDP has spearheaded the donors' push towards a broader national ownership of key plans. The preparation of the Development and Poverty Reduction Strategic Programme, which is considered pivotal in the response to HIV/AIDS, is an example of changes in governance. While the Interim PRSP was solely government inputs, the final Development and Poverty Reduction Strategic Programme was a government document prepared with the support of donors coordinated by UNDP. Concerns have been raised about ownership that is exclusively government, as opposed to national (including NGOs and community based organizations), but there were important improvements in a broad-based participatory process in preparation of the final document. Similarly, the 2001 National Strategic Framework for the National Response to HIV/ AIDS in Ethiopia 2001-2006 was prepared with little participation of stakeholders other than the government. The preparation of the Ethiopian Strategic Plan for Intensifying Multisectoral HIV/AIDS Response 2004-2008 has, on the other hand, been much more participatory including CSOs, NGOs and donors.

Nevertheless, it was noted that UNDP and its partners had made limited progress in overcoming obstacles to more collaborative approaches between government and non-governmental partners. This has important implications given the government's very limited capacity to address HIV/AIDS.

4.1.2 Recognition of rights and empowerment of PLWHA, women and vulnerable groups

UNDP has played a catalytic role in several initiatives that have reduced stigma in Ethiopia and contributed to greater recognition of the rights of PLWHA. Acceptance of PLWHA has increased and the Media and Arts Initiative and the CC process have contributed to this. At the community level, PLWHA reported that CC had created a more supportive and less stigmatized environment in pilot communities. 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.

Ethiopia has not yet developed specific laws related to HIV/AIDS and rights of PLWHA.[8] However, UNDP involvement in the recent revised penal code was reported to have contributed to making an important headway in including articles that are gender sensitive, recognize sexual and reproductive health rights, and mitigate harmful traditional practices. An ombudsman has been selected and is establishing his office.

Empowerment of women is a prominent feature of changes related to certain projects. This has manifested

7 Examples of important developments in 2005 include scaling up of LDP, strengthening of NGOs such as EVMPA and NCWA and commencement of major up-scaling of CC by UNDP and partners including government.

8 Legislative measures were noted to require a long time and great effort to enact and to be effective. A UNDP sponsored study shows, for example, that only 28 percent of respondents mentioned the government legal structure as a mechanism of helping women in case of abuse. See Miz-Hasab 2004 and National Committee on Traditional Practices Ethiopia 2003.

most prominently in the recent formation of the National Coalition of Women Against AIDS. There are also strong indications that CC participatory approaches at the community level and some LDP breakthrough initiatives, such as Mothers Against AIDS, have helped to empower women, PLWHA and their communities. Changes in traditional practices, such as female genital mutilation, have also been reported in communities involved in CC.

4.1.3 Institutional change and decentralization

Ethiopia has been well rated by the World Bank for its performance in policy and institutional change, including decentralization, which are felt to have created a more supportive environment for HIV/AIDS responses. UNDP has contributed to this shift through its governance, capacity development, mainstreaming and L4R programmes. The L4R process and the CC, in particular, are creating a more receptive environment for a decentralized HIV/AIDS response. Especially in SNNPR, there are indications that involvement of regional HAPCOs and other leadership in LDP has strengthened decentralized systems for HIV/AIDS responses. Other regions have become involved more recently. A number of breakthrough initiatives in the governance sphere (see Annex 5) have emerged from LDP.

4.1.4 Policy and strategy development

Informants noted that UNDP played a significant role in generating the government's commitment to addressing HIV/AIDS. To a large extent, this was through a committed Resident Representative who built on UNDP's strong engagement in the processes of donor consultation, coordination and policy dialogue with the government. One well-placed informant noted that UNDP had specifically contributed to the effort by national and international organizations to harmonize Ethiopia's health policy, strategies and implementation modalities with the national and global perspectives. As a result, the health sector received higher priority in development planning, was better aligned with the Sustainable Development and Poverty Reduction Programme (SDPRP) and the MDGs, and was a stronger candidate for budget support by donors. These changes, combined with UNDP's influence in decentralization in the health sector, were thought to have resulted in significant strengthening of the ability to mount HIV/AIDS responses in the sector. UNDP was also mentioned as having promoted a more multisectoral approach to diseases of poverty that had greater chance of achieving MDGs.

Another change emerging from UNDP work was that national and regional strategies are starting to adopt lessons and approaches developed through UNDP's CC projects. Some informants also suggested that parliamentarians and other policy level personalities who have been involved in LDP and other capacity building initiatives are influencing policy.

UNDP's activities were also thought to have changed relations between the government and non-government media. This might influence media practices and, possibly, the revised Press Law. Despite some reservations among private and international press organizations, the Press Law process has shown some encouraging signs of change. The new Press Law will greatly affect the environment in which the response to HIV/AIDS will evolve.

4.2 LEADERSHIP

UNDP has enhanced leadership on HIV/AIDS in several spheres, particularly through the LDP. The LDP has reached approximately 750 trainees from diverse levels and areas of work. Almost all are in leadership positions with the potential to influence a large number of people and institutions. All reports, independent reviews and interviews suggest that the process has led to substantive changes in participants' leadership attitude and practice.

Several sources commented that LDP had contributed to clearer understanding among leaders of roles in the HIV/AIDS response. Most LDP processes have produced 'break-through' projects and innovative initiatives by participants and their institutions (see Box 2 and Annex 5). Many are reportedly ongoing and others have been spawned as a result of the process. Actual scale and sustainability of impact could not be assessed in this evaluation. However, requests to incorporate LDP methodology into routine civil service training also suggest that it is seen to be effective.

4.2.1 National level leadership

UNDP has contributed to greater visibility of national level leadership in relation to HIV/AIDS. The national President was present at events such as launching of a CC project. A number of parliamentarians and government officials have been affected

BOX 2. FOSTERING LEADERSHIP THOUGH LDP

The goals of the Leadership for Results (L4R) approach and the Leadership Development Programme (LDP) are to foster leadership, which is an important factor in the response to HIV/AIDS. Leadership capacity should be developed at all levels—from the individual through to community and national levels. One participant's experience illustrated how UNDP is contributing to this development through its LDP.

Dr. X is a qualified surgeon with a number of years of experience. He had moved into a management position in a private health enterprise when he was included in the LDP.

After initial skepticism, he was convinced by the innovative and self-exploratory approach, and became an active participant in group work. Consequently, he was selected to act as a facilitator.

"As a surgeon, my role model(s) ruled it over the theatre and ward and I had molded my behaviour along those lines. I had little regard for what was going on around me: the persons involved, their perceptions and feelings, the working environment beyond the small circle around the surgical table. There were problems, such as mysterious absences of key staff and mysterious shortages of materials etc., which hampered the surgical work. Now that I have been through LDP, I could, in retrospect, see how I could have done better, be more sensitive to people's reaction and my own.

At the beginning, I did not really believe in LDP, I thought it would be more of the same… From the emotional intelligence/competence process, from the various management conversations … I have a better understanding of the process of leadership, control my emotions better and can see that I am more effective in getting things done."

Since LDP, he has been instrumental in successfully launching a workplace-based HIV/AIDS programme in his enterprise and is currently involved in the preparation of an LDP in the Amhara region, where he will be the main coach. He later took training for coaching LDP and is now a very enthusiastic and credible coach of international standard.

by LDP. One promising outshoot of LDP is the National Women's Coalition Against AIDS, whose membership includes the First Lady and a number of senior women politicians and ministers. This was established through UNDP initiatives and technical and material support. It is an advocacy group on gender, poverty and HIV/AIDS, and intends to mobilize women in all walks of life. The National Women's Coalition Against AIDS was only established in 2004 but seems to already be providing some substantive leadership. The First Lady has been active in advocacy on HIV/AIDS and gender issues at national and regional levels as part of National Women's Coalition, and some local associations are starting their own CC projects.

Recent initiatives to engage influential religious leaders have won the commitment of various denominations to new projects to mainstream HIV/AIDS in their development and spiritual work. Unfortunately, implementation is too recent to assess final outcomes.

4.2.2 Regional and community level leadership

Limited regional and community level leadership on HIV/AIDS in Ethiopia was seen as a particular challenge by several informants. UNDP has contributed to some mobilization at this level. In SNNPR in particular, LDP appears to have been important in building HAPCO and other leaders' commitment and skills, and clarifying their roles. Regional presidents have been visible in launches of certain UNDP activities.

At the community level, CC also enhanced leadership for HIV/AIDS responses in the pilot communities. A prominent example was the active involvement of *Geda* leaders on HIV/AIDS issues in Yabelo.

4.2.3 Arts and media leadership

Changes in arts and media leadership related to HIV/AIDS can be discerned in Ethiopia, although rigorous data on outcomes was not available. The media was reported to be advocating more strongly for HIV/AIDS responses and addressing issues in a more open and sensitive way. There are also signs of changes that make the socio-cultural environment more supportive of positive HIV/AIDS related attitudes and action. HIV/AIDS related issues are addressed more openly and constructively and positive role models are appearing more frequently in the media. There are a large number of stakeholders in this process, and much of the Arts and Media for Social Transformation Initiative is at a relatively early stage for assessing outcomes. But UNDP has clearly played a significant role in initiating processes, supporting new initiatives, promoting development of an institutional base, building capacity and coordinating stakeholders.

The Arts and Media Workshop of 2002 was a prominent UNDP-sponsored activity in the sector. It

brought together painters, poets, singers and media practitioners from across the country in one forum for the first time. The workshop led to a number of immediate artistic and communication outputs, and inspired participants with a number of ideas for future development. A number of radio and other media broadcasts were offshoots of this workshop.

Enhanced media leadership on HIV/AIDS issues has been expressed in the formation of Ethiopian Volunteer Media Professionals Against AIDS (EVMPA). This was started after the Arts and Media Workshop of 2002 with UNDP material support. EVMPA has brought together media practitioners from the government and the private sectors. Current membership is approximately 100 journalists and media professionals from all around the country. It has influential advisory board members, including the Minster of State of Information. EVMPA has already initiated a number of activities, including the Mothers Against HIV/AIDS Initiative (see Box 3).

There are very promising indications that the LDP has made progress in developing leadership on HIV/AIDS in Ethiopia. However, available information makes it difficult to accurately assess some dimensions of the LDP. New initiatives to extend LDP suggest that there is strong potential for scaling up of coverage through increasing numbers of trainees and coaches. These include plans to institutionalize LDP in the Civil Service College and Ethiopian Management Institute. Yet it is still not completely clear whether UNDP can soon establish a critical mass of effective leadership on HIV/AIDS overall and within certain HIV/AIDS related institutions. It was also difficult to draw conclusions about the precise scale and depth of outcomes and, thus, the efficiency of LDP as an intervention.

Sustainability is another unresolved concern. Some uncertainty remains about the longer term effectiveness and sustainability of key changes and HIV/AIDS related action by LDP participants, including initiatives such as EVMPA, the Women's Coalition, and Mothers Against AIDS. Steps have recently been taken to form an LDP alumni group, but previously, there was no formal mechanism for consultation or enhancing sustainability. This was cited as a specific weakness of the LDP process. A number of participants keep in touch with each other through workshops and spontaneous networking, for exchange of experience and mutual support, but relationships appear ad hoc and scarce. Another limitation identified at some of the institutions was that high turnover of officials can undermine the ability to actually implement and consolidate initiatives.

BOX 3. MOTHERS AGAINST HIV/AIDS—AN LDP 'BREAKTHROUGH' INITIATIVE

Some members of the LDP process used the CC approach to organize mothers (house makers) in one *kebele* in Addis Ababa. They are now in their seventh month and have approximately 50 members. They meet twice a week for about an hour in the *kebele* meeting hall.

At first, there were some objections to their meeting from husbands and neighbours who were not involved. But the programme has now gained acceptance.

The group clearly articulates better awareness, breaking the silence, reduced stigma and increased preparedness to support PLWHA as outcomes of the process. Most members had gone for voluntary counseling and testing themselves and intend to persuade their husbands to do the same. They were notable participants in the recent AIDS Day celebrations.

Their perceived comparative advantage is their peer approach to mothers. The effort is innovative and has potential for an important impact at family and community levels. There is an opportunity for UNDP Ethiopia to closely monitor developments and help document the process. It can assess and support potential for eventual scaling up, and facilitate contacts with possible donors and non-governmental organizations to support the group.

In the case of EVMPA, at the time of this evaluation, the organization still relied entirely on volunteer staff and its ability to attract sufficient assignments or funding remained unclear. However, it had been approached by national and regional HAPCOs, other government agencies (such as the Addis Ababa City Council) and UN agencies (such as UNICEF) to assist them in developing and conducting media related activities. There were also plans for EVMPA to conduct further LDP activities for the media.

4.3 CAPACITY DEVELOPMENT

Capacity development is a major challenge to Ethiopia, not just in the context of the HIV/AIDS response. UNDP has had a role in direct development of skills and also in developing more widely applicable

knowledge, methodologies, tools and capacity to use them in relation to HIV/AIDS.

4.3.1 Government capacity at national and regional levels

Through LDP, UNDP has enhanced capacity by increasing awareness, knowledge and skills to act in relation to HIV/AIDS among targeted leadership cadres at national, regional and sometimes lower government levels. Potential roles of UNDP in developing regional and lower level capacity and leadership were highlighted and members of the donor forum felt this was an important gap that UNDP could address. Some positive impact on leadership and capacity at these levels was noted from CCF and LDP.

4.3.2 Community level capacity (community conversations)

The most widely cited capacity building outcomes were in relation to CCs. Participating communities have developed the capacity to act on HIV/AIDS and other development issues. In particular, women have gained confidence, roles and skills that they did not have traditionally, as witnessed in the CC discussions.

There is substantial evidence that this increase in capacity has led to changes in individual and collective knowledge, attitudes and practices. Participants in the CC process and external observers agreed that the process has started dramatic changes in participating communities, despite the relatively short time in which CC has been implemented. Reported results include breaking the silence and stigma that surrounds HIV/AIDS, increased self-initiated voluntary counseling and testing, and discontinuing certain harmful traditional practices. In addition, effects that extend beyond HIV/AIDS related issues (such as development, gender and other issues) were also noted.

> "These community conversations have resulted in huge behaviour change. I have always believed that it would take generations even to show a willingness to address gender equality, and here [in Alaba] it seems to have happened virtually overnight"
>
> *S. Lewis, UN Special Envoy for HIV/AIDS in Africa 27/10/2004*

UNDP's role in this process has been determinant. UNDP has provided an effective methodology which, while not without precedent in development and health projects, has been innovative and inspiring to many stakeholders in the context of the national response to HIV/AIDS. All stakeholders reported that an alternative to CC would not have been introduced, or at least would have been very delayed, if UNDP had not supported CC. CC has drawn the attention and support of government agencies, NGOs and donors. It has been instrumental in creating a core of national facilitators to fuel the resonance effect in other *woredas* and regions (as discussed in Box 1).

CC has not yet had a large-scale effect in the national context, but there are promising signs of ability to increase the coverage of CC. The intervention has mustered strong support from government agencies, HAPCO and RHAPCOs in particular. The President of the Federal Democratic Republic of Ethiopia and chairperson of HAPCO has, in a recent press interview, praised outcomes of CC and strongly spoken for its scaling-up. The model has been adopted by the government, several UN agencies, other donors and NGOs.

UNDP Ethiopia plans to extend CC to 190 of the 550 *woredas* and to build national capacity to implement and manage CC. UNDP now defines its role as facilitating CC implementation by providing technical support, such as training trainers, coordination, advocacy and facilitating funding. A Community Conversation Implementation Guide is also being developed.

Nevertheless, achieving results on the required, less localized scale remains a challenge, and learning from current CC needs to be consolidated. Several issues were identified for further consideration to ensure sound scaling-up and sustainability of CC.[9]

- If ongoing external support and skills development is needed from NGOs or other parties, this could be difficult to sustain and exit strategies need to be considered. The current model of fortnightly meetings is also demanding and may result in 'conversation fatigue' before outcomes are fully realized and sustainable.[10]
- The effectiveness of CC as a methodology seems clear,[11] but greater understanding of the scale,

9 Most of this discussion is based on the Alaba experience.
10 Moves to institutionalize CC and related tools within government health and agriculture services seem promising in this regard.
11 The provisional results of the evaluation of CC released in 2005 provide more rigorous data on CC effects.

depth and ultimate nature of changes seems desirable to fine tune CC.

- Variations, such as the *woreda*-wide CC that is just emerging in Alaba, and the need and sustainability of joint quarterly meetings across sites needs to be assessed.
- Ethiopia is very culturally diverse, with more than 70 ethnic groups. Some elements of the approach will almost certainly need to be adapted to deal with this.
- Quality assurance was noted to be a concern in the scaling up of CC a number of active proponents and in the draft Strategic Paper. This is important to ensure that the process does not become derailed or diluted by scaling up that is too rapid.
- Cost and capacity issues related to scaling up CC remain unclear and may be very large. It is important to understand these issues before assuming that current models can be used for an adequate number of the 15,000 rural *kebeles* nationwide. Strategic interaction, policy dialogue and advocacy with government and other stakeholders seem essential to tackle these issues.[12]
- CC changes power relationships and depends on 'safe space' for discussion to be successful. CCs can generate issues that can be threatening, and can extend beyond HIV/AIDS to other developmental, socio-economic and even political arenas. Tensions with local authorities in Alaba indicate that the threat of community empowerment could lead other power structures to try to derail CC, and it is uncertain how easily safe space can be ensured a large scale.[13] Although it is unclear whether these tensions will be a common or large obstacle to CC, they may require changes in key stakeholder involvement in CC processes and in backup support for projects.

4.3.3 Capacity and systems to scale up innovations

An important outcome of UNDP's LDP has been development of a national group of LDP trainers with skills to grow LDP—both in HIV/AIDS programmes and in other arenas such as civil service reform. Nine coaches had been trained by international coaches by the time of this evaluation. They have shown dedication to running workshops, even when funding has not been certain. A number of them can now run workshops on their own and two have run LDP training in other countries. In addition, training capacity is now being institutionalized in the Civil Service College and Ethiopian Management Institute.

In the case of CC, the NGO Kembata Women Self-Help Organization has an emerging role in supporting implementation of CC in other projects, and other donors are starting to use CC methodologies (see Box 4). In addition, more than 600 trainers and 2,700 facilitators from different regions have been trained.

4.3.4 Civil society capacity

UNDP has supported some localized, but significant, capacity development within the NGO and CSO sector. In addition to developing capacity of NGOs such as the Kembata Women Self-Help

BOX 4. EXTENSION OF COMMUNITY CONVERSATIONS TO NEW AREAS

The World Food Programme has supported environmental investment in Ethiopia since the early 1980s. The MERET Project (Managing Environmental Resource to Enable Transitions to More Sustainable Livelihoods) supports long-term development in chronic food-insecure areas. It involves 74 of the most food-insecure *woredas* in 6 regions. In previous decades, planning and implementation used top-down methods. These approaches have been revised substantially with greater focus on targeting the most insecure areas on local-level participatory planning and appropriate intervention at the community level. The most recent innovation is the introduction of the community conversation (CC) approach in the decision-making process. This has been started recently with Kembata Women Self-Help Organization's technical support.

UNDP was approached for technical support and recommended that the World Food Programme should engage the Kembata Women Self-Help Organization, an offshoot of the Community Capacity Enhancement Approach. The organization has worked with the Ministry of Agriculture to develop the Local Level Participatory Planning Approach, which is based on the CC methodology, and to start implementing it in four *woredas*.

Source: Adapted from WFP Brief on MERET, July 2004.

12 The Ethiopia Assessment of Development Results (ADR) raise the issue of cost-effectiveness compared to others without giving any details. See also the recommendation of the ADR in relation to dialogue required for effective scaling up.

13 As the evaluation was progressing, KMG (Kembatti Mentti Gezzima-Tope, a group that focuses on the empowerment of women) and the CC in Alaba were going through a crisis. Local authorities apparently felt that CCs were trampling on political and/or religious domains.

Organization and Betel Rural Development Agency (BRUDA) in CC methodologies, other human and organizational capacity to respond to HIV/AIDS has been developed through initiatives such as EVMPA and the Women's Coalition. CSO capacity, such as that of Mothers Against AIDS and PLWHA groups, in CC communities has also been developed, although on a very localized basis. However, there was limited indication at the time of the evaluation as to how effective and sustainable these recent initiatives will be.

Several CSOs and NGOs indicated that UNDP funding and support for initiatives was not always reliable or sustained. This could threaten the effectiveness and sustainability of organizations.

4.3.5 Knowledge and tools to support HIV/AIDS and gender responses

UNDP has generated methods and tools in relation to LDP and CC that have led to significant outcomes. These are now being widely adopted. One area in which outcomes of knowledge generation are less certain is impact studies and research. Two impact studies, on food security and gender, have been completed and were intended to inform policy and operational decisions, as well as establish baselines for future impact assessment. Despite some dissemination activities, however, no clear outcomes from these studies could be established so far.

4.4 PARTNERSHIP COORDINATION

UNDP Ethiopia's support in the area of partnership coordination aims to improve integration of programming and multi-level policy perspectives of the national and regional government, donor partners and the UN system on issues regarding sustainable recovery, building local capacity and holistic approaches to longer-term development. Mobilization of UN partners to adopt a strategic results-oriented and collaborative approach in the context of UN Development Assistance Framework (UNDAF) is another specific thrust. UNDP has achieved results in several dimensions of partnership development.

4.4.1 Inter-agency coordination

UNDP Ethiopia was considered to have made a substantial contribution to coordination among donors and with the government. Until UNICEF took the chair in 2004, UNDP played a critical role in coordinating UN agencies' response as Chair of the UN HIV/AIDS Theme Group. The Theme Group comprises of UN Agencies, Bretton Woods institutions, UN Economic Commission for Africa (UNECA) and other institutions of the UN family, and is one of the largest UN Theme Group in Africa. The Theme Group held meetings approximately every two weeks and annual workshops. Substantial improvement in harmonization and more efficient inter-agency coordination within the UNDAF and the Result Matrix has been achieved over the years.

Another coordinating mechanism in which UNDP plays a leading role is the Development Assistance Group, which comprises of UN agencies, World Bank and bilateral agencies. UNDP co-chairs this group alongside the World Bank. In both the Theme Group and the Development Assistance Group, UNDP has reportedly played a major role in improving and consolidating relationships with the government. As indicated in section 4.1, UNDP roles in partnerships contributed to changes in the health sector and poverty initiatives that were relevant to HIV/AIDS—despite not being HIV/AIDS specific.

Strong Resident Representative leadership is seen as a critical success factor in partnership coordination. The key leadership that the UNDP Resident Representative previously provided on HIV/AIDS issues within the donor community and in interactions with government was often mentioned. However, UNDP seems to have missed some opportunities to capitalize on its strengths in partnership coordination. Several partners held the view that UNDP currently has a low profile in coordination on HIV/AIDS issues among donor agencies outside the UN. They also indicated that they would be receptive to stronger UNDP leadership in partnership coordination and in defining strategic direction for partners. However, they noted that UNDP was not always the most appropriate partner to lead coordination, as this was influenced by the availability and ability of UNDP staff, as well as alternative leaders from other agencies. Several development partners also felt that UNDP could have been more assertive in relations with the government at various times.

4.4.2 Government and civil society partnerships

Beyond donor partnerships, UNDP has developed strong partnerships with the government and some civil society players. UNDP helped keep the dialogue

open between UN agencies, donors and the government in a number of delicate situations, such as the Ethio-Eritrean War. Through its broad involvement in governance, capacity building, and the multisectoral response to HIV/AIDS, UNDP has created close partnerships with a large number of government agencies and organizations and has been able to build on these in the HIV/AIDS response. Because of its privileged relationship with strong ministries, such as the Ministries of Foreign Affairs and Finance and Economic Development, UNDP has good access to officials in authority. This puts it in a good position to facilitate dialogue between the government, the UN and other donor agencies.

The major partner in the government on HIV/AIDS issues is HAPCO. With HAPCO, UNDP is contributing to improved coordination among a large number of government agencies. LDP was reported to have had significant effects in developing partnerships across participating individuals and institutions. In addition, the Mainstreaming Task Force chaired by HAPCO, for which UNDP is Secretary, is also facilitating coordination. Even though big challenges remain (discussed in the mainstreaming section 4.5) this is an important forum for coordinating the response to HIV/AIDS and is bound to influence outcomes of the mainstreaming efforts. NGOs are represented in this Task Force and with the growing involvement of faith based organizations and others, the coordinating activities of this body seem set to grow.

4.4.3 Direct provision of capacity in support of the national response

UNDP reinforced HIV/AIDS responses by developing a dedicated HIV/AIDS team within UNDP (at a time when such capacity was limited in Ethiopia). This capacity was leveraged to help build the HIV/AIDS capacity of partners and UNDP's own programmes at earlier points in the period under review. However, the team's capacity is now overburdened and limited, and UNDP's influence in this role had become less significant.

4.4.4 Mobilizing resources

UNDP has had a limited role in mobilizing substantial funding resources for the HIV/AIDS response in Ethiopia. However, it has begun to have some success in mobilizing the government and other donors to adopt CC methodologies and extend interventions to more communities. At the local level, it was apparent that CC had led to mobilization of community resources to support PLWHA in Alaba.

4.5 MAINSTREAMING OF HIV/AIDS—MITIGATING IMPACT AND POVERTY ERADICATION

UNDP's involvement in mitigation of HIV/AIDS impact and poverty eradication is expressed mainly in its mainstreaming effort. This has aimed to develop the institutional capacity of the government and civil society to design and implement a truly multisectoral response to HIV/AIDS.

A series of workshops and meetings were held on mainstreaming for various representatives from UN agencies, the government, CSOs and the private sector—from the centre and the regions (and SNNPR, in particular). One of the workshops was for senior policy and decision makers. An upshot of this has been the formation of a Mainstreaming Task Force with HAPCO as Chair and UNDP as Secretary. Members include government agencies (Ministry of Finance and Economic Development, Ministry of Agriculture, Ministry of Labour and Social Affairs, and SNNPR HAPCO) that are represented by their HIV/AIDS focal persons, as well as NGOs such as Action Aid. The Task Force has established a Core Group (including UNDP, HAPCO and SNNPR HAPCO) that has focused on the development of a manual on gender and HIV/AIDS mainstreaming, 'A Handbook for HIV/AIDS Mainstreaming and Institutional Response'.[14] A draft was being finalized at the time of this evaluation and was expected to soon be in circulation.

4.5.1 Raising awareness and mainstreaming into plans and action

The mainstreaming movement, which UNDP has helped to spearhead, has raised awareness of the need for HIV/AIDS mainstreaming and to place HIV/AIDS on the agenda of donors, the government, the public and private sector, and key stakeholders, such as faith based organizations. Prior to 2003 and UNDP's initiative, the idea of mainstreaming was rarely addressed, although there have been attempts in some ministries to address HIV/AIDS independent of UNDP-related processes. Nevertheless there has been very limited progress on mainstreaming in

14 This updates HAPCO's "Mainstreaming Guideline on HIV/AIDS Interventions in Federal Ministries and Organizations," 2003.

TABLE 5. STATUS OF HIV/AIDS ACTIVITIES IN SELECTED CENTRAL INSTITUTIONS

#	Ministry /Institution	Anti-AIDS Activity	Review Policy, Strategies	Workplace Interventions				
				Information, Education, Communication and Behavioural Change Communication	Condom	STDs	Care and Support	Counseling
1	Ministry of Agriculture and Rural Development	Y	NM	Y	ND	ND	ND	ND
2	Ministry of Education	Y	Y	Y	ND	ND	ND	ND
3	Ministry of Labour and Social Affairs	Y	N	Y	ND	ND	Y	ND
4	Ministry of Finance and Economic Development	Y	N	Y	Y	ND	Y	ND
5	Ministry of Health	N	N	ND	ND	ND	ND	ND
6	Ministry of Youth and Culture	Y	N	Y	ND	ND	Y	ND
7	Ministry of Transport and Communication	Y	N	Y	Y	ND	ND	ND
8	Ministry of Capacity Building	N	N	ND	ND	ND	ND	ND
9	Ministry of Mines	Y	Y	Y	Y	ND	Y	Y
10	Ministry of Works and Development	Y	Y	Y	Y	ND	Y	Y
11	Central Statistics Commission	N	N	ND	ND	ND	ND	ND
12	WCE	Y	Y	Y	Y	Y	Y	Y
13	Tikur Ambessa Hospital	N	NM	ND	ND	ND	ND	ND
14	Pepsi Co	Y	NM	Y	Y	Y	Y	Y
15	Ethiopian Orthodox Church	Y	NM	Y	ND	ND	Y	Y
16	Save Your Generation Association	Y	NM	Y	Y	Y	Y	Y
17	Family Guidance Association of Ethiopia	NM	NM	Y	Y	Y	Y	Y
18	International Labour Organization	NM	NM	Y	ND	ND	ND	ND

Source: Adapted from Tamene T, "The Status of and Strategies for Mainstreaming HIV/AIDS into the Government Sector," From HAPCO: Stock Taking on HIV/AIDS, September 2004. Notes: Y indicates activity exists; N, no activity exists; NM, not mentioned; ND, no data given.

planning and implementation. At the national and, especially, regional level, mainstreaming was described as being at the 'embryonic stage', although there has been some progress in setting the stage for more concerted action, and in government and private workplace programme development.

A recent stock taking of mainstreaming at federal and regional levels[15] confirms limited and uneven implementation so far. At the federal level, most of the institutions studied had some HIV/AIDS activity, but very few had what could be called a review of policies, strategies and plan, or had started workplace interventions (see Table 5).[16] Most federal institutions carry out HIV/AIDS activities through task forces and focal persons. But focal persons, where they exist, are often from 'soft' units such as public relations, and most take on HIV/AIDS as an add-on assignment for which they get little additional support and on which they are not evaluated. Very few institutions in Addis Ababa allocate some budget for HIV/AIDS activities.[17] Most activity is covered from funds from HAPCO.

The situation is almost the same at the regional level, except for a more encouraging start in SNNPR, in which there are budding initiatives in a number of government institutions in assigning task forces, preparing a manual, assigning focal persons, launching workplace interventions and regularly monitoring

15 Tamene T, "The Status of and Strategies for Mainstreaming HIV/AIDS into the Government Sector," From *HAPCO: Stock Taking on HIV/AIDS,* September 2004.

16 It was also unclear whether, when initiatives existed, any could be specifically associated with UNDP.

17 Water Construction Enterprise and Pepsi Cola (Private) allocate funds from their own budget for work-place interventions.

activities. However, even in SNNPR, efforts are just taking off and review of sector policies, strategies and programmes has yet to be done. Amhara, Oromia and Tigray regions are at an even lower stage of development in terms of mainstreaming. Interestingly, in most of these regions, the Ministry of Education's mainstreaming tends to be more advanced than in other sectors in that curriculum review and mainstreaming of HIV/AIDS in the teaching-learning process has started.

4.5.2 Mainstreaming into specific activities and institutions

UNDP has played an important role in other more specific mainstreaming initiatives. One UNDP workshop, which was held outside of Ethiopia, seems to have led to changes within the Civil Service College (see Box 5).

A newer initiative, the results of which have not yet had time to manifest, is the enrollment of the main faith based organizations in Ethiopia into the mainstreaming process. The Ethiopian Orthodox, Protestant, Catholic and Muslim organizations have recently signed project agreements to mainstream HIV/AIDS in their spiritual and development tasks, including developing curricula and teaching materials for the variety of teaching-learning situations in their communities. The potential importance of this development can not be overestimated as these organizations converse on a regular basis with millions of their adherents. Faith based organizations' involvement in HIV/AIDS is not new. All are members of national and regional HAPCOs and have been active with various programmes, essentially in information, education, and communication and behavioural change communication. However, the mainstreaming process should help better articulate their contribution in their spiritual and development work and in their continuous contact with millions of the faithful.

4.5.3 Integrating HIV/AIDS and poverty agendas

Some mainstreaming of HIV/AIDS into the PRSP and MDG process has occurred with UNDP involvement. 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 missed an opportunity to provide stronger leadership for mainstreaming in the PRSP and MDG processes, and to achieve stronger results.

BOX 5. MAINSTREAMING IN A HIGHER EDUCATION INSTITUTION— THE CASE OF CIVIL SERVICE COLLEGE

The Civil Service College is a relatively new institution established to strengthen human resources in the civil service.* Students are civil service employees with a number of years of experience who are enrolled to upgrade their education. They are expected to go back into the civil service after completion of their education. The college also carries out a continuing education programme.

In June 2003, five staff from the college (the deans of the Business and Economic Faculty, Law Faculty, Urban Development Faculty, the Dean of Students and the Head of the English Department) along with five colleagues from Addis Ababa University attended a workshop on Mainstreaming HIV/AIDS in Tertiary Education in Johannesburg, which was sponsored by UNDP. On their return they, with other staff in the college, decided which courses in HIV/AIDS to integrate. They then developed curricula and teaching materials and have started to integrate HIV/AIDS in the selected courses.

In addition, awareness creation and behavioural change communication is being implemented through the organization of debate and discussion for students and staff. Students are encouraged to focus on HIV/AIDS in their graduation papers. Up to now, seven students have done their thesis on HIV/AIDS.

Members of the Faculty of Law are working on an initiative to start an AIDS Law Project. An HIV/AIDS Policy for the college has been drafted and is in the final phase of approval by the college authorities. There is also a plan (stipulated in the draft policy) to establish a Centre for Combating HIV/AIDS in the college.

The college sees these as important outcomes of UNDP initiative, through its sponsorship of the staff in the Johannesburg workshop. However, there is little communication with other higher educational institutions, not even with the colleagues in Addis Ababa University who have participated with them in the Johannesburg workshop. It would be appropriate for UNDP to support such exchange of information, teaching materials and experience in general.

* It is estimated that less than 20 percent of civil service staff have diplomas or higher qualifications.

An interesting fallout of UNDP's HIV/AIDS activities is that they have created methodologies and skills that have impacted broader development and poverty alleviation issues. Community empowerment and process development through CC has led to some communities addressing development issues beyond HIV/AIDS. Similarly, LDP has introduced methodologies that are now being applied to develop both HIV/AIDS and other leadership skills within the Civil Service College, including improved mainstreaming of gender in the curriculum and activities of the college and more articulate handling of harmful traditional practices in the various courses.

4.5.4 Mainstreaming HIV/AIDS and gender within UNDP

UNDP was considered to have developed a strong workplace HIV/AIDS response. However, it did not assume a leadership role among the UN agencies and it does not appear to have leveraged UNDP expertise from its We Care Workplace Initiative into broader national workplace responses as yet.

Benefits for the HIV/AIDS response arising from momentum created by UNDP's non-HIV/AIDS programmes were noted at several points in the evaluation. However, it appears that systematic mainstreaming of HIV/AIDS into other programmes is still at an early stage. At the same time, it appears that even if HIV/AIDS has not explicitly been mainstreamed into UNDP programmes or is beyond their capacity, several of these programmes have potential for important effects on the evolution of the HIV/AIDS response at various levels. For example, the outcomes of the Civil Service Reform Programme, including decentralization initiatives and strengthening regional and *woreda* level government, could have major impacts on the multisectoral response to the HIV/AIDS pandemic.[18]

5. CONCLUSIONS AND RECOMMENDATIONS

The last 20 years of Ethiopia's HIV/AIDS response have been difficult. Capacity, structures and resources to mount a response are very limited. There are signs of hope that prevalence has leveled in urban areas and encouraging increases in condom use and voluntary counseling and testing uptake. However, the scale of the epidemic in Ethiopia's large population remains a major challenge.

Within the context of a large country and challenge, as well as relatively limited resources, UNDP has contributed to some notable changes in the HIV/AIDS response. The development and enhancement of new and innovative leadership is the central pillar of UNDP's support to the country's response. This evaluation clearly shows that UNDP has played a positive role in this process and that it has comparative strengths in developing innovative approaches and precedents, and has a catalytic and coordinating role. Synergy between different parts of UNDP's HIV/AIDS Programme also seems to have been an advantage.

5.1 CONCLUSIONS

The comments that follow are meant to strengthen the good outcomes to date and should not distract from the merits of UNDP's achievements in the country. They also may not fully reflect important developments in relation to sustainability, scaling up and monitoring and evaluation after the period of evaluation.[19]

5.1.1 Governance

In the area of governance, UNDP has clearly played an important coordinating and catalytic role in creating a more enabling environment for the HIV/AIDS response at national, regional and community levels. The LDP process, and CC in particular, is important in positing HIV/AIDS as a governance challenge. Important precedents have been set in relation to empowering and increasing participation of PLWHA and women at national and community levels. In addition, an important

18 UNDP's focus on governance interventions is in the difficult emerging regions. This creates challenges both for its 'core' interventions and ability to mainstream HIV/AIDS at this stage.

19 Several important developments in relation to scaling up, sustainability and monitoring and evaluation have occurred since the evaluation. These include the following: LDP has been scaled up and conducted in five regions as well as for the Ethiopian Management Institute, the Civil Service Reform Programme and the Civil Service College; capacity of national coaches was increased through additional intensive training and six coaches have been contracted by UNDP; some measures have been taken to strengthen EVMPA, which has started delivering services to UNICEF, some regional HAPCOs, and others; and up-scaling of CC has started in earnest—CC is now being implemented in 190 *woredas* throughout the country (total of 550) by UNDP and partners and the government has adopted CC as the main community mobilization methodology in its strategy. As most of the implementing agencies are now government-sector offices, this seems to reduce the possible tensions highlighted in the evaluation and some of the concerns of sustainability.

foundation has been laid for stronger media roles in tackling HIV/AIDS.

These changes have occurred through UNDP's effective and visible role as a convener and coordinator of donor groups, through leveraging its relationships with government, and through its specific HIV/AIDS activities. Governance seems to be a natural area of UNDP comparative advantage and an area in which it can make an important contribution to strengthening policy, planning and institutions in Ethiopia. UNDP seems to have missed some opportunities for stronger inputs in relation to HIV/AIDS government policies and plans. An emerging area in which UNDP can make a strong contribution is strengthening decentralized levels of the HIV/AIDS response.

5.1.2 Capacity development

The most striking outcomes of UNDP efforts have occurred in relation to capacity development by CCs and LDP. These have had strong implications for leadership, governance and mainstreaming. Particularly in the case of CC, UNDP has made a significant contribution in introducing innovative approaches and methodologies, liaising with local partners, and training a core of national facilitators and trainers. One measure of its success is that it is now being adopted by government, NGOs and donors. The initiatives also suggest that innovative UNDP initiatives at the community level can have an important role in informing and influencing national strategies in response to HIV/AIDS.

Nevertheless, the scale of outcomes of CC and LDP has been limited so far, and the projects are still evolving. At the time of the evaluation, approaches to scaling up of LDP and CC interventions were being developed. However, it is apparent that it is desirable to develop a fuller understanding of outcomes, models, possible obstacles and tensions that may arise from CC, sustainability and exit strategies. This could help to fine tune the interventions and optimize efficiency, as well as to ensure that more powerful data can be used to mobilize resources and support.

5.1.3 Partnership development

UNDP has contributed considerably to coordination between UN agencies and other donors, and to harmonizing relationships between different partners and the government. It has also facilitated linkages between different government agencies and institutions. UNDP's close ties with powerful government ministries and its coordination role among the UN agencies are valuable comparative advantages. However, many partners would welcome a more assertive role for UNDP.

Further partnership development will raise new challenges. The HIV/AIDS response is still evolving rapidly and new approaches and roles are cropping up continuously. Recent and profound developments that could affect UNDP's role include large new sources of funding (from the GFATM, PEPFAR and others), and risks of re-medicalization of the HIV/AIDS response through heavy emphasis on antiretroviral therapy and the relocation of HAPCO into the MOH. In addition, other partners within the UN may, at times, be better equipped to play certain partnership coordination roles.

5.1.4 Mainstreaming

A clear, coordinated mainstreaming process and a truly multisectoral response are only starting to emerge in Ethiopia. By all accounts, UNDP has played a significant role in reaching this stage. However, it also seems to have missed opportunities for stronger roles in mainstreaming in the workplace and across its own programmes.

The ground for major breakthroughs has been prepared as a number of sectoral agencies, NGOs and faith based organizations are poised to launch major mainstreaming drives. The next two years will be critical to realizing the potential for mainstreaming. However a number of challenges await UNDP and its partners. Actively sustaining momentum behind mainstreaming will be important in the face of possible medicalization of the HIV/AIDS response. Monitoring and refinement of mainstreaming processes and the use of mainstreaming guidelines will be needed to ensure that they achieve results. In addition, UNDP advocacy will be needed to upgrade the status of the mainstreaming task force and HIV/AIDS focal persons if they are to achieve what is required for a truly multisectoral response.

5.2 RECOMMENDATIONS

1. UNDP should continue promoting development of stronger governance in relation to HIV/AIDS, including consolidation of media-related initiatives. Interventions at the regional and *woreda* level should be given particular attention.

2. UNDP should pursue its intentions of scaling up CC. UNDP should also ensure that it consolidates its current CC pilots and that the national response learns all necessary lessons for future development of CC from Alaba, Yabelo and new sites.

3. UNDP Ethiopia should be supported to change its roles in relation to CC. Appropriate moves seem to have been made for UNDP Ethiopia to shift its focus from implementation of CC towards: facilitation of action and financial support by the government and donors with larger resources; quality assurance of CC initiatives; monitoring and evaluation; and adaptation of models to different cultural circumstances.

4. UNDP should improve understanding of how to create a sustainable, strong national trainer/facilitator core that builds on relationships with NGOs such as the Kembata Women Self-Help Organization but ensures sustainability and ability to achieve adequate scale.

5. Extension of the LDP should be supported as a way to address needs for HIV/AIDS leadership capacity. However, more attention should be given to deepening understanding of whether optimal outcomes and sustainability are being achieved. This could help to ensure efficiency and ability to motivate for appropriate support for LDP. In particular, networking mechanisms such as an Alumni Association or other mechanisms to consolidate outcomes of training should be explored and supported by UNDP.

6. Earlier consideration of consolidation, sustainability and exit planning for both large programmes and particular interventions should be institutionalized (although the early stage of UNDP Ethiopia initiatives and recent sustainability initiatives are acknowledged). Specific consideration should be given to follow-up support of prominent initiatives such as EVMPA, Arts and Media Workshop, National Coalition of Women Against AIDS, and the Mothers Against AIDS, as their potential could be lost through early disengagement while they are still at a young stage. UNDP should use its influence and resources to facilitate funding of these projects by other agencies if it cannot fund them directly.

7. UNDP should revitalize its role in development and coordination of partnerships, partly to enhance the national response, but also to facilitate support for scaling up of UNDP innovations by partners with larger resources. Plans for partnership facilitation should include clear assessment of needs and roles in Ethiopia, as well as capacity requirements for UNDP to play any proposed role.

8. Adequate ongoing support should be given to mainstreaming to ensure effective outcomes. A number of factors could result in loss of previous investments by UNDP if this does not occur. Mainstreaming in faith based organizations is a particularly promising area where UNDP should assume that methodological and technical support and capacity building will be beneficial.

9. To meet the requirements of its expanded HIV/AIDS commitments, including innovation and consolidation of innovations, UNDP should strengthen its HIV/AIDS staff capacity and expertise.

10. UNDP should continue to emphasize increasing its internal efficiency. In a number of cases, delays, inefficiency and frustrations were attributed to bureaucracy in UNDP.

ANNEX 1. ACRONYMS AND ABBREVIATIONS

CC	Community Conversations
CCF	Country Cooperation Framework
CO	Country Office
CSO	Civil Society Organization
EMSAP	Ethiopian Multisectoral HIV/AIDS Project
ETB	Ethiopian Birr (currency)
EVMPA	Ethiopian Volunteer Media Professionals Against AIDS
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, TB and Malaria
HAPCO	HIV/AIDS Prevention and Control Office
LDP	Leadership Development Programme
L4R	Leadership for Results
MDG	Millennium Development Goal
MOH	Ministry of Health
NGO	Non-governmental organization
PEPFAR	President Bush's Emergency Plan for AIDS Research
PLWHA	People Living with HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
RHAPCO	Regional HIV/AIDS Prevention and Control Office
SPPD	Support to Project Planning Development
SNNPR	Southern Nations, Nationalities and Peoples Region
UNDAF	UN Development Assistance Framework
UNGASS	UN General Assembly Special Session on HIV/AIDS

ANNEX 2. REFERENCES

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ANNEX 3. PEOPLE INTERVIEWED

GOVERNMENT OF ETHIOPIA

Fatuma Abafita, Head RHAPCO Oromia, Regional HAPCO (focus group discussion)
Kumelachew Aberra, Director, Civil Service Reform Programme Office, Ministry of Capacity Development
Dr. Yayeh Addis, Head RHAPCO Amhara, Regional HAPCO (focus group discussion)
Kemal Ali, Monitoring and Evaluation Team Leader, HAPCO
Dr. Ashenafi, Head RHAPCO Addis Ababa, Regional HAPCO (focus group discussion)
Hussein Faris, Plan and Programme Evaluation Team Leader, HAPCO
Dr. Zeleqe Gobe, Deputy Head of RHB, SNNPR
Desalgne Hailemariam, President of the Region, SNNPR
Dr Tsegaye Legesse, Head RHAPCO Tigray , Regional HAPCO (focus group discussion)
Dr. Ersido Lendebo, Head RHAPCO SNNPR, Regional HAPCO (focus group discussion)
Negatu Merke, Head HIV/AIDS Prevention and Control Commission, HAPCO
Zemedkun Tekel, Head of Information and Public Relations Dept., Ministry of Information

UNDP

Estifanos Abebe, HIV/AIDS Team
Dr. Geira Baruda, Programme Officer
Signe Fredinkse, Programme Officer
Brutawit Habtesellasie, HIV/AIDS Team
Patricia Kadia, Junior professional consultant
Berhanu Legesse, Consultant on CC for UNDP (formerly Kembata Women Self-Help Organization)
Nileema Noble, Deputy RR
Morten Olesen, Programme Officer, Governance Unit
Kelemework Tekyle, ARR, HIV/AIDS and Social Sector

UN SYSTEM

Emebet Admasu, NPO, UNAIDS
Gideon Cohen (chair) and members, Donor Forum
Bunmi Makinwa, UNAIDS Country Coordinator and Focal Point for African Regional Organizations, UNAIDS

BILATERAL DONORS

Mirgissa Kaba, OIC for HIV/AIDS Section, UNICEF
Bjorn Lundqvist, UNICEF Country Representative, Chair UNTG, UNICEF
Mulumebet Merhatsidk, Programme Assistant, HIV/AIDS, WFP

NON-GOVERNMENTAL ORGANIZATIONS

Gifti Abasiya, State Minster of Women's Affairs, Chairperson, National Women's Coalition Against AIDS
Sisay Abebe, Journalist, EVMPA

CIVIL SOCIETY

Community Conversations Groups (2), Alaba Special Woreda
Dr. Bogalech Gebre, Alaba Special Woreda
Nuredin Jemal, Programme Coordinator, Islamic Affairs Supreme Council
Abdulhafez Kemal, A/Director, Islamic Affairs Supreme Council
Dr. Berhanu Tadesse, National Coach, Manager, Medical and Professional Services, Selam Health Care Plc

OTHER

Dr. Michael Abebe, Academic Vice-President, Civil Service College (group discussion during LDP training in Nazareth)
Mesfin Abebe, Head, Reform Development and Consultancy Services Dept. CSRP-O
Joseph Friedman, LDP Consultant
Alemayehu Haile, LDP coach
Dr. Michael Aberra Haile, President of the College, Civil Service College (group discussion during LDP training in Nazareth)
Dr. Derese G Kassa, Assistant Lecturer, Sociology & Anthropology Department, Addis Ababa University
Konjit Worku, Head Women' Centre, Civil Service College (group discussion during LDP training in Nazareth)
Dehme Mengistu, LDP coach
Negash Shifferaw, Coach, Co-Owner, BIRTUnet Development & IT Solutions PLC
Solomon Tesfaye, External and Public Relations Officer, Civil Service College (group discussion during LDP training in Nazareth)

ANNEX 4. PLANNED MAJOR OUTCOMES AND ISSUES OF RELEVANCE TO UNDP'S HIV/AIDS PLANS

1. GOVERNANCE

1.1 Increased effectiveness of parliament to perform its legislative and oversight functions[a]

1.2 Legal and regulatory frameworks reformed to improve access to justice with effective ombudsman and other human rights oversight bodies either established and/or in operation[a] (see 5.3)

1.3 Legal reforms and formulation of anti-discrimination legislation for PLWHA and gender equality advocated[b]

1.4 Financial and human resources mobilized and allocated in support of decentralization and local governance in rural and urban areas through improved efficiency, accountability and transparency in the civil service at federal and regional levels[a]

1.5 Enhanced country ownership of policy/strategic documents/programmes[e]

1.6 Broad-based participation in the development of policy/strategic documents/programmes[e]

2. LEADERSHIP FOR DEVELOPMENT

2.1 An enabling environment to achieve the goals of the UNGASS commitment created through capacity development of Ethiopia's leadership at all levels (See 3.6).[c] Multi-stakeholder national policy dialogues to achieve UNGASS goals and create an enabling environment promoted (addressing prevention; treatment and care; socio-economic impact mitigation; mobile and migrant populations; and reducing vulnerability and vulnerable groups)[b]

2.2 Multi-stakeholders leadership programmes for responding to HIV/AIDS established and supported[b]

2.3 Increased awareness of policy makers of the link between HIV/AIDS, gender and development, and the legal and policy gaps related to it, and concrete steps taken to improve both the policy and legal limitations related to HIV/AIDS and gender[d]

2.4 Leadership capacities of organizations and networks (including for PLWHA and CSOs) developed[b]

2.5 Leadership coalitions for transformative development established and supported[b]

2.6 Community Conversation

3. CAPACITY DEVELOPMENT

3.1 National anti-poverty strategy—Sustainable Human Development and Sustainable Development and Poverty Reduction Programme (SDPRP)—developed and implemented and capacity built to monitor attainment of MDGs[a]

3.2 Institutional, societal and individual capacity built to plan and implement multisectoral strategies at both national and sub-national levels to limit the spread of HIV/AIDS and mitigate its social and economic impact.[a] The development of the Government's and Civil Society's institutional capacity has led to the design and implementation of a truly multi-sectoral response to HIV/AIDS[c]

3.3 HIV/AIDS and gender integrated into government policies, strategies and planning processes of key ministries[d]

3.4. The policy, legal and regulatory framework reformed to substantially expand connectivity of information and communication technologies[a]

3.5 Strengthened institutional and human capacity to manage and sustainably utilize natural resources of national and global significance.[a] National and Regional HRDS with an HIV/AIDS focus prepared[b]

3.6 An enabling environment to achieve the goals of the UNGASS commitment created through capacity development of Ethiopia's leadership at all levels[c]

3.7 Integration of research results in sectoral strategic planning has resulted in reduced vulnerability of target sectors to HIV/AIDS and in the reduction of its impact (both at federal level and in selected regions, zones and *woredas*), as well as in the mitigation of the impact of sector activities on the prevention of infection in the communities[d]

3.8 Cognitive maps and mental models utilized for enhanced development effectiveness[b]

3.9 Increased male responsibility and women's empowerment that leads to greater control of women over their sexuality and life, resulting also in increased safe sex[d]

3.10 National AIDS Councils strengthened (National HIV/AIDS strategic planning processes reviewed and implemented)[b]

4. PARTNERSHIP DEVELOPMENT FOR COUNTRY LEVEL DEVELOPMENT

4.1 Improved integration of programming activities and multi-level policy perspectives of national and regional governments, donor partners and the UN system on issues regarding sustainable recovery, partnership to build local capacity, and a holistic approach towards longer-term development[a]

4.2 Mobilization of UN partners to adopt a strategic results-oriented and collaborative approach in the context of UNDAF[a]

4.3 Roundtables on resource mobilization and high-level seminars on HIV/AIDS undertaken[b]

5. MITIGATION OF HIV/AIDS IMPACT AND POVERTY ERADICATION

5.1 Institutional, societal and individual capacity built to plan and implement multisectoral strategies at both national and sub-national levels to limit the spread of HIV/AIDS and mitigate its social and economic impact[a]

5.2 Individual and community responses to the epidemic developed and linked to interconnectedness and how individual attitudes and practices influence its spread[b]

5.3. Workplace Programmes on HIV/AIDS promoting awareness and on reducing vulnerability of UNDP staff and their dependants developed and implemented[b]

5.4 Improved food production and food security at national and household levels[a]

5.5 Strengthened legislative framework in place to protect people infected and affected by HIV/AIDS and increased participation of organizations of PLWHA, HR organizations and women's rights organizations in the national response[c]

5.6 Mass media, community media and religious media in Ethiopia advocating powerfully for HIV/AIDS as a national priority and addressing HIV/AIDS issues in a more open, sensitive and responsible way[c]

5.7 HIV/AIDS and gender integrated in the design and implementation of all UNDP supported programmes[c]

5.8 HIV/AIDS mainstreamed into development planning instruments (national development plans and budgets, PRS/PRSPs, expenditure frameworks, and HIPC and other debt processes), CCA/UNDAF and Country Programmes[b]

5.9 HIV/AIDS mainstreamed into Line-Ministries and sectoral policy studies[b]

5.10 Sub-national and district level HIV/AIDS responses planned and implemented[b]

5.11 Community plans developed for responses, linked to national policy and planning process[b]

5.12 HIV/AIDS integrated into global and regional development initiatives[b]

5.13 HIV/AIDS aspects of Convention on the Elimination of Discrimination Against Women (CEDAW) implemented[b]

5.14 HIV/AIDS strategy and response in emergency settings developed[b]

5.15. Strategies addressing the loss of workforce due to HIV/AIDS formulated[b]

5.16 Communication strategies formulated to address stigma and discrimination to protect the rights of PLWHA and promote gender equality[b]

5.17 Transformational programmes designed for communication to address underlying causes, ignite hope and produce results[b]

5.18 Arts and media used to promote awareness and develop capacity to respond[b]

5.19 Advocacy networks developed to promote transformational development practice, including strategies and actions for HIV/AIDS[b]

5.20 Commitment to pro-poor growth of policy/strategic documents/programmes[c]

5.21 Increased visibility of HIV/AIDS in the MDG campaign advocated[b]

5.22 National progress of HIV/AIDS MDG monitored[b]

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[a] From ADR: 19
[b] From HIV/AIDS Strategic Results Framework
[c] From HIV/AIDS and Dev Project
[d] From HIV/AIDS and Gender and Dev
[e] From PRSP Evaluation

ANNEX 5. BREAKTHROUGH INITIATIVE GROUPS, FIRST ROUND OF LDP, CIVIL SERVICE REFORM AND UNDP STATUS OF ACTIVITIES

(as of 30 November 2004)

Group, Number of People in Group (Female)	Vision	Goals	Status and Next Steps
A. Afar and Federal Level, 5(1)	To create a better working culture in Afar Regional State. We stand for making Capacity Building Office of Afar a work-conscious model of the region.	■ Green area in the compound by the end of July 2005 ■ 80 percent of the employees of the bureau coming and leaving on time by the end of July 2005 ■ Fully implemented expenditure management and control system by the end of September 2005	Had more than one meeting (the Afar sub group). They have completed their proposal and have had a meeting with the rest of the staff at their bureau. Have enrolled their colleagues in their vision and have decided to make their bureau a model. Planned to continue their enrollment.
B. Benishangul Gumuz and Gambella Regional States and Federal Level, 6(2)	We stand to create committed civil servants in Benishengul Gumuz region.	■ To increase performance 25 percent ■ To eliminate lateness ■ To eliminate avoidable absenteeism 85 percent ■ To enable employees to meet their deadlines 100 percent ■ To minimize failures by 65 percent ■ To minimize overhead costs 25 percent ■ To apply result oriented performance appraisal in more than 5 bureaus	Have had meetings with the region's president, finance and plan heads and were able to enroll them in their vision. Have prepared their report and have sent it to the team in Addis and Negash. Have planned to continue their enrollment and implementing their plan. ■ Action plan prepared ■ Focal person nominated
C1. Oromia and Federal Level, 5(2)	We stand for the possibility of shortening the lengthy working process by providing the most effective and efficient service delivery.	By June 2005 ■ To attenuate working processes ■ To minimize complaint rates by 80 percent	Had more than three meetings. Have developed outline of their activities and proposal and shared tasks among their team. Planned to have their last meeting on 2 December 2004. ■ Data collection method designed ■ Project divided into 5 components, first phase completed
C2. South Nation Nationalities Regional State, 3(2)	We stand to bring up commitment of leaders for effective and speedy implementation of CSRP in SNNPR.	By the end of June 2005 ■ Finalized and implemented BPR Study in 25 bureaus ■ 45 bureaus implement result oriented performance appraisal ■ Technical support provided for 45 bureaus by regional steering ■ Integrated implementation of the sub-components of CSRP in 45 bureaus ■ Efficient and effective service delivery in 25 bureaus ■ 50 percent of the leaders own the CSRP ■ Customer complaints reduced by 50 percent ■ Conversations with top leaders, plan of action produced	Report not available.
D. Hareri, Addis Abeba and Dire Dawa City Administrations and Federal Level, 10(2)	We stand for the possibility of implementing result oriented management performance in the Dire Dawa Administration Civil Service Commission by June 2005.	■ To create awareness on result oriented management performance in the whole staff by December 2005 ■ To have a change agent team in the commission by 31 December 2004 ■ To set measurable standards and to implement manual by February 2005 ■ To start implementing manual by April 2005 ■ To have the whole staff fully internalized; implementing and evaluating result oriented performances by June 2005	This group is working in Harar. Some members are working in Addis and the first meeting has been undertaken in Harar with the financial assistance of UNDP/CSR office. The group have had meetings and undertaken enrollment workshops within their organizations. ■ TOR prepared, situation analysis conducted ■ Decided to conduct training 10 December
E. Federal, Civil Service Reform Offices, 11(3)	We stand for gender balance in the Ethiopian civil service.	■ To create gender balance in Ethiopia by 2011 ■ To develop a radical gender programme	This group has met three times already and has worked out the objectives and activities. The have undertaken a half day awareness workshop to their colleagues on gender issues. The team has prepared a TOR for their initiative.

Group, Number of People in Group(Female)	Vision	Goals	Status and Next Steps
F. Team Leaders and Planners, 10(2)	We commit to have civil servants on quality service delivery, and to have civil servants dedicated to the motto "customer is the king".		Has met three times and has worked on their action plan. The leader submitted the minutes of their meeting and action plan to Ato Negash. ■ Data collection method (questionnaire) prepared ■ The group is working on developing a leaflet
G. Team Leaders and Admin Experts, 11(2)	We stand for establishing an integrated and coordinated CSRP mgt system in our organizations.	■ Guidelines for refined framework of CSRP management system ■ Documentation of existing CSRP management system (organization and group level) ■ Documentation of existing CSRP problems (organization and group level) ■ To accomplish 95 percent of the plan (as a result of commitment) with limited resources	■ 5 meetings held ■ Brainstorming session organized ■ Guideline developed ■ 3 hours' presentation prepared, based on 1st LDP session, presented to directors of Ethiopian Telecommunications
H. Department Heads and Admin Experts, 8(3)	We are committed to establish and implement a strong and efficient work culture in our organizations, that fully support and effect the public service delivery.	■ To bring about acceptable working culture through sensitization and awareness creation on CSRP by June 2005 ■ To develop and implement ROPES and conduct training on the ROPES for the staff and managers by March 2005 ■ To develop and introduce incentive and reward system for the staff by the end of April 2005 ■ To introduce acceptable ethics, positive thinking and value system for the whole staff by January 2005	This group has met three times already and has discussed the scope of work and the action plan. ■ During the last 6 weeks 1 whole afternoon meeting once a week ■ Action plan prepared ■ To be developed: assessment and follow up plan
UNDP I, 6(5)	We stand for the possibility of improved programme/project quality and empowerment of UNDP employees through the revision of NEX manual.	■ Completion of strong proposal document, justifying the necessity of NEX review by the end of November 2004 ■ UNDP senior management to be committed with to the review process of NEX manual by December 2004 ■ Initiation of the negotiation process between government and UNDP during 1st quarter of 2005	Had more than three meetings and shared assignments (chapters of the document they are going to build) among sub groups. Have submitted their proposal to UNDP's senior management. Team leader has submitted summary report of the group's activities.
UNDP II, 5(3)	We stand for an HIV/AIDS free workforce and a caring work environment to those infected and affected in Ethiopia.	■ To put in place the B.I.G. Working group as a formal working group targeting workplace intervention by holding meeting with supervisor and DRR by November 2004 ■ To review existing situation/policies in place targeting workplace interventions in UNDP Ethiopia, thereby identifying gaps and limitations by December 2004 ■ To prepare a detailed action plan for B.I.G. by the end of December 2004 ■ To call a general staff meeting to impact our intentions and work plan (get feedback / make it participatory) by the end of December 2004 ■ To create a work group / coalition and networking within UNDP units generating motivation and commitment by the end of December 2004 ■ To implement action plan for work place intervention ■ To enforce the implementation of work place policies on HIV/AIDS (testing / ARVs / workshops) by the end of December 2005	Have been having formal and informal meetings.

LESOTHO COUNTRY STUDY

HIV/AIDS

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

By Keiso Matashane-Marite and Ikwo Arit Ekpo

The authors thank the UNDP Country Office Lesotho for the invaluable help it provided.

LESOTHO

CONTENTS LESOTHO COUNTRY STUDY

1. INTRODUCTION

1.1 INTRODUCTION

This report presents the results of an outcome evaluation of UNDP's role and contributions to the HIV/AIDS response in Lesotho. It discusses the outcomes and significant changes that have occurred from 1999 to 2004 as a result of UNDP's support to HIV/AIDS efforts in Lesotho within the context of the Millennium Development Goals (MDGs) and the Declaration of Commitment. It delineates the outcome of UNDP's programme strategies and efforts to address HIV/AIDS, especially in the areas of policy, knowledge management, funding mechanisms and coordination. In addition, it assesses UNDP's role as UN Resident Coordinator and the extent to which UNDP has successfully coordinated and implemented joint actions within the UN family of agencies to respond to HIV/AIDS. The role of UNDP as chair of the UN Expanded Theme Group on HIV/AIDS, in relation to other development partners and stakeholders, is also examined.

The findings of this evaluation are expected to assist UNDP in repositioning itself to more effectively support the fight against the HIV/AIDS pandemic. Findings are also expected to inform future programme strategies and decisions on how UNDP should allocate and channel its resources and support to the national response.

UNDP's direct efforts to combat HIV/AIDS in Lesotho were launched in 2002. They did not start in 1999—part of the period under review. UNDP Lesotho's evaluation is therefore in the context of the overall Country Cooperation Framework (CCF) of 2002-2004, a document that was revised to 'core stream' HIV/AIDS and transformational leadership in the three thematic areas of democratic governance, energy and environment, and poverty reduction and food security. The findings of this evaluation will be reported in the context of significant outcomes in five thematic areas: governance, leadership for development, capacity development, partnership coordination for development results, and mitigating HIV/AIDS impact and poverty eradication.

The evaluation examines the relevance and efficiency of UNDP's contributions and efforts to combat HIV/AIDS. It assesses UNDP's ability to leverage additional resources while strategically managing its relationships with development partners and maintaining its collaborative commitments with the Government of Lesotho (GOL).

In 2003, when UNDP decided to review the second CCF 2002-2004 and put HIV/AIDS and transformational leadership at the core of all its programmes, it was a deliberate and strategic decision for successfully managing partnership efforts and collaborative commitments. Governance was articulated as UNDP's focus for achieving leadership results and scaling up the HIV/AIDS response. While maintaining a focus on core streaming HIV/AIDS into all programmes, governance and leadership remained a conduit for achieving significant and extensive outcome.

UNDP focused substantive efforts on governance and leadership through training and advocacy initiatives to transform policy, build institutional capacity, and gain commitment for expanded action on HIV/AIDS. This culminated in the joint national stakeholder symposium of Leadership for Results: Towards Accelerating Implementation of the National Response to the HIV/AIDS Pandemic in November 2004. UNDP's strategic focus and action has led to an increased demand for voluntary counselling and testing (VCT) services and an open articulation and declaration by GOL to facilitate measures to keep all HIV-negative Basotho negative, while providing measures to enable HIV-positive Basotho to live longer and more productive lives.

1.2 COUNTRY BACKGROUND

Lesotho is a mountainous country covering an area of approximately 30,350 square kilometres. It has a population of 2.2 million people[1] and is surrounded by the Republic of South Africa. It is classified as one of the 49 least-developed countries in the world, with a per capita income of USD 423. In 2001, 58 percent of the population were reported to live below the poverty line. The 2004 UNDP human development index ranks Lesotho 145 out of 177 countries.[2]

Two thirds of the country's surface land area is highlands with a limited natural resource base. Only 9 percent of the lowland is arable and suitable for agricultural production. The growth potential of the

1 Ministry of Finance and Development Planning, "2002 Lesotho Population Data Sheet," Government of Lesotho, Lesotho, 2002.
2 UNDP, "Human Development Report 2004," 2004.

agricultural sector is therefore limited due to the scarcity of arable land. Agricultural productivity is affected by adverse weather conditions, serious soil erosion and a poor land tenure system. Intensive cultivation and grazing patterns further aggravate the situation. Lesotho is primarily a subsistence agricultural economy.

In comparison with other Sub-Saharan and least-developed countries, Lesotho has made important strides in addressing many of its development problems. Political stability and governance reform remain fundamental issues that need to be addressed to effectively reduce the impact of the socio-economic challenges facing the country. The GOL has made efforts to stabilize and revitalize the economy by enacting policies to liberalize and restructure key economic sectors through financial sector reform, privatization of publicly owned utilities, and infrastructure development. These reforms include the establishment of legal and institutional frameworks for privatization, restructuring of para-statals, and strengthening and reforming public sector investment programmes.

The World Bank and the International Monetary Fund (IMF) have assisted Lesotho in its economic reform process. Since 2001, the government's medium-term policies have been guided by an Interim-Poverty Reduction Strategy Paper (PRSP) completed in December 1999, and the preparation of a full participatory PRSP formally approved by the cabinet in November 2004 and supported by a loan agreement under the Poverty Reduction and Growth Facility of the IMF. Consequently, Lesotho has adopted the PRSP as a formal economic development strategy. The GOL has also embraced a comprehensive public service reform programme by embarking on a zero-tolerance campaign against corruption and has overhauled its financial management system to restructure its revenue base.

Economic management has improved considerably in the last few years in the wake of the structural adjustment support from the IMF and the World Bank. A budget deficit of more than 9 percent per capita gross national product (GNP) in 1988-1989 was transformed into a surplus of 3.2 percent per capita GNP by 1995-1996.The rate of inflation was reduced from 20 percent in 1989 to 9.6 percent by 1995.

Between 1988 and 1998, Lesotho regained its economic growth as a result of large-scale construction of the Lesotho Highlands Water Project. The textile industry is also an important source of economic growth and continues to thrive due to benefits from the African Growth and Opportunities Act of 2001. The Act has granted duty-free access to Lesotho-made textiles imported into the United States.

Despite these economic strides, Lesotho continues to face a number of serious challenges in its efforts to achieve sustainable human development. The economic growth of the past few years has not been equitably distributed, and unemployment remains high--estimated at 40 percent.[3] Unemployment has been worsened by recent economic recession, which led to the retrenchment of migrant workers from South Africa. Despite this, labour migration still remains a strong feature of Lesotho economy. Migration is both within the country and external—from Lesotho to South Africa. Migration has also made a contribution to the spread of HIV/AIDS in Lesotho. On the whole, the policy reform environment has augured well for GOL to strengthen institutional capacity in order to respond to priority issues like HIV/AIDS, poverty reduction, and repositioning of the nation's priorities. But Lesotho's long history of weak institutional capacity and policy frameworks continue to pose challenges and have led to lack of vibrancy and incoherent and uncoordinated efforts in the fight against HIV/AIDS.

1.3 METHODOLOGY

The methodology for this evaluation was a guided process. First, the outcome theme areas were developed and appropriate instruments for interviewing specific groups of informants were developed. The instruments and information were used to train the national consultants, who provided input for finalizing the instruments and evaluation process. Strategies for carrying out the evaluations, timeframe for deliverables and schedules for international visits were discussed at a regional workshop, organized by the UNDP Evaluation Office in Johannesburg in October 2004, following which the evaluation was conducted.

The guidelines and instruments were used to collect information from senior policy makers, middle management officials, collaborating agencies and other development partners. Focus group discussions were also held with members of the District AIDS Task Force (DATF) in four districts of Lesotho (see Annex 4), using appropriate guidelines and instruments.

3 Statistical information is a key area of concern with the CWIQ (Bureau of Statistics 2003) providing the latest figure for unemployment at 24.3 percent.

Literature and documentation review provided direction and in-depth familiarity about UNDP's role and contribution to the HIV/AIDS response in Lesotho. The following documents were reviewed: policy papers, Common Country Assessment (CCA) and CCF reports, the PRSP and MDG reports.

A broad spectrum of informants was interviewed for this evaluation, starting with senior policy officials in UNDP and other UN agencies (UNICEF, WHO and UNAIDS). The GOL officials were interviewed including the Assistant Minister of Justice, principal secretaries, directors and officers of key government ministries. Consultations were also held with civil society representatives, development partners and people living with HIV/AIDS (see Annex 3).

The international consultant's visit to Lesotho in December 2004 was used to validate the findings of the evaluation. During this visit, interviews were held with GOL and UN officials, and other stakeholders, including members of the UN Staff Association, the Office of the First Lady, and Chairperson of the Parliamentary Select Committee on HIV/AIDS.

A Stakeholder Validation Workshop was also held to present, discuss and validate the preliminary findings and outcome of the evaluation. The participants at the workshop represented a wide spectrum of individuals from UNDP, UN agencies, bilateral donor agencies, senior GOL officials (including the assistant Minister of Justice), organized labour, non-governmental organizations (NGOs) and people living with HIV/AIDS (PLWHA). This forum was also used to derive consensus on recommendations that could be used to move the national response on HIV/AIDS forward.

2. HIV/AIDS SITUATION

Lesotho is the third worst country in Southern Africa affected by HIV/AIDS, with an estimated adult prevalence rate of 28.9 to 31.7 percent by the end of 2003.[4] This has increased the burden on the nation to deliver adequate healthcare services. Decline in life expectancy is estimated at 48.7 years for men and 56.3 for women. It is estimated that by 2010, 30.7 years in life expectancy will be lost due to AIDS. This has resulted in tremendous national set back on past economic development gains.

By the end of 2003, 320,000 to 330,000 adults and children were estimated to be living with AIDS; 55 percent of them were women.[5] Young women between the ages of 15 to 29 years are particularly affected as they constitute almost 75 percent of all reported AIDS cases in this age group.[6] AIDS is a leading cause of morbidity and mortality in Lesotho, and it is regarded as a major threat to Lesotho's attainment of the MDGs for combating poverty and promoting sustainable human development.

The impact of HIV/AIDS in Lesotho is reflected in the economy. HIV/AIDS has deepened the levels of poverty, weakened the family resource base, and burdened the health and social welfare sectors. HIV/AIDS has drastically reduced household incomes for much of the population. Because AIDS primarily affects the productive age group of 15 to 49 year olds, loss of income by primary wage earners has resulted in debilitating effects on households and communities. Families are no longer able to afford basic services like primary healthcare and education, and households are increasingly diverting their resources to medical and funeral expenses. AIDS has reduced or reversed development gains as family resources that could have been used to improve family and community welfare are being used to care for the sick and bury the dead. Agricultural production and food security are threatened by the inability of people to produce enough food to sustain them. Increasing poverty levels are also contributing to vulnerability to HIV/AIDS. The proportion of the population falling below the poverty line has remained approximately 60 percent. Levels of poverty have also been measured by declining food security. Stakeholders cited poverty and culture as the two biggest challenges facing Lesotho in the face of HIV/AIDS.

The effects of HIV/AIDS in Lesotho are even more visible in the area of orphans and vulnerable children. Children orphaned by AIDS are becoming a visible tragedy. The UNAIDS report for a Barcelona 2002 conference indicated that in Lesotho more than 25 percent of all children are orphans. Four out of five of those orphans are due to AIDS. Orphans are increasingly becoming street children, neglected

4 UNAIDS/WHO, "Epidemiological Fact Sheet, 2004 Update," 2004.

5 Ibid.

6 Government of Lesotho, "Monitoring the UNGASS Declaration of Commitment on HIV/AIDS," Lesotho, April 2003.

and abused, and are in turn exposed to the risk of vulnerability to HIV/AIDS. They are being recruited and exploited as child labour force. Approximately 68,000 to 100,000 children have been rendered orphans,[7] placing additional burdens on traditional coping mechanisms for foster care and adoption. These systems may no longer be able to absorb the large number of children who have been rendered orphans by AIDS. Existing institutional care is insufficient to meet the demands of the increasing number of children who have lost their parents to AIDS.[8]

3. COUNTRY RESPONSE

3.1 NATIONAL RESPONSE

The GOL and highest leadership have recognized the challenges brought about by HIV/AIDS and have adopted a multisectoral approach in response to the pandemic. In 2000, His Majesty the King declared HIV/AIDS a national disaster and the government endorsed a National Strategic Plan and adopted a comprehensive policy framework to address HIV/AIDS. These documents reiterate the GOL commitment to prevent HIV transmissions and manage the impact of HIV/AIDS. Policies and implementing institutional structures have been established to address issues related to HIV/AIDS. Programmes have been developed to address the prevention of transmission, treatment, care and support, and impact mitigation. The policy framework also recognizes the efforts of key partners such as NGOs, community groups and development partners. The government has re-affirmed its political commitment at all levels and emphasized the need to embark on a multisectoral and coordinated response to HIV/AIDS.

The policy framework is complemented by the GOL decision to adopt "Turning a Crisis into an Opportunity: Strategies for Scaling Up the National Response to the HIV/AIDS Pandemic in Lesotho," a publication of the UN Expanded Theme Group, as a working document for scaling up national response to HIV/AIDS. UNDP, in its capacity as chair of the Theme Group, also co-chaired by the United States Ambassador, has played a pivotal role in producing and using this publication to launch an advocacy campaign to raise GOL leadership awareness and elevate commitment to the fight against AIDS.

Another major step was the establishment in 2001 of the Lesotho AIDS Programme Coordinating Authority (LAPCA) to coordinate HIV/AIDS activities in the country. Major functions and responsibilities of LAPCA include: consolidation of sectoral plans, development and dissemination of policy guidelines, and harmonization of HIV/AIDS and sexually transmitted infection activities for a national multisectoral response. LAPCA also has overall responsibility to provide information and technical advice and assistance to sectors. However, LAPCA has experienced a number of challenges that have affected its ability to deliver results-based coordination. One of the major constraints has been its location as a unit under the Prime Minister's office. It has been difficult to advance a multisectoral approach to HIV/AIDS as a government unit, a situation similar to the previous mandate given to the Ministry of Health and Social Welfare (MOHSW). Lack of resources and authority has made it difficult to mobilize a multi-sectoral response that could lower prevalence rates.

The government response has also facilitated the establishment of multisectoral task forces comprising of HIV/AIDS focal points in both the public and private sectors. Task forces are responsible for reviewing, consolidating and endorsing sectoral operations and playing an advisory role to LAPCA. GOL implemented a policy for all government ministries to allocate 2 percent of their budget to HIV/AIDS programmes. However, this allocation has now been reduced to 1 percent to each line ministry, with the remainder being allocated to the MOHSW to strengthen the GOL programme on antiretroviral treatment (ART) for the purchase of drugs. An estimated M53.2[9] million or USD 8.8 million is allocated to various government departments for programmes targeting civil servants.

The national response to HIV/AIDS has not been without challenges. LAPCA was established rapidly as a coordinating body with little in-depth analysis of structural, human resource and organizational development requirements. It was charged with an enormous task of coordinating all HIV/AIDS activities with only a modest professional staff capacity and

7 UNAIDS/WHO, "Epidemiological Fact Sheet, 2004 Update," 2004.

8 Southern African HIV/AIDS Dissemination Service, "Review of HIV/AIDS Related Initiatives in Lesotho," Government of the Kingdome of Lesotho, Lesotho, 2002.

9 M indicates Maloti, the currency of Lesotho is Maloti, which is equivalent to USD 14 cents.

unclear roles and responsibilities to enable it to carry out its mandate. The challenge of HIV/AIDS and the slowness in reversing the spread might be seen in the context of apparent difficulty in discussing key coordinating issues in an open and frank manner.

As a way of responding to weak institutional capacity and addressing increasing prevalence rates, the GOL has obtained approval from the cabinet to establish an autonomous, broad-based National AIDS Commission (NAC) that will ultimately replace LAPCA as the national AIDS activities coordinating agency. NAC will be accorded the autonomy that LAPCA lacked, and it will be modelled after the Independent Electoral Commission (IEC), which successfully brought Lesotho to democracy. It will be established by an Act of Parliament and thereby have the legal capacity to function with flexibility and authority to facilitate effective coordination. It is also envisaged that the institutional structure of NAC will reflect the structure of Basotho society and thereby broaden stakeholder participation and enhance accountability. Representation of stakeholder groups, such as women, PLWHA, faith-based organizations and community leaders, will add value to policy decisions and ensure inclusion of the interests of those most vulnerable to the epidemic.

UNDP, the Department for International Development (DFID) and other international development partners have played visible and significant roles by offering support to GOL through consultations and continued dialogue to facilitate the decision to establish NAC. The Cabinet Sub-committee on HIV/AIDS has now approved the structure of the NAC.

There are mixed feelings and apprehension among stakeholders about the potential effectiveness of NAC, given the performance of its predecessor, LAPCA. These concerns should be taken into consideration to ensure that the institutional framework of NAC and LAPCA as the Secretariat is effectively organized to meet the demands of coordination. The mandate of NAC must be backed by appropriate legal authority and supported by requisite human, material and systems resources for coordinating, monitoring and evaluating AIDS activities in the country.

National efforts to effectively respond to HIV/AIDS are frustrated by weak institutional, policy and legislative frameworks. Moves towards legislative reviews and developing new legislation to address challenges of HIV/AIDS are slow. Coordination of efforts in this area also remains weak, as illustrated by structural and institutional challenges that currently face LAPCA.

3.2 NON-GOVERNMENTAL RESPONSE

There are currently more than 90 NGOs involved in a broad range of HIV/AIDS programmes and activities in Lesotho. Civil society involvement is especially visible in the area of prevention and HIV/AIDS education. The Lesotho Council of NGOs has started a programme on HIV/AIDS. This development will complement the efforts by Lesotho NGOs AIDS service organizations to coordinate NGO involvement in this area. Currently, coordination and a diminishing resource base remain critical challenges to civil society response.

The private sector response has three components: research and advocacy, workplace outreach, and home-based care and support. The Ministry of Labour and Employment has produced a policy guideline similar to the Southern African Development Community Code of Conduct, focusing on prevention and control of HIV/AIDS in the workplace. This policy document has not yet been finalized. Employers in Lesotho have established a Business Coalition against HIV/AIDS. This was prompted by the decision of employers to initiate workplace programmes for their employees with specific emphasis brought about by the risks and increased vulnerability as seen through the garment sector workers and the security business—both major members of the Association of Lesotho Employers and Business.

3.3 UNDP RESPONSE

UNDP's support to Lesotho's efforts to scale up HIV/AIDS response has been undertaken within the context of the second CCF of 2002–2004. UNDP has addressed HIV/AIDS as a governance issue. The CCF was developed as a result of a consultative process, within the overall context of the formulation of the National Vision and Poverty Reduction Strategy and the Public Sector Improvement and Reform Programme. The programme of support and collaboration as stipulated in the CCF consists of three thematic areas: poverty reduction, good governance, and energy and environment. The CCF was also

developed to respond to the ongoing GOL process of designing and implementing pro-poor policies to promote effective sustainable human development.

The continued increase in HIV/AIDS prevalence rates, despite the implementation of several national initiatives, is undoubtedly one of the key challenges facing Lesotho. It is in recognition of this recurring trend, coupled with the problems of poverty, food insecurity, and weak service delivery systems, that UNDP began a consultative process with GOL in July 2002 to examine and propose viable options and solutions to improve service delivery, capacity utilization, public service performance, and social mobilization. Building on the opportunity brought about at the launching of the 2002 Global Human Development Report, which had the theme 'Deepening Democracy in a Fragmented World', UNDP supported the new government to focus on the country's key development challenges, constituting the most representative parliament since its independence. UNDP's initiative and strategic focus for forging partnerships and building leadership capacity at all levels has been to scale up the national response to HIV/AIDS and advocate for renewed commitment to a multisectoral response to the epidemic. Prominent in this is the recognition that Basotho are best placed to find the answers to their development challenges.

UNDP has charted a strategy to support the WHO 3 by 5 Initiative[10] by working through the UN Resident Coordinator System to support high-level leadership and advocacy efforts by WHO to secure national commitment to the 3 by 5 Initiative. In collaboration with WHO, UNDP works with the MOHSW to make necessary changes for the implementation of the 3 by 5 Initiative. UNDP has also carried out high-level advocacy and support to address the overall national human resource implications of HIV/AIDS in the public sector, by developing a national human resource plan for the public sector and plans for the expansion of training and capacity development for all cadres of health staff.

3.3.1 Scaling up national response to HIV/AIDS

Guided by the 2002-2004 CCF and commensurate with the UNGASS Declaration on HIV/AIDS, UNDP agreed to collaborate with the government, its development partners and civil society to implement the national strategy to address HIV/AIDS. UNDP continues to play a crucial role in supporting national and institutional capacity development to mitigate the impact of HIV/AIDS and sustainable human development. The United Nations Development Assistance Framework (UNDAF) has identified HIV/AIDS as a key strategic area for all UN agencies in Lesotho.

In this context, in 2002, a multi-disciplinary diagnostic mission of UN policy advisors was led by UNDP to jointly analyze the HIV/AIDS situation in Lesotho and identify key synergistic entry points that could catalyze action. The mission held extensive consultations with GOL, civil society, development partners and the private sector. UNDP and the UN family agencies in Lesotho presented possible options for addressing the HIV/AIDS pandemic to the Prime Minister, his cabinet and senior officials. This was made possible by the leadership role played by UNDP in leading a multi-disciplinary, multi-agency mission that was tasked with a vision to reverse the escalating trend of HIV infections in Lesotho. The result of the team's work and UNDP's consultative process with other key stake-holders is the publication spearheaded by UNDP through the UN Expanded Theme Group on HIV/AIDS and with the GOL, "Turning a Crisis into an Opportunity: Strategies for Scaling Up the National Response to the HIV/AIDS Pandemic in Lesotho." This publication was adopted by GOL in 2003 as an official working document and reference manual.

Stakeholders have attributed much of UNDP's success and response to support national efforts to the strength and visionary leadership of the outgoing Resident Representative, Scholastica Kirmayo. Strong leadership was cited as one of the driving forces behind the success of UNDP and GOL's campaign for Universal HIV Testing.

3.3.2 UNDP programmes

As part of the global re-profiling initiative, UNDP Lesotho began its transformation exercise in 2001 to effectively strengthen its human resource base and technical expertise. This was done to align its staff profile to the evolving development needs of the country and the technical competencies required to make the country office effective. Recognizing the challenges of HIV/AIDS on the workforce and operating on the premise that 'charity begins at home', UNDP launched its workplace programme

10 3 by 5 is a global target to get three million people living with HIV/AIDS in developing countries on antiretroviral treatment by the end of 2005.

titled 'We Care', which targeted UN staff members and their families. We Care complements the UN Personnel Policy on HIV/AIDS and the ILO Code of Practice and the World of Work. The goals of the programme are to:

- Promote prevention through information, education and training.
- Promote the rights of staff members and their dependants, living with and/or affected by HIV/AIDS.
- Alleviate the impact of HIV/AIDS on staff members and their dependants.
- Ensure access to care and support for staff members, their spouses and dependant children.
- Foster a supportive work environment for staff members and their dependants.

This programme also aims to establish an environment that is free from denial, fear and discrimination against HIV/AIDS. It aims to create an informed staff community that is ready to take personal responsibility to act as a catalyst for change. The programme hopes to create caring UN agency country offices in Lesotho. It caters for access to appropriate care, including access to anti-retroviral treatment for staff and their family members. Implementation was initially slow, due to staff attitude and lack of understanding of programme goals and objectives. But the We Care Programme has successfully organized HIV/AIDS awareness programmes and information exchange for UN staff and their family members, with particular success with the children and youth of UN employees. The programme has been extended to include other UN agencies' employees. UNDP has therefore been effective in mobilizing the UN community in Lesotho to address issues of HIV/AIDS in the workplace.

In addition, UNDP has focused on transformational leadership and change management to promote improved demand for services. Looking towards private sector principles and change management processes, UNDP has supported a Leadership for Results Programme on individual change and transformation for principal secretaries under the leadership of the Government Secretary and also for the National Assembly and Ministry of Local Government.

UNDP has supported large-scale, multi-level social mobilization and advocacy campaigns for HIV/AIDS competence at district and community levels. In December 2003, it used transformational leadership capacity building methods to pilot initiatives at Qacha's Nek,[11] resulting in social mobilization to encourage the demand for services. UNDP plans to expand this programme to the remaining nine districts of Lesotho in collaboration with the Ministry of Local Government. This training programme was designed based on the principle that an effective response to HIV/AIDS requires total transformation and committed leadership that operates within the scope of new and innovative ways of thinking.

Transformative leadership capacity development enables local structures and key civil society stakeholders to apply methods that could lead to breakthroughs in goals and actions, resulting in the achievement of AIDS competence. This programme is designed to encourage participants to develop and use innovative responses to the HIV/AIDS threat in Lesotho. UNDP has collaborated with the Ministry of Local Government, MOHSW and the German Agency for Technical Co-operation (GTZ) to implement the programme on transformational leadership. Two important steps included working with the DATFs for innovative approaches to encourage community level responses, and working with national response stakeholder representatives of respective line ministries and civil society organizations in HIV/AIDS. UNDP is assisting the two houses of Parliament, Senate and the National Assembly, to harness the power of traditional leadership throughout the country in an effort to scale up the fight against HIV/AIDS. Similarly, the National Assembly is being supported through the parliamentary select committee on HIV/AIDS to develop capacity for empowering members to include HIV/AIDS in law making.

3.4 DEVELOPMENT PARTNERS' RESPONSE

Development partners' response to HIV/AIDS in Lesotho is a coordinated exercise. However, the level and extent of support to GOL and specific HIV/AIDS programmes differ from agency to agency. UN agencies have developed their own strategies to respond to HIV/AIDS within UNDAF and their country programmes. There have been attempts to coordinate a response at the UN level as demonstrated by structures like the UN Expanded Theme Group on HIV/AIDS. The latter forum includes development partners resident in Lesotho. Chairing of the Theme Group is rotational with a UN agency sharing the task with a development

11 A remote mountainous district in the south of Lesotho.

partner. At the time of this evaluation, UNICEF was the chair and Development Cooperation Ireland (DCI) the co-chair. UNDP was the preceding chair with the Embassy of the United States as co-chair. During their tenure, "Turning a Crisis into an Opportunity" was published and adopted as a working government document, and GOL agreed to establish the NAC as a national coordination agency for HIV and AIDS activities, one of the key recommendations of the book.

The Expanded Theme Group offers an opportunity for UN agencies, donors and international NGOs to come together in partnership with GOL to support national efforts to combat and scale up HIV/AIDS activities. The theme group has contributed to these efforts by providing both financial and technical assistance. UN agencies coordinate their efforts in response to the pandemic through a number of programmes and initiatives, for example, the WHO 3 by 5 Initiative and the UN Fund for International Partnership (UNFIP).

The WHO 3 by 5 Initiative has clearly delineated the partnership implications of successful implementation of the programme and has called upon all development partners to assist in creating synergy between prevention, care, and support programmes in national efforts towards the provision of treatment through the 3 by 5 Initiative. UN agencies have assumed leadership to ensure effective implementation of the 3 by 5 Initiative.

WHO has assumed overall responsibility for advocacy, technical leadership, and securing national political commitment, while other UN agencies have each declared an area of responsibility in accordance with their strategic and technical focus. Partnership collaboration was noted during the Universal Campaign for HIV Testing, especially between WHO and UNDP in promoting readiness towards the implementation of the campaign. UNAIDS' support to the national response has been largely in the provision of information, technical support, and resources, and as the Secretariat to the UN Theme Group on HIV/AIDS. Like UNDP, UNICEF has placed HIV/AIDS at the centre of all of its programmes. In addition, UNICEF is supporting geographic expansion of the Prevention of Mother to Child Transmission Campaign and strengthening the capacity of health institution nationwide to deliver adequate health services.

The United Nations World Food Programme's (WFP's) response to HIV/AIDS has largely been through its emergency and food relief programmes, which ensure that food distribution efforts are combined with HIV/AIDS prevention messages. NGO implementing partners are used to distribute condoms. WFP is implementing a nutrition-based HIV/AIDS programme to address the nutrition needs of AIDS patients by distributing food and Corn Soya Blend to health centres. Community health workers work with WFP to target patients who are on home-based care. WFP collaborates with other UN agencies, WHO, UNICEF, community based organizations, and the Ministry of Agriculture and Food Security to support the 3 by 5 Initiative. Food aid is used as an entry-point for the continuum of care approach to provide nutrition education and raise awareness regarding the nutritional needs of PLWHA. WFP collaborates with the Ministry of Agriculture and Food Security to support actions to improve general food security in the homes of people who are ill, including providing assistance for cultivation, storage and cooking.

The UNFIP project is another HIV/AIDS mitigation development partner initiative. UNFIP is a collaborative partnership between four agencies—the United Nations Populations Fund, WHO, UNICEF and UNDP—with UNAIDS playing a coordinating role. This project targets the youth, especially adolescent girls, with HIV prevention and reproductive health messages. The UNFIP programme has trained more than 400 youths on micro lending schemes to enable them to start projects and has played a significant role in the establishment of youth centres and strengthening of partnerships with the MOHSW. However, this project has not reached its full potential due to lack of involvement of stakeholders in design and planning. It faces implementation challenges as a result of legal issues surrounding the definition of the age of consent for youth younger than 21 years and management issues related to coordination within the government, and needs more effective programming as opposed to planning.

Apart from the support provided by UN agencies, other development partners are providing support towards the fight against HIV/AIDS in Lesotho. For instance, DCI has a bilateral agreement with GOL and provides up to 7 percent of its assistance (EUR 650,000) to HIV programmes.[12] DCI advocates for

12 Government of the Kingdom of Lesotho, Lesotho AIDS Programme Coordinating Authority, "Review of HIV and AIDS Related Initiatives and Activities in Lesotho," review undertaken by SAFAIDS, 2003.

integration of HIV/AIDS into the development process and for greater coherence among development agencies, has supported GOL in strengthening coordination structures such as LAPCA and the establishment of NAC, and has helped GOL access resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Its support extends to information, education and communication, technical support for DATF, care of orphans and vulnerable children, and HIV/AIDS activities through the Christian Council of Lesotho.

The DFID has also provided significant support through the implementation of the poverty support programme. This includes supporting the establishment of the NAC and collaborating with UNAIDS and UNDP to scale up the national response within the overall framework of the 3 by 5 Initiative.

Overall, development partners have made significant contributions in the fight against HIV/AIDS in Lesotho. This is evident in the restructuring of their programmes and areas of focus to respond to national HIV/AIDS priorities. Their support to GOL efforts includes strengthening institutional capacity, policy environment, advocacy and programmes to mitigate the impact of AIDS.

4. MILLENNIUM DEVELOPMENT GOALS

The Lesotho 2003 MDG report is a joint process undertaken by GOL and UNDP. The report emphasizes the link between MDG goals and HIV/AIDS and is titled "The War Against HIV/AIDS." This title is indicative of the priority Lesotho has placed on HIV/AIDS as a critical MDG that determines successful attainment of the other seven MDGs. Stakeholders have pointed out that UNDP, as a UN agency responsible for overall human development, has a legitimate mandate to actualize attainment of the MDGs in Lesotho. UNDP and GOL have succeeded in linking HIV/AIDS with MDGs as well as contributing to a policy environment that advocates prioritizing the fight against HIV/AIDS as a strategy for attainment of all eight MDG. The report shows an overall positive policy commitment, political will, advocacy initiatives, and institutional and corporate reforms that will lead to a more conducive environment for the attainment of MDGs. The following progress has been made on MDGs in Lesotho.

4.1 COMBAT OF HIV/AIDS

Lesotho will halt and begin to reverse the spread of HIV/AIDS by 2008. The HIV/AIDS pandemic is regarded as the principle threat to attaining the MDGs and reducing poverty and promoting sustainable human development. A successful strategy in handling HIV/AIDS will ensure the attainment of the other MDGs. Stakeholders have confirmed that UNDP has assumed a leadership role for policy directive and advocacy on HIV/AIDS.

This evaluation notes the combination of cultural, economic and behavioural factors that fuel the HIV/AIDS pandemic in Lesotho. High levels of poverty and entrenched gender inequalities further elevate vulnerabilities. However, GOL has made fighting the epidemic a matter of national priority, setting a goal to reduce the prevalence rate from 31 percent (in 2001) to 25 percent by 2008. GOL has established a national machinery and policy framework for the achievement of this goal and proposed establishment of an NAC that is autonomous, with a more representative membership of stakeholders and a mandate to coordinate the multisectoral response to the pandemic.

Lesotho has also adopted an HIV/AIDS policy and strategic plan to coordinate stakeholders in the fight against HIV/AIDS. These will have to be reviewed and updated once the NAC is established and operational. Indications of political will, especially at the highest levels of leadership in the GOL, reaffirm the seriousness to scale up the response to HIV/AIDS. The Prime Minister is in the forefront of the national commitment to Universal Voluntary Confidential Counselling and Testing. UNDP's contribution to the attainment of this MDG is in the area of policy, strategy, advocacy and partnership collaboration. This is supported by UNDP's commitment to core-stream HIV/AIDS in all its programmes.

4.2 ERADICATION OF EXTREME POVERTY AND HUNGER

GOL aims to reduce the proportion of people living below the poverty line by half between 1990 and 2015. HIV/AIDS is eroding traditional household coping mechanisms for food insecurity by reducing the capacity to produce and purchase food, depleting household assets and exhausting social safety nets. Food insecurity in Lesotho threatens to intensify and exacerbate the spread and prolong the epidemic. As a

way of addressing this goal, GOL has finalized the development of the PRSP with HIV/AIDS as a priority and cross-cutting issue for poverty reduction.

The PRSP and Vision 2020 provide a comprehensive framework for fighting poverty in all its complex dimensions. These policy initiatives form the basis for greater government response to the priorities and needs of the people, while ensuring efficient and transparent allocation of resources. The attainment of this goal is therefore dependant on a successful and targeted strategy to address HIV/AIDS. UNDP's support to the eradication of extreme poverty and food insecurity has been articulated in the CCF 2002-2004. UNDP is involved in the PRSP policy development and is committed to initiatives for employment creation. UNDP has structured its programmes to address HIV/AIDS as a central focus for poverty reduction and food security. To this end, UNDP has contributed to a policy environment by establishing a relevant link between poverty, HIV/AIDS and food insecurity. Advocacy and programme focus has led to the prioritization of poverty eradication and food security as a prerequisite for development.

4.3 ACHIEVEMENT OF UNIVERSAL PRIMARY EDUCATION BY 2007

GOL has set a target to ensure that boys and girls complete primary school by 2007. The linkages of this goal to HIV/AIDS are based on the impact of the pandemic on young girls. Even with the strong Free Primary School Programme implemented in 2000, evidence shows that girls are increasingly dropping out of school to assume responsibility for care and support of the sick and to generate income for families who have lost income due to HIV/AIDS. UNICEF and WFP are providing direct support to counteract the affects of the pandemic on education and assist GOL in reaching its goal of universal primary education. UNDP plans to support the Ministry of Education and Training in core-streaming HIV/AIDS by using innovative ways to enhance Information Communications Technologies in service delivery, including education.

4.4 PROMOTION OF GENDER EQUALITY AND EMPOWERMENT OF WOMEN

Lesotho has made efforts to eliminate gender disparity at all levels of education and increase the participation of women in development by 2015. GOL is committed to promoting gender equality as a fundamental human right and as a democratic imperative by adopting the Gender and Development Policy and enacting legislation that will advance the legal rights of women.

The MDG report points to measures that have been taken to address gender imbalance, such as Cabinet approval of a comprehensive policy that will form the basis for mainstreaming gender concerns in the design, implementation and monitoring of government policies and programmes. The linkages to HIV/AIDS are tied to figures that point to the disproportionate impact of HIV/AIDS on young women. By the end of 2003, 55 percent of reported AIDS cases were women, and among younger age groups, the figure was as high as 75 percent.[13] Prevailing gender disparities fuel the spread of HIV/AIDS and prevent the attainment of gender equality. The challenges to attaining this goal are tied to ensuring equal representation of women in decision-making positions, facilitating affirmative processes that support gender balance in public and private sectors, and promoting the rights of women to control economic resources.

4.5 REDUCTION OF CHILD MORTALITY

Lesotho has made efforts to reduce infant mortality by two thirds between 1990 and 2015. This goal was made bearing in mind the increasing child mortality as a direct result of HIV/AIDS. The long-term development prospects of Lesotho are linked to the health and well being of its children. HIV/AIDS is eroding the child survival gains made through primary health care and intensive immunization strategies. Infant mortality has increased from 74 per 1,000 live births to 80 per 1,000 live births, due to AIDS. In order to attain the goal of reduced infant mortality, children's access to basic health care services, HIV/AIDS and food security requirements that expose children to greater risk of malnutrition and disease need to be addressed. Improvement in child survival programmes is being approached by GOL through the Health Sector Reform Programme.

4.6 IMPROVED MATERNAL HEALTH

Lesotho's goal in this area is to reduce three quarters of maternal mortality between 1990 and 2015 through the reduction of vulnerabilities of adolescent girls to pregnancy-related complications and unsafe

13 Government of Lesotho, "Sentinel Surveillance Report," Ministry of Health and Social Welfare, 2003.

abortions. This goal will be achieved by addressing the following key challenges that hamper the reproductive well being of women: improving access to quality reproductive health services, facilitating male involvement in reproductive health issues, and promoting and integrating HIV/AIDS related services for improved maternal health. These programmes will be supported by the following policy initiatives: revising the National Population Policy, drafting the Reproductive Health and Adolescent Health policies and the Safe Motherhood Initiative Programmes, and introducing population and family life education in schools.

4.7 ENSURING ENVIRONMENTAL SUSTAINABILITY

The purpose of this MDG is to integrate the principles of sustainable development into country policies and programmes by reducing by half the proportion of people without sustainable access to safe drinking water and basic sanitation. HIV/AIDS, poverty and food insecurity complicate efforts towards the achievement of environmental protection. The key challenge is to ensure the inclusion of HIV/AIDS strategies in environmental management programmes. For example, there is a need to coordinate policy initiatives to address land degradation and the sustainable use of the natural resource base by identifying appropriate interventions to address poverty, reduce pressure on the fragile environment, and provide relief to communities severely affected by HIV/AIDS.

4.8 DEVELOPMENT OF GLOBAL PARTNERSHIPS FOR DEVELOPMENT

Lesotho intends to develop open, regulated, non-discriminatory trading and financial systems under this goal. Progress towards achieving this MDG is dependent on forging sound international partnerships, improving financial management and restructuring public revenue processes, promoting sustainable investment and trade strategies, and strengthening national capacities to provide an enabling environment for private sector investment and growth.

The national response to the HIV/AIDS pandemic is a key factor in Lesotho's ability to attain its MDGs. Some progress has been made by GOL through demonstrated commitment to create an enabling policy environment and reforms, but the development challenges posed by the triple threat of HIV/AIDS, food insecurity, and weakened governance, require the development of innovative and interrelated strategies to address them. UNDP has contributed to the improved policy environment and enhanced GOL commitment, and needs to continue to bring to the forefront the cross-cutting nature of HIV/AIDS in order to continue to mobilize multiple sectors and actors with the appropriate technical resources to address the pandemic.

5. OUTCOME OF UNDP CONTRIBUTIONS AND SUPPORT

5.1 GOVERNANCE

5.1.1 Policy development

UNDP has addressed HIV/AIDS as a governance issue and has advanced the need to develop and implement responsive policies and adopt strategic, inclusive and participatory approaches for advocating a rights-based agenda, where service delivery systems are created and strengthened to respond to the public's demands for services. GOL has made significant shifts in policies between 1999 and 2004 to intensify national response and commitment to the challenges posed by HIV/AIDS.

UNDP has contributed to the receptive policy environment, which encourages sharing of responsibilities[14] through reforms. GOL is currently carrying out reforms within the public sector with the development of the following initiatives: Vision 2020, PRSP, and MDG Report documents; public sector reform and improvement; reform of legislature and gender, population and anti-corruption policies. These policy and reform initiatives are indicative of GOL's readiness to embrace new ideas. A significant outcome attributed to UNDP is its seizing the opportunity of GOL receptiveness to change to energize key actors to action. A crisis situation where public servants and the average Basotho were 'burnt out' due to lack of technical resources and the overwhelming demands of the epidemic were reversed by UNDP's advocacy efforts, which convinced GOL that 'business as usual' was not appropriate for handling the current levels of the epidemic.

UNDP has been the driving force behind the willingness to embrace change, through open

14 A mixed-member system of parliament in the National Assembly.

dialogue with partners to admit its resource requirements for combating the epidemic and requests for development assistance.

UNDP's strategies in response to HIV/AIDS in Lesotho were developed within the context of the second CCF 2002-2004, which delineates three key areas of collaboration with the GOL: democratic governance, poverty reduction, and energy and environment. In reviewing its CCF, UNDP has focused on governance as a central theme for addressing the HIV/AIDS pandemic. Governance as defined by UNDP Lesotho includes: *policy development,* defining the management and allocation of resources; *stakeholder approaches,* defining who and how people can scale up the national response; and *delivery of services,* defining how resources are used to effectively deliver services to the public.

During the past decade, Lesotho has operated without a coherent national policy response to match the huge challenges posed by the AIDS epidemic. But UNDP has responded by engaging the GOL in policy dialogue and capacity-building initiatives to redirect its efforts and strengthen its capacity to scale up the national response.

UNDP has also supported the development of policies focused on poverty reduction as they relate to HIV/AIDS. UNDP was engaged in drafting and finalizing the PRSP, which addresses HIV/AIDS as a major priority for poverty reduction in the country. UNDP jointly produced the 2003 MDG Report with the GOL, which also focuses on HIV/AIDS as a central issue that must be addressed in order to ensure the attainment of the country's MDGs. By drawing attention to the critical role and negative impact of HIV/AIDS as a deterrent for achieving national development goals, UNDP has been able to successfully use governance as a central theme to respond to AIDS.

Currently, Lesotho enjoys a stable political environment, which facilitates good governance and enables the state to respond to national development challenges, such as HIV/AIDS. This environment is the result of the successful and peaceful 2002 elections.[15] Since the elections, Lesotho has enjoyed international support due to its national commitment to peace and reconciliation, a situation that is drastically different from the period of polarization and turbulence in 1998.

UNDP has contributed to the stable political environment, and a series of events has helped provide UNDP with the political advantage it now uses to further its contributions to the HIV/AIDS response. The first of those events was related to UNDP's role in the 2002 elections. The second was the launching of the 2002 Human Development Report and UNDP's hosting of the symposium on Deepening Democracy. These two events have provided opportunities for UNDP to successfully demonstrate the distinct linkages between democracy, good governance, and development—thereby making a strong case for the need for political commitment and leadership in combating HIV/AIDS. During the 2002 General Elections, UNDP's role in 'brokering' peace included the coordination of national observers and assistance in writing the joint statement by development partners to declare the elections 'free and fair'. UNDP is therefore perceived as a neutral and trusted partner whose mediatory role has led to peace and stability in the country—a positive outcome largely attributable to the 'dynamism and bravery' of its Resident Representative and Coordinator of the UN system in Lesotho. The Resident Representative has been described as a person who did not hesitate to offer policy advice at a time when the political situation was unstable.

The current peaceful political environment[16] in Lesotho augurs well for good governance and therefore for leadership attention to addressing the HIV/AIDS pandemic. In 2003, UNDP was at the forefront of the launch of the Universal Testing Campaign in Lesotho and contributed to the mass mobilization of leaders and community members to test and determine their HIV status as directed by the Prime Minister. This initiative has resulted in a policy move by government and the private sector to mobilize employees to undergo voluntary testing. Several GOL ministries have conducted VCT campaigns to encourage public servants, especially senior civil servants, to be tested for HIV, and to scale up advocacy campaign for the provision of VCT services to Basotho as a basic human right.

15 Kimaryo S, Okpaku J, Githuku-Shongwe A, Feeney J, "Turning a Crisis into an Opportunity: Strategies for Scaling Up the National Response to the HIV/AIDS Pandemic in Lesotho," 3rd Press Publishers, New York, 2004.

16 Lesotho seems to be enjoying peaceful, stable governance after a history of political and election riots and conflicts. The 2002 elections have introduced a mixed member system in parliament that reflects Multi-Party Democracy.

VCT campaigns have also influenced policy development in the private sector, especially in the textile industry where some factories have subscribed to universal testing and mobilized their own staff members to go for testing. There have been mixed reactions to the Universal Testing Initiative or 'Know Your Status Campaign' in Lesotho by stakeholders. Some have described it as a major contribution to Lesotho's readiness in implementing the provision of treatment and medication under the WHO's 3 by 5 Initiative and the GFATM, while others have described the planning as incohesive, as it may have violated the human rights of some participants. However, everyone acknowledges that the campaign has created the demand for services and more people are ready to be tested.

UNDP Lesotho has provided a policy guide for GOL on how to scale up the response to HIV/AIDS. The document "Turning a Crisis into an Opportunity," although developed to address the Lesotho situation, is also useful reference material for other countries in the Southern Africa region. It would be particularly useful for high prevalence countries that are facing similar governance and development challenges. The document has been widely disseminated in Lesotho and neighbouring countries. This document complements the government of Lesotho's policy on HIV/AIDS and the proposed revised strategic plan that guides the implementation of its policies.

5.1.2 Public sector management

The GOL, through the office of the Government Secretary,[17] has taken the initiative to transform and improve the public sector in order to maximize its accountability and ability to provide HIV/AIDS services. The government has identified a need to help senior policy officers better recognize the importance of HIV/AIDS, and therefore place it as the central theme of policies, programmes, plans and activities related to development and service provision. This transformation process is intended to change the public service into a 'robust world class' service provider that will respond to the challenges posed by HIV/AIDS pandemic and meet its service provision requirements.

In compliance with the GOL public sector reform, UNDP has advocated for a core streaming,[18] rather than a mainstreaming, approach to HIV/AIDS. In collaboration with the Regional Service Centre and with the support of the regional programme on HIV and Development, UNDP has engaged principal secretaries in 'systems thinking'[19] to change the provision of service delivery. UNDP is supported by GOL leadership for its approach to development programming, because its strategies are in harmony with the government's commitment and policy to reform the civil service through the Public Sector Reform and Improvement Programme. The reform process by GOL has achieved significant changes, which has created a receptive environment and willingness to embrace new ideas for scaling up the response to HIV/AIDS. The systems thinking and transformational leadership training has enhanced the recognition of the impact of HIV/AIDS, such as loss of corporate skills and institutional memory, and poor delivery of services as a result of ill health and absenteeism. UNDP's engagement of senior policy makers was therefore timely, relevant and strategically important for the reform and transformation process.

UNDP has also interacted with the two houses of Parliament, the Senate or Upper House and the Lower House or National Assembly. Joint initiatives with the Senate were carried out through the Office of the President and the Office of the Clerk of the Senate. The President and Clerk were both leaders in the 'Know Your Status Campaign' by taking part in public testing for HIV/AIDS with other senior government officials. Senators were encouraged to take part in the VCT initiative in order to demonstrate good leadership to the public. UNDP supported the Senators with capacity building training programmes and assisted in the development of an action plan for implementing HIV/AIDS programmes.

The programmes targeted traditional leadership and service providers—such as chiefs, traditional leaders and initiation school instructors—with a view to building an HIV/AIDS competent society. This strategy provided the competence necessary to transform leadership and enhance HIV competency

17 The Government Secretary is the secretary to cabinet and head of public service.

18 Kimaryo et al (2004) argue that a *core stream* approach is a systems approach that is a crucial move towards achieving an HIV/AIDS competent society. The authors argue that HIV/AIDS needs to be at the centre of all major government policies and strategies for development.

19 Van der Merwe L, Centre for Innovative Leadership, 2004.

in communities. The initiative has led to greater commitment from Senators to carry out their plan of action and advance HIV/AIDS literacy and ability. This is exemplified by their facilitation of access to the 2 percent budgetary allocations for institutional structures. The Senate has subsequently organized follow-up capacity-building workshops with assistance from DCI to advance and revitalize the commitment to building HIV/AIDS competence.

Similarly, joint initiatives with the National Assembly through the Office of the Speaker of Parliament have enhanced institutional changes, including the democratization of parliamentary processes. The parliamentary reform is restructuring systems to enable members of parliament to be accountable to the public and to keep the other two arms of government accountable and responsive. The establishment of Parliamentary Committees is a major outcome of that reform, and has led to the birth of the Select Committee on HIV/AIDS. UNDP has been very supportive during the establishment of the select committees, especially the Select Committee on HIV/AIDS and the Parliamentary Reform Committee. UNDP provided special assistance in capacity building and raising the confidence of members.

The overall reform process of parliament through the launching of a Parliament Reform Committee in November 2004 by the Prime Minister, gave hope to institutional changes that will bring HIV/AIDS to the centre of parliamentary debates, and ultimately lead to the development of legislations on AIDS. UNDP visibly and actively supported the National Assembly to reorganize and reposition itself to adequately respond to the HIV/AIDS pandemic.

5.1.3 Civil society and empowerment

UNDP has engaged civil society groups—such as NGOs, the media and PLWHA—on capacity building initiatives. However, interviews with some stakeholders indicate that this engagement was not adequate. Given the extent and level of consultation that UNDP has been able to accomplish with GOL, stakeholders felt that UNDP could have used similar approaches to achieve comparable results with civil society groups.

UNDP has missed opportunities to build stronger partnership networks with civil society organizations. However, a newly formed network of PLWHA acknowledged that UNDP helped them establish, organize and operate as an entity—an accomplishment that may not have materialized without UNDP's intervention. In addition, UNDP collaborated with NGOs and media groups during the launch of the Universal Testing Initiative and NGOs have benefited from the transformational leadership training that was extended to DATF. These initiatives were meant to build capacity, generate HIV competency, and empower the different groups to rise to challenges posed by HIV/AIDS. Partnerships were built with civil society during a social mobilization initiative in Qacha's Nek, where the Know Your Status Campaign was launched by the Prime Minister. The strategy was to empower and create awareness so that community members would come out to test and determine their HIV status, and seek access to ART. This has been an important aspect in reducing vulnerability to HIV/AIDS and its impact, because once people acquire knowledge, they are empowered to demand for services, such as VCT and treatment.

5.1.4 Participation and inclusiveness

As a strategy for scaling up the national response to the pandemic, UNDP mobilized all sectors of society through its Leadership for Results Programme. Community participation was seen as a gateway for achieving an HIV competent society—where individuals, households and communities could help generate demand for the delivery of efficient quality services. UNDP used an inclusive, participatory approach to accelerate the process by involving structures at the community level. Its key partner in this endeavour was the Ministry of Local Government. UNDP had already worked with the Ministry through the Empowering Communities for Development Planning—a programme that contributes towards the reduction of poverty and HIV/AIDS through strengthening institutional, technical and entrepreneurial capacities of local and community groups to respond to development challenges.

The government committed itself to establishing community councils and local governance structures, which were elected in the April 2005 Local Government Elections. In 2004, Parliament passed the Local Government Amendment Act in an effort to affect the decentralization of democracy and bring governance closer to the people. The restructuring of local government, when accomplished, will assist in the fight against HIV/AIDS, because communities will be allocated a space within the local government

to plan and design their own programmes. These reform initiatives are expected to increase public participation and decentralize decision making to the community level, facilitating the flow of information to beneficiaries and leading to better assessment and response to community needs.

The plan to elect community councils throughout the country will provide an opportunity for scaling up the national response to the HIV/AIDS pandemic. The Interim Community Councils' (ICCs) local governance structures are being trained to draft their HIV action plans in some communities through a programme supported by GTZ, Ministry of Local Government and UNDP. ICCs have benefited from the social mobilization that was carried out during the Know Your Status Campaign. The Ministry of Local Government in collaboration with GTZ is continuing to support these councils by strengthening their capacity to respond to issues at the community level. UNDP has developed a programme of support that will require further coordination and collaboration to effectively support the impact of the local governance structures.

UNDP used governance as a central theme and strategy for addressing the HIV/AIDS response in Lesotho. This approach enabled UNDP to position itself closely with the major decision makers in government. The strategy has worked well, because UNDP has been able to provide policy guidance at the executive and community branches of government—targeting the right government agencies to achieve results. When the Prime Minister declared AIDS "the biggest threat to humanity," UNDP was able to respond by encouraging the Prime Minister and senior government officials to publicly test for HIV and advocate for Universal Testing for all citizens. This public event led to the demystification of HIV testing and has generated a demand for services. The publication and dissemination of the strategies for responding to the epidemic through "Turning a Crisis into an Opportunity" and its adoption as a reference manual also leaves a lasting legacy for UNDP. It has been used as a blueprint for action and a basis for revising the National HIV/AIDS Strategic Plan and provides guidance for developing workplace policies and coordinating AIDS activities in Lesotho through the establishment and operationalization of the NAC.

5.2 PARTNERSHIP COORDINATION

5.2.1 Inter-agency coordination and country coordination mechanism

UNDP has made efforts to establish partnerships and engage in joint initiatives with government, UN agencies, other donor agency development partners, private sector, and civil society organizations in an attempt to scale up the national response to HIV/AIDS. Since HIV/AIDS is regarded by the government and the UN system as the greatest development challenge facing the country, it presents a key strategic area for all UN agencies operating in Lesotho to cooperate.[20] Each agency has embarked on different initiatives to address HIV/AIDS, focusing on national priority areas relevant to its technical expertise and area of comparative advantage.

UNDP, through the UN Expanded Theme Group, has strategically positioned UN agencies to provide support and policy guidance to the overall national response. The Expanded Theme Group, whose secretariat is the UNAIDS office, is comprised of representatives from all resident donor agencies, national and international NGOs, PLWHA, heads of UN agencies and government officials. The group has been an effective forum for donor coordination, partnership exchange, joint initiative formulation, and addressing united donor community concerns to GOL. It was this forum that generated the publication "Turning a Crisis into an Opportunity" and facilitated its adoption as a reference manual. The process that led to the development and publication of this document points to high-level collaborative efforts through partnership, leadership and commitment by members to work together and achieve a common goal. The UNDP Resident Representative and U.S. Ambassador as co-chairs, led the group in producing a comprehensive strategy for combating AIDS. The publication of "Turning a Crisis into an Opportunity" is the culmination of the efforts by all development partners to meet the daunting challenge of combating AIDS.

The decision by the Expanded Theme Group to produce a policy guide and manual was strategic and was the result of its willingness to share the responsibility for scaling up the national response. Each partner made contributions based on its technical expertise and resources—providing policy

20 The UN Common Country Assessment Lesotho, 2004.

TABLE 1. UNDP LESOTHO BUDGET (USD)

Source of funding	Programmes supported	Funds allocated	Funds used	Balance
UNDP				
HQ-BDP	LDP	148,000	148,000	0
	We Care	30,000	30,000	0
HQ-RBA	SACI	70,000		
	Regional Project	75,000	55,000	90,000
Country Office	UNFIP	286,730		
	ECDP	215,720		
	DSS	70,250		
	Others	200,000	772,700	0
Others				
DFID		1,500,000		
Canada		35,000		
British		45,000		
Irish		274,212		
BCPR		100,000	369,000	1,584,712

Note: LDP indicates Leadership for Development Programme; SACI, South African Capacity Initiative; UNFIP, UN Fund for International Development; ECDP, Empowering Communities for Development Planning; DSS, Development Support Services; DFID, Department for International Development; and BCPR, Bureau for Crisis Prevention and Recovery, UNDP.

advice, technical direction and writing segments of the book—with UNDP spearheading and coordinating the overall efforts. The major outcome under the partnership theme is an increased level and clarity of policy commitment by GOL and its reaffirmation of the priority and focus on HIV/AIDS as a development issue that needs urgent attention. GOL's adoption of the document as a reference manual is confirmation of that commitment. It further strengthens the partnership between government, donor community and other development partners, and mobilizes and expands stakeholder involvement in the overall national response.

5.2.2 Managing growing external assistance for scaling up response

UNDP began core-streaming HIV/AIDS into all of its programmes in late 2002. Table 1 illustrates expenditures for implementing advocacy campaigns to create awareness and training programmes for capacity development and transformational leadership. The training expenses built the capacity of stakeholders, Parliament, Public Service, DATFs, the country office and the UNCT, and support to the national Know Your Status Campaign. Expenditures from the Country Office Administration, Resident Coordinator budget and regional programme have been estimated at more than USD 200,000 from 2001 to 2004 for consultancies, capacity building and publication expenses for the "Scaling Up" document. The Leadership Development Programme, which was supported by the UNDP HIV and AIDS Group under the Bureau for Policy Development, has also had a significant impact on the DATFs and National Response Stakeholders.

In 2003, UNDP Lesotho also channelled USD 471,850 to support LAPCA for mainstreaming HIV/AIDS into the National Development Planning Framework and to mitigate the impact of AIDS on sustainable human development. The funds also supported NGO partnership coordination and the establishment of a PLWHA network organization. Different development partners, such as DFID, USAID and Bristol-Myers Squibb, have partnered with GOL to support projects on HIV/AIDS. DCI has a bilateral agreement with GOL and has allocated 7 percent of its budget (EUR 650,000) to HIV/AIDS programmes.[21] DCI supports strengthening partnership coordination, focusing especially on LAPCA, and the integration of HIV/AIDS into the development process. It has also helped GOL access resources from GFATM, which have supported DATF's operations and support groups for HIV/AIDS.

21 Government of the Kingdom of Lesotho, Lesotho AIDS Programme Coordinating Authority, "Review of HIV and AIDS Related Initiatives and Activities in Lesotho," review undertaken by SAFAIDS and LAPCA, 2003.

UNDP supported the WHO 3 by 5 Initiative. This Initiative provides universal access to treatment for people living with HIV/AIDS. In its dual capacity as UN Resident Coordinator, UNDP was able to mobilize high-level leadership and mounting advocacy to support WHO's efforts by securing national commitment to the 3 by 5 Initiative. The high-level missions of the United Nations Secretary General (UNSG) Special Envoy on HIV/AIDS also had a significant impact in bringing the MOHSW on board.

The UNDP's Leadership Development Programme helped strengthen the systems and capacity of public sector entities. In addition, UNDP assisted the Ministry of Local Government in developing strategies for decentralizing effective delivery of the 3 by 5 Initiative. UNDP has played a catalytic role in collaboration with WHO by working with the MOHSW to make the necessary changes for implementation of the Initiative as well as collaborating with the UN Expanded Theme Group and the Office of the Government Secretary to support the Know Your Status Campaign. In its support of Universal HIV Testing Initiatives, UNDP has facilitated a process for creating a 'demand and supply' environment for the implementation of the 3 by 5 Initiative and has strengthened partnerships with relevant actors and agencies in order to develop, roll out and expand the treatment plan for the country. UNDP's role in the acquisition of mobile CD4[22] equipment, ART administration training, and purchasing and utilization of mobile centres, is particularly note worthy.

5.3 LEADERSHIP FOR DEVELOPMENT

The second CCF of 2002-2004 was prepared in 2003. It states that UNDP is committed to core-streaming HIV/AIDS in its cooperation with GOL, in addition to pursuing the thematic areas of governance, poverty reduction, environment and food security. UNDP-supported programmes and operations focus on approaches that combat HIV/AIDS and embrace transformational leadership strategy by placing leadership for development as a central strategy for achieving these goals.

UNDP's entry point for implementing its leadership for development strategy for the fight against HIV/AIDS in Lesotho was the Universal Testing or Know Your Status Campaign. UNDP mobilized different leaders to set an example for testing for HIV and assume a 'front-row' position in the advocacy campaign against AIDS. There has been a conscious effort by UNDP to advocate against AIDS and respond to the pandemic within the context of Basotho culture, using existing realities to illustrate the disruptive impact of the disease on their way of life.

5.3.1 Advocacy and communication

UNDP has used the Leadership for Results Programme as a tool for transforming leadership approaches, including the thought processes of senior cabinet officers, to influence their response to the need for delivering HIV/AIDS services to their constituencies. Advocacy campaigns have been launched to encourage the participation and secure the commitment of different cadres of leadership to advance their HIV competence in response to the challenges posed by the pandemic. UNDP has supported multi-level social mobilization and advocacy campaigns for Universal Testing for HIV, using advocacy and the transformational leadership approach. Through constant collaboration with various public-sector decision makers, including principal secretaries, parliamentarians, DATF, community leaders, and civil society organization members, UNDP has transformed leadership through policy advice and capacity development.

Since December 2003, UNDP has organized a series of advocacy activities and campaigns in partnership with Ministry of Local Government, Office of the Government Secretary and the two houses of Parliament. Different types of advocacy activities, capacity-building and social mobilization workshops and seminars, and formal and informal meetings have been carried out. These activities have enabled local institutions and key civil society stakeholders to apply transformational skills and increase their HIV/AIDS competence.

UNDP has forged partnerships at various levels of leadership. It has used these partnerships to emphasize the importance and role of leadership. It has advocated for individual leaders to assume personal responsibility and take action to influence positive changes within their area of influence in order to defeat AIDS. This approach has helped to revive a new sense of responsibility, with the

22 Used to monitor CD4 or T-cells (immune system cells that help protect the body from infection).

realization that leadership could no longer continue to do business as usual. Prevention, care, treatment, support, and impact mitigation activities have been carried out. In addition, related development issues such as poverty, food insecurity and gender equity are being addressed, to reduce vulnerability to HIV infection.

Leadership response led to the Senate's decision to participate in the VCT campaign and lead by example. To date, not all members of the Senate have been tested, but discussions are still being held to encourage the participation of all members in both houses of Parliament. The Prime Minister, cabinet ministers, the Government Secretary, principal secretaries and senior civil servants led the campaign for Universal Testing by publicly pioneering the testing for HIV.

UNDP has a unique responsibility as the lead and coordinating agency of all UN member agencies at the country level. This position advantageously provides it with the mandate to assume leadership challenges with GOL. UNDP has made it clear to GOL that leadership is a critical ingredient in the fight against AIDS. UNDP has consistently interacted with the Prime Minister, Members of Senate, Members of the National Assembly, Government Secretary, Principal Secretaries, and other government officials to drive home this message.

5.3.2 Gender

Gender equality and women's empowerment remains a priority for UN interventions, reflecting the government's identified priority programmes.[23] UNDP is part of the UN Theme Group on Gender. This committee comprises of representatives from UN agencies and government, and coordinates UN efforts on gender equality, providing support to gender initiatives within and outside the UN system. UNDP supports GOL gender initiatives by providing resources and technical support towards advancing gender equality. UNDP support to GOL has been especially visible in the political empowerment of women, especially those in decision-making positions. UNDP has placed a UN Volunteer within the Ministry of Gender, Youth, Sports and Recreation to provide technical assistance to its joint UNFIP programme on combating HIV/AIDS among youth and adolescent girls.

Gender inequality is central to HIV/AIDS transmission in Lesotho. In 2003, the United Nations Fund for Women (UNIFEM), in collaboration with the Southern African HIV/AIDS Information Dissemination Service, organized a workshop for government, NGOs, community-based organizations and the private sector to review the link between gender inequality and HIV/AIDS. This workshop also reviewed how the Convention on the Elimination of All Forms of Discrimination Against Women has been put into operation. There are current efforts to establish policies and legislative measures to address the legal position of women. UNDP has been a part of this process.

GOL also adopted a Gender and Development Policy in 2003, and UNDP provided support through the Theme Group. This policy provides a framework for instituting measures to promote equal opportunities for men and women, boys and girls.

However, gender policy implementation in Lesotho remains weak. It is an area where UNDP support is critically needed. Gender equality remains a priority for UNDP, and it is envisaged that UN advocacy and programme interventions in the next UNDAF will focus on providing such support to Lesotho.

5.3.3 Private sector involvement

The promotion of the involvement of the private sector in the fight against HIV/AIDS in Lesotho has been noted in the Leadership for Results Programme, which states that transformational leadership initiatives will strengthen the capacity of a cross-section of national stakeholders,[24] including the private sector. This will enable them to initiate processes and actions to ensure HIV competence throughout Lesotho by optimally using structures like NAC to achieve breakthrough actions towards HIV competency. Kimaryo[25] observes that employers are beginning to respond to the HIV/AIDS pandemic as evidenced by the formation of the Business Coalition Against HIV/AIDS and the initiation of HIV/AIDS workplace programmes. For instance, one of the largest garment factories in Lesotho, the Chinese Garment Manufacturers factory, has

23 The UN Common Country Assessment Lesotho, 2004.

24 UNDP, "UNDP & UN Support to HIV/AIDS Pandemic in Lesotho: Position Paper," New York, 2004.

25 Kimaryo S, Okpaku J, Githuku-Shongwe A, Feeney J, "Turning a Crisis into an Opportunity: Strategies for Scaling Up the National Response to the HIV/AIDS Pandemic in Lesotho," 3rd Press Publishers, New York, 2004.

an HIV/AIDS workplace programme and the proprietor has financed HIV testing equipment for employees in collaboration with local NGOs. UNDP, in partnership with the Ministry of Trade and Industry, Cooperatives and Marketing and trade unions, also supported initiatives to strengthen the Know Your Status campaign by launching the VCT programme for approximately 50,000 workers.

Employers are at different stages of implementing a 1999 GOL policy document on HIV/AIDS, which is complementary to the Southern African Development Community Code of Conduct, a policy on non-discrimination that focuses on prevention and control of HIV/AIDS in the workplace. CARE-Lesotho has also been visible in this area, especially in the Universal Testing Campaign through its Private Sector Coalition Against AIDS Project. CARE's involvement includes the provision of counselling to people who have been tested for HIV.

UNDP has contributed to private sector involvement in the fight against HIV/AIDS. However, its involvement could have yielded more impact if a more intensive mobilization of the private sector had taken place, given this sector's capacity to mobilize resources better than other stakeholders. Opportunities still exist to intensify the partnership with the private sector, as it will contribute to scaling up the national response in Lesotho.

5.4 CAPACITY DEVELOPMENT

UNDP has been acknowledged by stakeholders and other UN agencies for its capacity building contributions to the fight against HIV/AIDS. During the period under review, a series of training programmes and workshops were organized for UN staff members, senior government officials, parliamentarians, DATF members and NGO representatives. UNDP contributed to capacity development through the following programmes: Leadership for Results, Systems Thinking, Seven Habits of Highly Effective People by Franklin Covey Institute, and capacity building for HIV/AIDS workplace programmes.

5.4.1 Human resource development, retention and use

UNDP's strategy for scaling up the national response to HIV/AIDS is centred on building capacity to support responsive governance at all levels of Basotho society. Starting with the highest levels of government, UNDP built the capacity of senior policy makers, then moved on to strengthen capacity at the community and peripheral structures.

UNDP believed that its capacity development efforts could only become effective if the transformation process started within its own structures. Consequently, capacity development programmes were designed and implemented for training UNDP staff. For instance, UNDP staff members were trained using the Seven Habits of Highly Effective People offered by Franklin Covey Institute before the course was extended to other stakeholders. This process started in 2002, with the strengthening of the UNDP human resource base and aligning technical expertise and staff profile with the evolving needs of the country. Resources were mobilized from donors and used to develop a continuous programme of staff development for more effective planning, accountability and transformational leadership. This training created an effective learning environment that enabled staff members to provide support and advice to partners.[26] In an effort to retain staff and alleviate the impact of HIV/AIDS on staff members and their families, UNDP also developed a workplace HIV/AIDS programme, called 'We Care', which was designed to promote prevention through information sharing, education and training. The programme was successfully extended to UN staff and family, and the UN held their own Know Your Status Day in June 2004.

UNDP has approached HIV/AIDS as a leadership challenge, through capacity development. Training programmes were implemented to build capacity of leadership, especially within GOL, to enable public sector official response to the HIV/AIDS pandemic. Capacity-building initiatives supported by UNDP have contributed innovative approaches to ensure that institutional structures support and generate flexible, responsive and accountable governance. These structures are in the civil service at all levels, including management, local government, and community councils. Principal secretaries and senior civil servants have undergone management training, organized in partnership with UNDP. The transformational approach was also extended to the two houses of Parliament, the Senate and the National Assembly, civil society organizations and the private sector.

26 UNDP, "UNDP & UN Support to HIV/AIDS Pandemic in Lesotho: Position Paper," New York, 2004, page 3.

UNDP used its comparative advantage and mandate as Resident Coordinator of the UN system to develop programmes that are strategically in line with the GOL reform policies, articulated in such documents as the National Vision 2020, PRSP, MDG Report and other policies that have been developed to respond to the nation's development needs.

5.4.2 Knowledge generation, management and sharing

UNDP has supported capacity-building workshops on transformational leadership for members of the DATF and civil society representatives. UNDP programmes were designed to generate new thinking, new possibilities and new actions to bring about a response to HIV/AIDS that accomplishes the following three national strategic imperatives:

- All HIV positive people in Lesotho lead longer and healthier lives
- All HIV negative people remain negative
- All Basotho attain a better quality of life

The transformational leadership programme was designed to yield the following outcomes: effective leadership in transforming the response; and development of measurable, observable, breakthrough action plans by training participants to address imperatives that would ultimately lead to increases in HIV/AIDS competence. When asked about the impact of the training programmes, members of DATF expressed satisfaction and stated that it improved their capacity to plan and manage their programmes.

The success of prevention and control of the HIV/AIDS pandemic depends on effective coordination of efforts at all levels. At the national level, the coordination and mobilization of all stakeholders is done by LAPCA. At the district level, coordination is the responsibility of DATF. These structures have been established in the districts to bring all stakeholders together. Stakeholders at the district level include government ministries, the private sector, and civil society, including religious organizations and traditional healers. The mobilization of stakeholders provides a forum for sharing strategies in response to the pandemic. The DATF is housed within the office of the District Secretary, who is also the Chairperson or convener of the Task Force meetings. The Task Force members work with AIDS support groups and community members.

When the Know Your Status Campaign was launched in Qacha's Nek in 2004,[27] the Ministry of Local Government, in collaboration with UNDP and GTZ, organized extensive social mobilization both before and after the campaign. The campaign was preceded by a workshop, which attracted approximately 350 people from a wide spectrum of Basotho society. Participants were drawn from community members, traditional healers, teachers, herd-boys, traditional leaders, the youth, interim community councils, and civil servants. After this workshop, DATF has continued to work with other stakeholders and community members to increase HIV competence in their districts.

The process would probably not have been as successful without the capacity building support provided to DATF under the Transformation Leadership Programme. DATF members reported that the training helped them build confidence and improve their communication skills. This initiative provided an opportunity for the Task Force members to work together as a team—planning activities and sharing strategies and experiences. It also helped energize the teams and assisted them with the planning and development of district HIV/AIDS activities.

However, when asked about their involvement in the Know Your Status Campaign, members of the Qacha's Nek DATF expressed some dissatisfaction about the extent of their involvement in this historic event. They pointed out that, although they assumed a meaningful role later in the follow up process, as they have continued to work with the ICCs that are the current community structures under the Ministry of Local Government, they were not included in coordination of the launch of the programme. This represents a missed opportunity for UNDP. The Ministry of Local Government and UNDP included and worked with the ICCs, but did not adequately include the DATF in coordinating the launch, which was spearheaded and attended by the Prime Minister, the Ministers of Health and Social Welfare and Local Government and the Archbishop of the Catholic Church. This was interpreted as unwillingness of central structures to utilize expertise and knowledge at district and community level.[28] An

27 During the Social Mobilization Workshop for Community Leaders in December 2003, the Prime Minister noted VCT as a basic human right for all Basotho. The formal launch of the Know Your Status Campaign was held in March 2004.

28 Focus Group Discussion with Qacha's Nek DATF.

alternative approach would have been the inclusion of DATF from the beginning.[29] Working with all local structures ensures follow up and continuity, enhances monitoring and evaluation, and ultimately improves sustainability of programmes.

This evaluation confirms that UNDP has contributed significantly to capacity development within its institution and extended transformational leadership training to enhance the capacity of other stakeholders.

5.5 MITIGATION OF HIV/AIDS IMPACT AND POVERTY ERADICATION

In its consultative and participatory process of the development of the PRSP, GOL identified HIV/AIDS as a priority and cross-cutting issue. This policy paper outlines strategies for Lesotho to adopt in order to minimize its vulnerability to HIV/AIDS and therefore reduce the effects of poverty. Government policy initiatives point out the need to scale up the response to HIV/AIDS as a strategy towards addressing poverty reduction and attaining human development.[30]

UNDP has identified poverty reduction as a priority theme under the second CCF 2002-2004 within the overall framework of the National Vision and PRSP. Efforts to scale up the response to HIV/AIDS and address poverty eradication fall under the thematic practice area of poverty reduction. A specific programme on environmental management for poverty reduction has incorporated capacity building and transformational leadership as a driving force to address poverty reduction and food security within the thematic practice area of energy and environment.

The environment programme has utilized youth groups to rehabilitate land and reduce degradation to conserve land and increase food security. Food security and nutrition are recognized as critical elements for building readiness for the implementation of the 3 by 5 Initiative. This is because good nutrition is a vital component for implementing an effective ART programme. The Land Reclamation Programme encourages communities to embark on communal gardening and to resuscitate home gardening. The environment programme has used transformational leadership to demonstrate the links between HIV/AIDS, environmental management and food security as pre-requisites for mitigating the impact of AIDS and contributing to the national response against HIV/AIDS. UNDP and the UN system in Lesotho is assisting with the development of a Food Security Policy.

5.5.1 Workplace programmes

UNDP Lesotho has addressed HIV/AIDS through its support for institutional strengthening, its overall response guided by the accelerated UN response to HIV/AIDS. UNDP's two-prong approach of responding to HIV/AIDS from within the UN system, while offering similar support to collaborative partners, has yielded significant results. Its efforts to support workplace programmes for HIV/AIDS, both internally and among stakeholders, has helped mitigate the impact of the pandemic on its employees and the employees of the stakeholders supported by UNDP.

The thrust of UNDP's strategy has been to ensure that all programme activities core-stream HIV/AIDS and all workplaces establish exemplary workplace policies. UNDP Lesotho's workplace programme, We Care, provides support to employees, their family members, and other UN agencies. This programme minimizes the impact of HIV/AIDS on employees by creating awareness and keeping employees informed. It is a good example of UNDP's capacity to lead by example. UNDP has developed and implemented an internal workplace programme that can be emulated not only by UN agencies but also by other stakeholders. UNDP, in collaboration with WHO, further provided support to the development of a VCT programme within the Ministry of Trade and Industry, Cooperatives and Marketing. This has had a catalytic effect on other line ministries and should form a solid basis for the implementation of the ILO Workplace Programme being spearheaded by the Ministry of Labour and Employment.

5.5.2 Poverty reduction

UNDP has a specific programme to support poverty reduction within the framework of CCF 2002-2004 with GOL. Its approach has been to strengthen systems by providing technical policy advice and financial support in the formation of both the

29 UNDP indicated that DATF were not involved in the launch in March 2004 because of security issues. The launch was supposed to be attended by four executive directors of the UN, WFP, UNAIDS, UNICEF and the Prime Minister.

30 MDG, Vision 2020, Gender and Development, Population Policy and PRSP, cited in the Kingdom of Lesotho Poverty Reduction Strategy Paper 2004/2005-2006/2007.

National Vision and PRSP and establishment of a national poverty monitoring system. The end result has been that the development documents are cognizant of HIV/AIDS as a development challenge. This has resulted in a more strategic focus to strengthen institutional capacity, with the ripple effect of a more efficient service delivery and human development sustainability. UNDP's approach has been consistent, applying structured capacity development to address a change in mindset through transformational leadership.

5.5.3 Resource allocation

In response to the Organization of African Unity Abuja Declaration, GOL enacted a policy that 2 percent of all ministries' budgetary allocation should be set aside for HIV/AIDS programming. This call by the Prime Minister has been carried out by most government ministries. When UNDP strengthened its interaction with the government to address HIV/AIDS as a governance and leadership challenge, the government simultaneously created a conducive and responsive fiscal policy environment by setting aside resources for HIV/AIDS. However, due to the magnitude of the effects of the pandemic, the current allocation of 2 percent is insufficient to fully implement the national strategies. Despite the increases in external resources from GFATM and the U.S. Government, Lesotho continues to face resource and capacity limitations to tackle mitigation, care and treatment. The GOL has re-assigned 1 percent of the ministry allocations to the MOHSW for the implementation of the ART programme.

5.5.4 Advocacy and communication using visits of UN dignitaries

The period of 2002 to 2004 marked a number of important events that strengthened the partnership between the UN agencies and GOL. In 2002, shortly after the general elections, the UNSG visited Lesotho, reaffirming his commitment to continue to support the country in its fight against the pandemic. It was also a development moral booster. UNSG's visit helped to put at the forefront Lesotho's HIV/AIDS challenges. In addition, Lesotho benefited from a visit made as part of a Southern African joint mission, by the UN Special Envoy of the UNSG for Humanitarian Affairs, James Morris and Special Envoy for HIV/AIDS Stephen Lewis. Their visits to Southern Africa and to Lesotho in particular, focused attention on the devastating effects of HIV/AIDS on women and girls.[31] This helped create awareness and draw attention to policy and programme expansion to include advocacy and action to improve the situation of women and girls. Policy dialogue has also started to refocus and redirect programmes to address the hardships experienced by this portion of the population. The repeated high-level visits by UNSG Special Envoys, UNAIDS Director and UNICEF Executive Director have also resulted in boosting the confidence of Basotho to stand up to the challenges of reversing the negative effects of AIDS on development and strive towards the attainment of the MDGs.

5.5.5 Civil society development

UNDP's efforts to build capacity for scaling up efforts in the fight against HIV/AIDS have been mostly concentrated at the level of interaction with GOL and related structures such as Parliament. Nevertheless, there have been some efforts by UNDP to interact and build capacity within civil society organizations, including NGOs, the media and the private sector. Civil society development efforts started with transformational leadership training, where DATFs were encouraged to develop breakthrough initiatives in the fight against HIV/AIDS. In this project, for instance, the Maseru DATF started an initiative called Cutting Off AIDS with Hair Dressing Salons. Awareness and training workshops were held for salon workers to promote AIDS awareness and prevent AIDS transmission through hair care. Information and awareness creation materials were developed and placed in the hair dressing salons and other strategic places. Through the Regional Programme on HIV and Development, UNDP's efforts in this area were also extended to the National University of Lesotho, with a capacity-building programme for lecturers to start AIDS initiatives and support research for senior and graduate students. Training has also been offered to PLWHA organizations, and there have been recent efforts to support the formation of a network of PLWHA.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

This evaluations shows that key changes are taking place in Lesotho's efforts to respond to the challenges

31 UNAIDS, "Facing the Future Together: Women, Girls and HIV and AIDS in Southern Africa," 2003.

posed by HIV/AIDS. These changes are at policy, institutional, partnership and operational levels. Outcomes are evident at the political, service provision and organizational levels. The role of UNDP in responding to the challenges of HIV/AIDS in Lesotho has mostly been in upstream policy advice, capacity building, and support to initiatives that link development efforts to HIV/AIDS. UNDP has been acknowledged by other UN agencies, UNICEF, WHO and UNAIDS to have assumed a leadership role in its capacity as Resident Coordinator. UNDP has also been commended for using its position as the leading UN agency to show leadership in the fight against HIV/AIDS. UNDP has strategically used its position and mandate as a development agency to address human development issues around AIDS by offering policy guidance and direction to the Lesotho government.

6.1.1 Creating an enabling policy and development environment

UNDP has not lost many opportunities to use its position to foster an enabling and responsive development environment. There have been a number of advantages to UNDP's delayed entry into the HIV/AIDS response programme. By 2002, Lesotho had managed to establish an inclusive democratic government that not only promised lasting peace after a period of turbulence, but also allowed for a system of governance to share responsibilities and the challenges confronting the country. A number of important initiatives had been implemented, including the formation of parliamentary committees chaired by members of the opposition parties. These initiatives augured well for sharing responsibilities towards development of the country.

The policy environment was conducive and receptive. GOL had established a policy machinery to drive reforms, as evidenced by the public sector reforms, law reforms and development of HIV/AIDS population and gender policies. This receptive environment was an indication of the country's readiness to embrace new ideas and an admission by leadership of the need for external assistance. UNDP's entry was therefore timely, welcomed and conducive for development agendas to thrive. However, it should be noted that the national response to HIV/AIDS is weakened by insufficient coordination and capacity and resource limitations. Attempts to develop policies are underway, but the policy framework remains relatively weak.

Despite UNDP Lesotho's delay in adopting HIV/AIDS as part of its corporate strategy, since 2002 its efforts have been focused on achieving results and are widely commended. UNDP has made serious attempts to mobilize and energize all sectors of Basotho society to contribute towards the national response. Institutions that were losing momentum due to insufficient resources, loss of institutional memory, and fatigue have been mobilized to action because UNDP demonstrated that doing business as usual will not reverse the daunting challenges posed by the pandemic. UNDP has made tremendous efforts to reverse the situation by mobilizing the entire nation to action.

However, UNDP has missed opportunities that could have maximized its efforts to combat HIV/AIDS in Lesotho. For example, UNDP had an inadequate strategy for forging and nurturing strong relationships with civil society, including media organizations, and did not engage the private sector in intensive partnerships, similar to those used with GOL. Some efforts have been made through training to build capacity, but opportunities for full engagement have not always been fully explored. There were efforts to include NGOs in the leadership development programmes, but there were no clear plans to provide policy guidance. Consequently, civil-society and private-sector responses to the pandemic at all levels remain largely unfocused, uncoordinated, with insufficient resources, and without the vigour to mobilize participation. Civil society involvement has not been exploited to its full potential. This is particularly notable for organizations of PLWHA, since they can be visible and effective advocates for anti-discrimination policies against PLWHA.[32]

6.1.2 Partnership coordination

Partnership coordination is another area where UNDP Lesotho has made its mark by catalyzing action for the national response to HIV/AIDS. UNDP played a visible leadership role in policy advice and advocacy resulting in the working document, "Turning a Crisis into an Opportunity" and support for the Universal Testing Programme. This initiative culminated in the Know Your Status Campaign, which was pioneered by high-level

32 Through collaboration with UNAIDS and development partners, Lesotho has launched a national network of people living with HIV and AIDS called LENEPWA. With decentralized structures, this is a good opportunity for the UN and development partners to provide support at the local level.

leadership in the country. This was a gesture of political will on the part of government, contributing to creating an enabling environment for mass public mobilization of Basotho citizenry to take charge of their lives. Significant changes are also noted in the area of treatment and administration of anti-retrovirals. UNDP is working in partnership with WHO to prepare for the implementation of the 3 by 5 Initiative. UNDP is expanding the level of its involvement, by creating partnerships with the local structures through its established partnership with the Ministry of Local Government, to advocate for VCT so that communities can gain access to treatment through the WHO 3 by 5 Initiative. UNDP's contribution to the national response to AIDS has been strategic, timely and relevant. It has come a long way towards providing a link between poverty reduction, attainment of MDGs, and effective management and mitigation of the pandemic.

6.2 RECOMMENDATIONS

Some lessons have been learned and significant changes have occurred because of UNDP's strategic support towards the national response for HIV/AIDS in Lesotho. The following recommendations will strengthen and enhance the impact of future UNDP interventions in the fight against HIV/AIDS in Lesotho:

1. UNDP has worked extensively to foster partnerships with GOL and other stakeholders. Continued policy interaction is highly recommended. But given the missed opportunities for strengthened partnerships with civil society, especially organizations of PLWHA, UNDP should design a plan of action for engaging and building the capacity of civil society organizations.

2. "Turning a Crisis into an Opportunity" is a good manual and has been used to enhance the national response to HIV/AIDS. However, it is underutilized. This document should be used as a focal point for convening roundtable discussions about Lesotho's resource requirements for scaling up the response to HIV/AIDS and implementing some of the strategies recommended in the publication.

3. UNDP should review the current mechanisms for accessing development funds and enter into dialogue with GOL to refine procedures and expedite access to funds for activities. This recommendation is critical because of the current rate of utilization of external resources, such as the GFATM. Addressing this issue would increase Lesotho's absorptive capacity for resources, encourage additional funding from other sources, and increase the number of interventions implemented to reduce the impact of AIDS.

4. UNDP should strengthen its relationship with community level structures, particularly in view of its collaborative efforts with the Ministry of Local Government. Confining policy guidance to the upper echelons of leadership could lead to the dissatisfaction of district personnel. Besides, the structures at the district level are necessary to implement several initiatives, and their participation is essential for sustainability. Social mobilization for district initiatives should include coordinating structures like DATFs to ensure sustainability and empower them to participate and take responsibility in the fight against AIDS.

5. UNDP should consider supporting programmes for strengthening the linkages and collaboration between district structures and AIDS support groups at the community level. The support groups already play an important role in mitigating the effects of the pandemic in their communities and should be encouraged to scale up their activities by linking them to funding resources.

6. UNDP should encourage the government to expedite the provision of services and improve health facilities to respond to the demand for VCT that is being created by the Know Your Status Campaign. Health and social welfare facilities are critical components of the service delivery programmes for scaling up the response to the pandemic.

7. The role and responsibilities of UNDP, UNAIDS and other UN agencies in the HIV/AIDS response should be clearly defined and articulated. UNDP should continue to work very closely with these stakeholders to achieve the common objective of reducing the impact of the pandemic.

8. UNDP should continue to work with GOL to ensure the creation and establishment of a

functional NAC, with the requisite mandate to effectively coordinate the national response. UNDP should allocate resources to ensure strengthened capacity of NAC to carry out its functions effectively.

9. Current allocation of 2 percent budget by line ministries for AIDS activities is inadequate, particularly with the recent directive to set aside 1 percent for the implementation of the 3 by 5 Initiative. UNDP should assist GOL in developing a plan and carrying out resource mobilization activities to raise enough funding to implement the national strategic plan.

10. UNDP should be more strategic in developing coherent plans before embarking on activities that are likely to generate increased demand for services. UNDP should have a follow up plan to ensure that resources are available to meet those demands.

11. UNDP has been able to achieve a substantive outcome due to its capacity to mobilize specialized technical expertise of other UN agencies and development partners. It should also be sensitive and diplomatic in its dealing with these partners and give collective credit when being commended for its achievement.

ANNEX 1. ACRONYMS AND ABBREVIATIONS

ART	Antiretroviral Treatment
CCF	Country Cooperation Framework
DATF	District AIDS Task Force
DCI	Development Cooperation Ireland
DFID	Department for International Development
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOL	Government of Lesotho
GNP	Gross National Product
GTZ	German Agency for Technical Co-operation
ICC	Interim Community Councils
IMF	International Monetary Fund
LAPCA	Lesotho AIDS Programme Coordinating Authority
NAC	National AIDS Commission
NGO	Non-governmental Organization
MDG	Millennium Development Goal
MOHSW	Ministry of Health and Social Welfare
PLWHA	People Living With HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
UNFIP	UN Fund for International Partnership
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNSG	United Nations Secretary General
VCT	Voluntary Counselling and Testing
WFP	United Nations World Food Programme
WHO	World Health Organization

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ANNEX 3. PEOPLE INTERVIEWED

GOVERNMENT OF LESOTHO

Mona Hlasoa, DS's Office Berea, Deputy District Secretary, Ministry of Local Government
Liengoane Lefosa, Director, Ministry of Finance & Planning
Malitlallo Majara, Ministry of Local Government, Acting P.S., Ministry of Local Government
Kubutu Makhakhe, Principal Secretary, Prime Minister's Office
Tiisetso Matete, Communication Officer, LAPCA
Teboho Mohlabi, Communication Officer, LAPCA
Thabang Mokobori, Communication Officer, LAPCA
Monica Mokoma, LAPCA Coordinator, Berea, LAPCA
Agnes Mongoako, Chief Rehabilitation Officer, LAPCA
Mathato Mosisili, First Lady of the Kingdom of Lesotho, Prime Minister's Office
Motloi Motloi, Chair DATF, Qachas'Nek
Dr. Khauhelo Raditapole M.P., Chair of HIV/AIDS Committee Parliament, National Assembly
Metsing Ts'ehla, LAPCA Coordinator, Qachas'Nek

UNDP

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Victoria Diarra, UNV Social Statistician
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Puleng Letsie, HIV and AIDS Officer
Naoki Maegawa, JPO – Strategic Policy and UNFIP
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Catherine Moat, Communication Specialist, UNDP South Africa
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Gertrude Moshoeshoe, Information Management Clerk
Moroesi Putsoa, National Intern Systems Desig
Motselisi Ramakoae, Environment & Energy Programme Officer
Veronica Sekhibane, Human Resources Associate
Sara Viskum, UNV Project Officer
Gwynneth Wang, HIV and AIDS Intern

UN SYSTEM

Dr. Bertrand Desmoulis, Resident Representative, UNICEF
Dr. Agostino Munyiri, Project Officer Child Survival, UNICEF
Tim Rwabuhemba, Country Coordinator, UNAIDS
Dr. Samuel O. Sackey, Epidemiologist/Disease Prevention & Control Officer, WHO

BILATERAL DONORS

Monaphathi Maraka, Coordinator, RHAP US Embassy

CIVIL SOCIETY

'Madamane Damane, Positive Action
Gillian Forrest, Social Worker, CARE
Crosby Magumela, Laboratory Technician, Qachas'Nek
Refuoe Makhakhe, Youth Development Officer, Qachas'Nek
Mpolelo Matete, Youth Volunteer, Qachas'Nek
Nthati Masupha, Positive Action
Ranku Moerane, Coordinator AIDS Education Unit, Christian Council of Lesotho
Mponeng Moiloa, Positive Action
'Mahlompho Nkoka, Positive Action
Albert Pitso, Positive Action
Tebatso Qhobela, Positive Action

OTHER

'Mahlompho Fokoane, District Secretatiet, Thaba-Tseka
Mpho Kopano, Nurse, Thaba-Tseka
Doug Long, US Peace Corp Volunteer, Thaba-Tseka
Jonathan Love, Senior Partner, Consultant Leadership for Change Programme
Morongoenyane Mokhothu, Youth Officer, Thaba-Tseka
Dr. Pearl Ntsekhe, Director, Senkatana Clinic
Dr. 'Mamochaki Shale, Senior Lecturer, Team Leader, Integrating HIV/AIDS into Curricula, National University of Lesotho

ANNEX 4. PARTICIPANTS OF STAKEHOLDER WORKSHOP

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T.C. Mohlabi, Communication, LAPCA
Monethi Monethi, Director Planning, Local Government
Nthati Moorosi, Communications Officer, UNDP
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Erastus R. Njeru, Consultant, Regional AIDS Training Network/University of Nairobi
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'Mamotsamai Ranneileng, Head, HIV & AIDS Unit, National University of Lesotho
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'Mamochaki M. Shale, S. Lecturer, NU
Veronica Sekhibane, Human Resource Associate, UNDP
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NAMIBIA COUNTRY STUDY

HIV/AIDS

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

By Scholastika Iipinge

The author thanks the UNDP Country Office Namibia for the invaluable help it provided.

NAMIBIA

CONTENTS NAMIBIA COUNTRY STUDY

1. COUNTRY BACKGROUND

Namibia is one of the youngest and most stable democracies in Africa. The country gained independence on 21 March 1990. It is a large country of 824,000 kilometres^2, spanning 1,440 kilometres at its widest point and 1,320 kilometresat its longest. Approximately 40 percent of the total population lives in the north-central part of Namibia.[1] The population is 1.8 million and is growing at 2.6 percent annually. Approximately 40 percent of the population is less than 15 years of age.

International agencies classify Namibia as a lower middle-income country, with an annual average capital income of approximately USD 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, which combines income with other measures such as health and education, Namibia falls 59 places to a rank of 124.[2]

There is great inequality in wealth and income in Namibia. The top 1 percent of the population spends more money than the lowest 50 percent of the population. Eighty five percent of the poorest households are located in the rural areas, living from subsistence farming. The perceived gap between average rural and urban incomes, and the assumptions of perception of better job opportunities in urban areas, fuel migration from rural areas to the urban areas. The rural-urban migration adds additional pressure on already strained local authorities with respect to service delivery and cost recovery issues, resulting in pockets of severe urban poverty.

Namibia played a key role in the formulation of the UN Millennium Declaration. The President and Prime Minister served as Co-chairs of the Millennium Summit and President of the UN General Assembly respectively. The Government of Namibia has committed itself to implementing the Millennium Declaration and to systematically monitoring the Millennium Development Goals (MDGs) within the context of national and sectoral development frameworks.

Namibia has geared itself to participate fully in the MDGs. The MDG campaign forms part of a national process of strengthening policies that will mobilize all Namibians and the international community behind Namibia's Vision 2030. Under this Vision, Namibia will enjoy 'Prosperity, Harmony, Peace and Political Stability'. National targets and indicators were developed from the global framework of the Millennium Declaration to ensure that the MDGs are firmly rooted in the national development milestones of Vision 2030 and the objectives of the Second National Development Plan II (NDP II).

Among the MDGs and their associated targets, the National Planning Commission (NPC) report of 2004[3] shows that combating HIV/AIDS—measured by HIV prevalence among pregnant women—is the only goal in which the situation in Namibia is worsening.[4]

Unemployment is one of the challenges to the government, especially among Namibian youths. The unemployment rate in Namibia was estimated to be approximately 35 percent in the 2002 census. According to the Ministry of Labour, youth unemployment is approximately 40 percent or twice that of the general population.

To combat unemployment, the government introduced the National Youth Services Scheme in 2002. The scheme intends to attach youths to companies for one year after secondary schooling. After completion of their one-year internship, some youths are sent for further studies while some are provided with technical training to provide them with necessary skills for self-employment.

While this strategy reflects the government's priority on youth, this scheme is still in its infancy and the increasing spread of HIV/AIDS among the young challenges the government to deepen its emphasis on youth employment. The National Youth Services Scheme is aimed at equipping youth groups with skills and knowledge that would empower them to protect themselves from contracting HIV.

2. HIV/AIDS SITUATION

In 2004, the NPC reported, "Namibia is facing an HIV/AIDS crisis of devastating proportions."[5] Namibia is

1 National Planning Commission, 2004.
2 UNDP, 2001/2002.
3 National Planning Commission, 2004.
4 Performance on Goal 8, on per capita overseas development assistance, is also worsening, but this goal is outside the control of the Government of Namibia.
5 National Planning Commission, 2004.

ranked among the seven countries hardest hit by the epidemic in the entire world. It is estimated that one in every five people between 15 and 49 years of age is infected with HIV. HIV/AIDS is the number one threat to the country's human development.[6]

The first case of HIV in Namibia was diagnosed in 1985. In 1986, four cases were reported. By the end of 2003, Namibia had recorded a cumulative total of more than 136,000 cases of HIV/AIDS. In 2002, a national prevalence rate of 22 percent was reported.[7] The percentage ranged among regions from 7 percent to 43 percent. The national prevalence rate is estimated at 19.5 percent per the 2004 HIV Sentinel Zero Survey. However, the figures indicate that the most sexually active age group (15 to 34 year olds) experienced a leveling off or decline in HIV prevalence.

The HIV/AIDS epidemic is expected to impact negatively on health care delivery and to consume up to 17 percent of the health budget.[8] AIDS has been the leading cause of death in Namibia since 1996. According to the estimates of the Ministry of Health and Social Services (MoHSS), approximately 24,000 people will die from AIDS-related illness by 2005. That is 66 people every day, almost 3 people every hour, or 1 person every 20 minutes. In some parts of the country, 50 to 70 percent of hospital admissions are AIDS-related. The impact is so severe that the average life expectancy in Namibia has fallen from 59 to 48 years in men and from 63 to 50 years among women.[9]

The epidemic has a particularly disturbing impact on children. It has resulted in a growing number of orphans in Namibia, estimated to be 100,000. For this population, the government has provided social grants as a support system. The HIV/AIDS burden has resulted in a situation where children are being relied upon as income earners and caregivers for sick family members. Due to the grants provided to orphans and vulnerable children by the government, families are taking in orphans to supplement their income with grants.

Factors compounding the epidemic in Namibia include high prevalence of other sexually transmitted diseases, poverty, widespread alcohol and substance abuse, gender inequality, high mobility of people, intergenerational sex, cultural practices and ignorance of how to protect oneself against infection.[10] The evaluation also found that structural inequality, poverty linked to transactional sex, stigma, peer pressure, migration and mobility, domestic violence, and non-disclosure and confidentiality regarding personal HIV status also led to increased prevalence. Food insecurity was also mentioned as a contributing factor that increases the vulnerability of individuals and communities to HIV/AIDS.

3. COUNTRY RESPONSE

This chapter examines the evolution of the national response to HIV/AIDS, locating this response within the overall context of national development policies and programmes.

3.1 NATIONAL RESPONSE

The early response to HIV/AIDS in Namibia was fundamentally health dominated. In 1987, the country started to respond to HIV/AIDS with the establishment of an AIDS Advisory Committee. With the country's independence, the President of Namibia launched the National AIDS Control Programme (NACP), with a mandate to coordinate and manage HIV/AIDS patient care and prevention activities. The NACP was based in the MoHSS, but it supported activities implemented by other ministries and non-governmental organizations (NGOs).

In 1992, the First Medium Term Plan (MTP I) was developed. The MTP I covered the period 1992-1998. Its purpose was to contain the spread of HIV/AIDS and reduce its impact on individuals and society. At this stage, the concept of a multi-sectoral approach to HIV/AIDS began to gain favor, although the HIV/AIDS response remained fundamentally led by the Ministry of Health, while some organizations implemented prevention activities with the support of NACP.

A review of MTP I conducted in 1997 found the following: extensive awareness campaigns had been undertaken to positive effect, there was political commitment to a national response, and management

6 UNDP, 2001/2002.
7 Amadhila L,"2002 HIV Sero-Survey 2002: Results of the Survey in Pregnant Women," Minister of Health and Social Services, Government of Namibia, Cabinet Briefing, 28, 2002.
8 National Planning Commission, 2004.
9 National Planning Commission, 2004:25.
10 National Planning Commission, 2004:26 and MoHSS, 2002.

structures were in place to scale-up the national response. The recommendations focused on the further development of programme management; conducting more targeted information, education and communication campaigns; and strengthening multisectoral involvement. A National Response Plan was formulated as MTP II. Developed and launched in 1999, MTP II covered the period 1999-2004. MTP II led to the establishment of the National AIDS Coordination Programme, replacing the NACP.

MTP II had six objectives for the National AIDS Coordination Programme:

1. Reduce the number of HIV infections in both adults and children.
2. Ensure that all Namibians living with HIV/AIDS and their families have access to services that are affordable, of high quality and responsive to their needs.
3. Empower individuals, families and community members with knowledge and skills related to prevention, home-based care and self-protection against HIV/AIDS.
4. Ensure that all Namibians living with HIV/AIDS and their families are not subjected to any form of discrimination.
5. Establish national and regional programme management structures for the coordination and monitoring of the implementation of the national response.
6. Ensure continuous support by both the national and international communities to address the socio-economic impact of HIV/AIDS.

MTP II broadened the framework for the AIDS response beyond a purely national bio-medical model to encompass national multisectoral and sub-regional responses to HIV/AIDS. It required the involvement of all sectors—strengthening the capacity of regional councils and local authorities to coordinate, manage and monitor HIV/AIDS. It established partnerships with private sector and civil society bodies to implement programmes.

NDP II complements the strategies and targets of MTP II. In 2003, the MTP II and NDP II targets were brought in line with the indicators developed for the Global Fund to Fight AIDS, TB and Malaria applications during a roundtable meeting with donors.

In 2003, MTP II was reviewed with the support of UNDP. The review highlighted some successes and weaknesses. The problems identified included: relatively weak structures, systems and processes at central and sub-regional levels; slow formulation of policies and laws; limited capacities for HIV/AIDS and tuberculosis programme planning, implementation and management at all levels; poor and/or lack of systematic mainstreaming of HIV/AIDS, manifested in an under-developed multi-sectoral response; uncertain financial flows and pipeline blockages, especially to sub-regional levels; and uncoordinated research to inform strategies. It was recommended that the identified shortcomings should be addressed in MTP III.

MTP III was developed with the successes and weaknesses of MTP II in mind, and using the MDGs, the UN General Assembly Special Session on HIV/AIDS, the NDP II and the Vision 2030 as guidance. Its main goal is the reduction in HIV incidence to below epidemic levels. MTP III focuses on the following:

- *Creating an enabling environment.* This could result in sustained leadership commitment, greater involvement of people living with HIV/AIDS (PLWHA), policy and law reform, and interventions to reduce stigma and discrimination.

- *Preventing infections.* This could result in strengthening capacity to deliver HIV/AIDS prevention programmes--targeting vulnerable populations, young people, and the general population with specific interventions to reduce their vulnerability.

- *Ensuring access to treatment, care and support services.* This could result in capacity development for expanded treatment, care, and support response, and treatment and care services to those infected and affected by the disease.

- *Mitigating the impact.* This could result in developing capacity for local responses and services for orphans, vulnerable children and PLWHA.

- *Establishing integrated and coordinated programme management at all levels.* This would include programme monitoring and evaluation, surveillance, and operational research in all regions.[11]

11 Government of Namibia, 2004.

For the implementation of MTP III, the following guiding principles were established: HIV/AIDS as a development issue; multisectoral engagement; broad political commitment; civil society involvement; reduction of stigma and discrimination; a continuum from prevention through care; a human rights-based approach; prioritization; good governance, transparency and accountability; access to care; confidentiality and privacy; and responsiveness and flexibility.

Unlike the development of MTP II, where little consultation was undertaken, the approach in developing MTP III was different. It was realized that the government alone could not achieve an adequate response to the HIV/AIDS pandemic in Namibia. Therefore, organizations and individuals from communities, ministries, parastatals, the private sector, NGOs, faith-based organizations, trade unions, organizations of PLWHA and development partners needed to become more actively involved in the planning and implementation of the response. Wide consultations were held with all sectors in all regions of Namibia for the development of MTP III.

The government assigned the overall responsibility for MTP III preparation to the Permanent Secretary of the MoHSS. The Permanent Secretary was supported by a core group representing all Directorates in the Ministry, the Chair of the UN Theme Group for HIV/AIDS, the Expanded HIV/AIDS Partnership Forum, UNAIDS, and Technical Advisors in the Ministry. The core group reported to the National AIDS Executive Committee, chaired by the Under Secretary for the MoHSS and finally to the Permanent Secretary. Every Ministry, through its Permanent Secretary and its HIV focal persons, was required to call a sector-wide meeting involving all key sector clusters. Each sector developed its own objectives and sector activities for the coming five years. After this process, a draft document was circulated through focal persons and regional AIDS coordinators to all sectors including the UN Theme Group for HIV/AIDS. Their comments were taken into account in the final document. The National Multisectoral AIDS Coordinating Committee and the National AIDS Committee endorsed the final document prior to approval by the Cabinet.

3.2 UNDP RESPONSE

Following Namibia's independence in 1990, the primary focus of UNDP in the country has been on poverty reduction, equity and human capacity development in order to address the legacy of apartheid in the country. It was only in the second UNDP Country Cooperative Framework 2002-2005 for Namibia that UNDP expanded its programme to include HIV/AIDS. UNDP aimed to support the national response to HIV/AIDS and to add value to the existing NDP II, Vision 2030 and MTP II and MTP III for HIV/AIDS.[12] With this programme shift, an HIV/AIDS Unit was established in the country office (CO), to support the UNDP response.

Among its various projects and programmes in Namibia, UNDP has an HIV/AIDS Support Programme. The objective of this Programme is to expand the capacity of national authorities in implementing the response to HIV/AIDS. The expected outcomes are to ensure that national development plans address the impact of HIV/AIDS on the poor, and build and strengthen institutional capacity to plan and implement multisectoral strategies on HIV/AIDS. To a certain degree this has been done. However, more needs to be done, especially on mainstreaming and policy formulation in most sectors in the country.

UNDP has focused on several key actions related to HIV/AIDS, including the following:

- *Creating a decentralized response to HIV/AIDS* in all 13 regions of Namibia. This is intended to move the discourse about HIV/AIDS outside the capital into the rural countryside, where more than 60 percent of the population lives.
- *Pooling together stakeholders* for strengthening and operationalization of multisectoral management, coordination and facilitation at the national level.
- *Supporting the development of the private sector response* to HIV/AIDS, which was done through the National Business Coalition on HIV/AIDS (NABCOA).
- *Establishing an HIV/AIDS Unit in the UNDP CO* in 2002 to provide policy and technical support to programme components and implementation. This has made UNDP more visible with wider outreach to various institutions.

12 UNDP, 2001.

- Using its position as the main development programme for the UN to *strengthen the activities of the various United Nations agencies,* with specific emphasis on the HIV/AIDS Theme Group, to operationalize the provisions of NDP II and MTP II.

As Chair of the UN Theme Group on HIV/AIDS, UNDP has assisted Namibia in operationalizing its national response to HIV/AIDS. UNDP interventions enhanced the national institutional capacity (government, NGOs, and private sector) to plan and implement multisectoral strategies to prevent the spread of HIV/AIDS and mitigate its social and economic impact. UNDP Namibia has, to a degree, missed an opportunity by not supporting national academic and research institutions for collaborative preparation, dissemination and application of socio-economic impact and other HIV/AIDS related studies, presumably because the research proposals were qualitatively inadequate. However, it should be noted that in terms of the programme execution modality, the government is responsible for programme implementation. In this respect, a socio-economic study is to be undertaken with additional support from the International Labour Organization. The Government of Namibia has been negotiating with tertiary institutions to conduct such a study, but no agreement could be reached. Furthermore, support is being provided through the Regional Centre to post graduate students for research.

Although UNDP has a specific programme for HIV/AIDS, it also has other programmes that address HIV/AIDS indirectly (see Annex 4). One example is the Poverty Reduction Programme and the land reform component. UNDP planned to facilitate the implementation of an effective land valuation, acquisition and estate management system. This would also help to create and implement a viable tax regime, which is conclusive to providing land and agriculture resources to those living in poverty or vulnerable to poverty in line with other policies and development frameworks for rural development.

After paying relatively little attention to HIV/AIDS for a number of years, towards the end of 2002, UNDP put HIV/AIDS fairly high on its agenda in Namibia. The relationship of UNDP and the government requires consultations by both parties based on the priorities of the country. The NEX modality allows national governments (such as the NPC in Namibia) to take the lead in decision making and in allocating funds to address HIV/AIDS within the framework of the needs of the country. This reflects true national ownership of development priorities.

4. OUTCOME OF UNDP CONTRIBUTIONS AND SUPPORT

This section of the report summarizes the national consultant's findings on the contributions and outcomes of UNDP's HIV/AIDS activities in Namibia under the five main themes of the evaluation: governance in relation to HIV/AIDS, leadership, capacity building, mainstreaming HIV/AIDS into other development activities and sectors, and partnership coordination for country results.

At the time of the evaluation, most of the programmes were only just being implemented or being planned for implementation. It would have been better to evaluate execution and outcomes towards the end of 2005, which was the end of the UNDP programme cycle in Namibia.

4.1 GOVERNANCE

4.1.1 Policy support

As rotating Chair of the UN Theme Group on HIV/AIDS, UNDP played a major role through its programme on HIV/AIDS in facilitating the development of policy and other legal frameworks relating to HIV/AIDS. However, the implementation of these policies and activities has been slow. Sometimes human and institutional capacities and guidelines are not there to facilitate the implementation, and this hinders the effectiveness of the programmes.

National and international volunteer expertise was provided through UNDP's HIV/AIDS Advisor in policy formulation. As a result, Namibia now has a policy related to the HIV/AIDS confidentiality and an MTP III for HIV/AIDS in Namibia. With the good working relationship between the government and UNDP, a current target for UNDP is to help government ministries and other sectors have their own HIV/AIDS policies. At the time of this evaluation, the Ministry of Defence was being helped in drafting its HIV/AIDS policy.

There is a need to train and employ more staff at the NPC to implement agreed upon programmes on

HIV/AIDS. Training for staff in project management and programme implementation would be useful. This problem, however, extends beyond HIV/AIDS issues.

4.1.2 Empowerment of women

UNDP's advocacy on rights and empowerment of women resulted in effective involvement of women in the forefront of the fight against HIV/AIDS. Most of the regional coordinators are women, and women head most community-based organizations. This phenomenon where women hold leadership positions in various non-governmental and governmental organizations is new to Namibia.

4.1.3 Advocacy on human rights

UNDP's support through training, its gender programme, and advocacy work in various local agencies has resulted in increased awareness of the human rights of those infected and affected by HIV/AIDS. Such advocacy is more visible in sectors with workplace programmes on HIV/AIDS.

4.1.4 Public sector management reform

UNDP support for a decentralized capacity building programme that is linked to its overall governance and decentralization thematic areas has enhanced sub-regional capacity for implementing HIV/AIDS programmes. This has led to a greater emphasis on making multisectoral programmes more accessible to the population.

UNDP is currently supporting the Ministry of Environment and Tourism, which is in the process of developing an institutional HIV/AIDS policy that includes educational and well-being programmes for those involved.

Namibia's political leadership has become increasingly concerned about the linkages between youth unemployment and HIV/AIDS and poverty. Political leaders have stressed the importance of skills development to tackle poverty. During the consultations for this evaluation, poverty was singled out as the root cause of vulnerability to HIV infection.

4.1.5 Community mobilization and involvement

UNDP's support, in addition to the support of other development partners, has resulted in effective community actions to respond to HIV/AIDS. This has been observed in increasing numbers of NGOs and faith-based organizations providing home based care and counseling to those infected and affected by the disease.

4.1.6 Civil society support

UNDP's support to civil society organizations has enabled them to carry out their activities. An example is Lironga Eparu,[13] which provides home care and training on self care to families and individuals infected and affected by HIV/AIDS, especially those who are rejected by their significant others because they have contracted the disease.

4.1.7 Decentralized response

UNDP was instrumental in decentralization of the HIV/AIDS response through its Programme on Decentralization of HIV/AIDS Response. This Programme included the recruitment of HIV/AIDS regional coordinators, who are now well vested with their responsibilities. The HIV/AIDS regional coordinators have good communication with local NGOs and faith-based organizations, which provide home based care at village level. Thus the decentralization has improved the HIV/AIDS information flow from central to sub-regional levels.

UNDP trained and paid all 13 regional HIV/AIDS coordinators when the project started. This funding activity has been taken over by the Ministry of Regional and Local Government and Rural Development. The coordinators are tasked with mainstreaming of HIV/AIDS in all government structures at the regional and sub-regional levels. However, UNDP as an agency has no direct or visible activities at the district level. The regional HIV/AIDS coordinator has established similar coordinators at the district level who work with the district development committees at constituency levels.

Regional HIV/AIDS coordinators are now being consulted as lead figures in their regions and give direction on what activities are to be undertaken in consultation with their community members. Community education on HIV/AIDS is maximized and HIV/AIDS counselors are in almost every district. To a degree, the rights of PLWHA are respected and understood at the community level. However, some respondents felt that there is need for UNDP to help redefine the roles of the HIV/AIDS regional coordinators because they are now expected

13 Lironga Eparu is an organization for people living with HIV/AIDS in Namibia. It has branches in almost all regions in Namibia.

to perform many activities, from setting up work plans to giving health education. In addition, although community members are generally well informed about HIV/AIDS facts, this does not always lead to change in behaviour.

4.1.8 Public-private partnerships

UNDP has a programme of support to public-private partnerships for the urban environment. The objective of this programme is to increase the access of the urban poor to basic environmental services by facilitating partnerships between the public sector, the business community, and the larger society. This development contributes to a healthy environment and the improvement of the living conditions in the peri-urban and urban areas of Namibia. This programme expects to:

- Produce preliminary guidelines and guiding principles for pro-poor public-private partnerships based on policy and legislation reviews.
- Design training modules and supporting tools, as well as conduct training courses at municipal level.
- Develop partnership strategies and select suitable projects within at least five municipalities.
- Develop business plans for at least five public-private partnership projects.
- Develop local legal framework, financing and contractual arrangements for the implementation of public-private partnership projects in the selected municipalities.

Through this programme, governance and service delivery is combined with strengthening the roles of local authorities. This takes place within the framework of decentralization and poverty reduction as a key concern for the national government. UNDP has a project with the Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICAALL) that focuses on five local authorities. This project provides local authorities with technical assistance and mentoring in order to enable them to assess the impact of HIV/AIDS on their service delivery abilities and on their source of revenue if communities are unable to pay for service deliveries. As a measure of progress, UNDP supported each local authority in developing and launching five-year plans before the end of 2005. The end result is a toolkit that could be applied at the local and regional level. Plans are underway to incorporate the toolkit in the polytechnic and university programmes for public administration candidates. This is considered a best practice. In addition, plans are underway to integrate the toolkit within the ongoing Public Private Partnership for the Urban Environment (PPPUE) Programme.

4.2 LEADERSHIP FOR DEVELOPMENT

4.2.1 Strong leadership on HIV/AIDS

As rotating Chair of the HIV/AIDS Theme Group, UNDP's contributions, together with other development partners, to the development of MTP III resulted in a decision to appoint focal persons for HIV/AIDS in all government ministries. NGOs and private sector enterprises are expected to follow. However, this is still in the process of implementation.

With a grant from UNDP, NABCOA became a leading agency in the business community. NABCOA has developed and is providing toolkits to the business communities. It is assisting firms in creating awareness and training employees. Although NABCOA claims that the budget from UNDP is not sufficient to implement all the activities that they have planned, the toolkits they developed are generating funds for the organization to be able to produce more toolkits and sell to other business institutions.

AMICAALL has also become a leading agency among the local authorities in relation to HIV/AIDS. It is currently in the process of developing a toolkit to be used by local authorities in the assessment of the socio-economic impact in their constituencies. This is a result of the assistance provided by UNDP.

4.3 CAPACITY DEVELOPMENT

4.3.1 Human resource development

UNDP's main capacity building achievement has been advocacy for human development through the national human development reports. Its advocacy has facilitated training of a variety of professionals in Namibia. Through the Regional HIV/AIDS Project, UNDP Pretoria facilitated training for some staff of the University of Namibia on mainstreaming. These trained personnel were then tasked to offer a core course on HIV/AIDS. The course was introduced at the University of Namibia for all first-year students in 2003. Trained University of Namibia staff are expected to train others in mainstreaming HIV/AIDS in all University programmes and activities.

Although most of the trained staff are now serving as resource persons at the University, some have been absorbed in NGOs. Unfortunately, this training was a one-time exercise and some of the trained people are not being used to the fullest at the University.

Although UNDP has made strides in reaching out to the highest levels of government by providing training to the government accounting officers in budgeting, HIV/AIDS impact assessment and general advocacy, it was not easy to assess the impact of such training. This needs follow-up. UNDP should put in place a monitoring and evaluation system to assess the impact of such training. In addition, UNDP has no representation at the inter-ministerial committee, which would enable UNDP to reach each ministry. If UNDP had representation on the inter-ministerial committee, it would have a better chance to open dialogue on policy issues at a high level of government and possibly facilitate better HIV/AIDS policy guidance to the government.

UNDP support resulted in increased awareness of HIV/AIDS as well as in increased knowledge on research and project management among municipal officials and NGO staff. Through such support, municipalities have taken up the mandate to reach out to communities and introduce home based care in their municipal areas. AMICAALL officials are now able to conduct research on HIV/AIDS, and have developed a training toolkit to be used by municipal employees. It has also introduced an outreach programme in some municipalities and each municipality is in the process of appointing an HIV/AIDS Focal Person in their institutions.

4.3.2 United Nations Volunteer (UNV) Programme

To help the Government of Namibia achieve its development and poverty reduction objectives, UNDP addressed the critical shortage of qualified professionals by providing human resources in the areas of poverty reduction and decentralization, and health services. This included support for HIV/AIDS and education training. Through its UNV Programme, UNDP was supposed to provide 1,070 international and national UNVs, half of whom were to be national UNVs. However, only approximately USD 200,000 was mobilized to recruit the UNVs for the period under review. This inadequate funding has hampered the UNV Programme, which resulted in fewer opportunities for national and international UNV recruitment. UNDP has recruited only 18 volunteers—7 international and 11 national—who are functioning at various levels of the government.

The impact of the UNV programme was not as expected. The programme needs to be revisited and strengthened with enough funds to enable it to address the shortage of capable human resources for the country. While not all of the 1,070 UNVs were to work on HIV/AIDS, this delay in recruitment represents a missed opportunity, as it became difficult to meet some of the programme goals. However, it should be noted that UNDP can only recruit if requests for recruitment are received and if funding is made available by the Government of Namibia.

4.4 MAINSTREAMING HIV/AIDS

4.4.1 Multisectoral response

As Chair of the UN Theme Group on HIV/AIDS, UNDP has played an instrumental role in facilitating effective actions by UN agencies for the multisectoral response to HIV/AIDS. This includes guidance, consultations and resource mobilization.

In the business community, some businesses have addressed HIV/AIDS as an important issue. NamPower, a member of NABCOA, included HIV/AIDS as part of the package of medical aid for all its workers and as part of its workplace programme, although it is hard to confirm that this happened because of NABCOA's activities. Nambia Communications Commission (NCC) and the Walvis Bay Corridor have benefited from the toolkits developed by NABCOA.

In the education sector, a curriculum is now in place for upper primary and junior secondary schools in Namibia that includes elements on HIV/AIDS in the Life Sciences subject. Some teachers have been trained in HIV/AIDS topics and are teaching students. However, it is difficult to determine the impact on the students or teachers who were trained, as no impact assessment has been done.

In the government, the Global Partnership Forum on HIV/AIDS has influenced government programmes to mainstream HIV/AIDS, but this is still in its early stages. In addition, UNDP has assisted the government in determining the impact of HIV/AIDS

on land reform. With the Land Reform Programme's emphasis on Land Tax, the government is trying to redistribute land to Namibians and, through this, empower communities economically and ensure food security, especially at household level.

One opportunity for mainstreaming that UNDP took full advantage of was a meeting of UNDP with the permanent secretaries. At this meeting, UNDP explained to the officers the importance of mainstreaming HIV/AIDS into all government structures and programmes. UNDP also used the opportunity to sensitize the officers to the financial implications of such a move. However, this seemed to have benefited only the individual officers because, although each ministry is now required to appoint an HIV/AIDS focal person, such persons are not relieved from other duties in the ministry/sector, nor are they given resources—such as budget, time, and support from senior management—to implement the activities set out in the MTP III.

4.4.2 Workplace programme

With UNDP support through the HIV/AIDS Programme, businesses have helped create awareness among employees using toolkits developed by NABCOA. The same is likely to happen with the toolkit developed by AMICAALL for local authorities to enable them to conduct their own socio-economic impact assessments among their employees.

The Workplace Programme has become an important issue in many areas in the government and business sectors. However, its effects remain to be seen. To ensure full implementation of the Workplace Programme as stated in the MTP III, UNDP should encourage the Prime Minister's Office to strengthen and give direction to the Workplace Programme in various settings.

The persons assigned to the Workplace Programme have other normal duties in addition to this assignment. Thus, the emphasis in their activity is not on the Workplace Programme but on their main functions.

UNDP has a Workplace Programme in place that does a good job of catering to its employees. The employees at UNDP talk freely about HIV/AIDS and the experiences they have with the disease. However, the officer responsible for it is a finance administrator who has limited time to devote to the Programme because of other responsibilities in the finance department. This is not a sign of commitment from the CO, although it has recently recruited an officer to run the 'We Care' Programme to take care of the Workplace Programme. The support to translate this commitment into action is still limited.

Some of the activities run by the Workplace Programme include the facilitation of behavioural change, where people are invited to speak to the UNDP workers or show videos or presentations. UNDP has what they call 'week a day' when the workers conduct activities related to HIV/AIDS. With a UN HIV/AIDS booklet that is given to all workers, UNDP is disseminating information to their workers and their families and friends. Staff are encouraged to adopt the practice of knowing their HIV status.

4.5 PARTNERSHIP COORDINATION FOR COUNTRY RESULTS

Through the CO and the President's HIV/AIDS Fund, UNDP supported the acceleration of the multisectoral implementation of MTP II (the National Strategic Plan on HIV/AIDS). This included strategic training to the National AIDS Executive Committee, technical support to determine the cost of carrying out the National AIDS Strategy, and the development of a communication strategy. It is worth noting that the President's HIV/AIDS Fund helped mobilize the private sector for HIV/AIDS prevention and care.

Many of the sectors targeted have HIV/AIDS policies and provide access to treatment for workers. They have also developed sector plans for the private sector. A UNDP project also aimed to raise awareness for the implementation of the national code on HIV/AIDS and employment. Seed funding came from UNAIDS, but additional resources were raised through Family Health International, the Theme Group, UNICEF and the private sector.

UNDP's partnership with the business community has been growing steadily. This resulted in the formation of NABCOA in May 2003, co-sponsored by UNAIDS with NAD 400,000 as seed funding. NABCOA is now creating awareness among its members in the business arena, and it has developed a toolkit for business organizations on HIV/AIDS. This toolkit is being ordered by many members and non-members of the organization to train their

employees. NABCOA claims that they would not be able to do the work that they are currently doing without support from UNDP and UNAIDS. NABCOA is now tasked to review the activities of the private sector in relation to HIV/AIDS.

4.6 AIDS SPENDING IN NAMIBIA

Both the Government of Namibia and UNDP have increased their budget allocations to HIV/AIDS activities between 2002 and 2007 (see Annex 4). However, it was indicated during this evaluation that UNDP's budget for HIV/AIDS has not always been fully used, although there have been claims that the funds are not available. This could be due to the delays in activities or failure to identify projects for allocated funds.

4.7 CHALLENGES AFFECTING UNDP RESPONSE

4.7.1 Resources

The lack of adequate financial and human resources at the UNDP CO and at NPC make it very difficult for UNDP and NPC to respond as expected. The lack of needed resources (money and qualified professionals) to run various programmes hinders progress and implementation of projects and policies.

4.7.2 Political commitment

Although the government has expressed its concern over HIV/AIDS, the implementation of the National Strategic Plan has been difficult in most sectors due to limited political commitment. Based on a telephone survey to determine if ministries had specific budgets for HIV/AIDS, this evaluation did not come across a single government ministry with a focused budget for HIV/AIDS activities except for the MoHSS. This is a sign of limited commitment from management. Focal persons appointed for HIV/AIDS are still undertaking these activities as added functions rather than as their principal task. This is the case in almost all sectors and institutions, including NPC and the UNDP CO. The same goes for Workplace Programme activities.

4.7.3 Policy frameworks

Although policies are in place, in most cases, there are no institutional mechanisms for their implementation due to lack of technical know-how and shortage of other resources.

NPC is overburdened with multiple programme implementation and coordination strategies and responsibilities. This resulted in missed deadlines and delayed programme implementation. There is need to review and structure the activities and responsibilities in NPC related to HIV/AIDS to improve the situation.

4.7.4 Comparative advantage of UNDP

Some respondents expressed the view that UNDP does not have much comparative advantage at all. With funds drying up, the UN agencies have developed a new system of business processes. They intend working as a system rather than as individual agencies. In the future, they expect to integrate their activities and may share funds.

In addition, some respondents did not have a clear understanding of the role of UNDP. Those who knew UNDP's role indicated that UNDP has an advantage over others because resources are sometimes channeled through it when addressing national programmes. Some UN agencies and entities and other development partners channel their development assistance to the government through UNDP. This is the case, for example, of UNAIDS and the Swedish International Development Agency (SIDA).

Until 2004, UNDP was the Chair of the UN Theme Group on HIV/AIDS in Namibia. The UN Resident Coordinator is housed within UNDP. This facilitated the engagement with other agencies and made it possible for UNDP to convince others as to what assistance the government requires in relation to HIV/AIDS. This positioning of UNDP facilitated advocacy for the mainstreaming of HIV/AIDS into all development programmes.

Through its poverty programme, UNDP has created linkages with civil society organizations and advocates for the rights of the vulnerable. It also has linkages with other UN agencies. However, it has capacity restrictions. It works with the local authorities and helps them with the decentralization of the response through AMICAALL. Various workshops were conducted to mainstream HIV/AIDS into the Government of Namibia's poverty programmes.

Informants felt that UNDP strikes a good balance between HIV/AIDS and other key development issues. The government policy is clear that all programmes should mainstream HIV/AIDS into

their activities and that the UNDP should provide assistance in accordance with government priorities. Examples include the regional poverty assessment profile in Ohangwena and the first report on the MDGs, both launched in 2004. There are frequently overlaps with other agencies' in-country programmes that address the same issues.

It should be noted that, despite the many UNDP training activities and workshops, assessments were not undertaken to determine the impact of such activities. This makes it hard to judge their impact. However, the workshop on Mainstreaming HIV/AIDS into Governance and Decentralization resulted in a number of local authorities starting to develop their own policies, and a key result of another related workshop was the mainstreaming of HIV/AIDS into the Poverty Reduction Action Plan.

4.7.5 Missed opportunities

While UNDP has provided support to the HIV/AIDS response, there were some missed opportunities. For example, consultations for this evaluation noted that UNDP just seeks results, but the implementation lies with NPC. Some results or projects are delayed and UNDP cannot do much about this, because it is the NPC's role to carry out projects. For example, the planned socio-economic impact assessment was delayed due to lack of human capacity at NPC (and lack of reaching an agreement between institutions as stated earlier). NPC needs a focal person whose sole responsibility is the administration of projects. The current assistant administrator is helping, but there is no staff at the NPC conversant with the UN system and project management procedures. Although all officers working with UNDP in various sectors received training on NEX, this training needs to be repeated due to staff mobility.

4.7.6 Limited UNDP CO human capacity

Lack of human resources in the UNDP CO has weakened UNDP HIV/AIDS activities in many respects. Staff turnover in the CO has resulted in staff shortages, especially due to low salaries. Also, the three-to-five year limited term of international staff disrupts continuity, especially for Resident Representatives. The HIV/AIDS Unit has been without an officer for more than eight months. This hinders progress in the UNDP response, as the individual standing in also has other responsibilities in the CO.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

While it is difficult to distinguish between UNDP and other UN agency and programme support, one can conclude that UNDP assistance in the fight against HIV/AIDS in Namibia has been both relevant and effective. Some respondents noted that it would be 'disastrous' if UNDP was not involved. Others could not imagine how UNDP could not be involved as it is a development agency and HIV/AIDS is a development issue. However, implementation has been slow.

A number of opportunities placed UNDP at an advantage as it implemented its 2002-2005 Country Cooperation Framework in Namibia. UNDP has higher-level access to the government at the country level and has contributed to the establishment and operation of a number of HIV/AIDS institutions.

Other notable contributions include support to the decentralization of the response to HIV/AIDS. UNDP has played a cardinal role in the decentralization of the response. This increased the flow of information to the sub-regions and the engagement of women.

UNDP seems to be working hard to build partnerships with the business community and municipal entities, which are demonstrating capacity to respond effectively to the disease. UNDP needs to continue to provide funding to these institutions. Although partnership with the private sector has been established, it needs to be expanded to NGOs.

A further UNDP contribution is increased involvement of all sectors in the fight against HIV/AIDS, as stipulated in MTP III.

The ordinary community member does not have knowledge of UNDP, and the role of UNDP. This needs to be addressed by UNDP's CO. It could be assigned to the sectors/organizations assisted by UNDP to explain to their communities who made it possible for them to reach out to the communities.

5.2 RECOMMENDATIONS

UNDP should build substantive capacity in the CO in order to meet the challenges it experiences. Possible future actions include the following.

- The HIV/AIDS Unit at the CO needs to be staffed. There is also a need for UNDP to improve its communication strategy so that community members become familiar with its roles in Namibia.

- UNDP needs to increase its budget for human capacity development to help the government and other sectors alleviate the shortage of qualified staff for HIV/AIDS activities.

- UNDP needs to strengthen its discourse with public authorities in all sectors to facilitate mainstreaming of HIV/AIDS in all development projects. It needs to work closely with the Office of the Prime Minister as the head of the public sector in Namibia.

- UNDP should make it its business to ensure that all sectors have a functioning HIV/AIDS workplace programme so that the human rights of those infected with and affected by the disease are respected and protected.

- The AIDS impact assessment study should be carried out as planned. If necessary, UNDP should facilitate implementation of the study.

- The government-UNDP relationship should be reviewed and strengthened, especially the use of financial support for HIV/AIDS. The two parties could agree on a timeframe for implementation of specific projects to avoid delays. Where the government cannot implement activities, UNDP could contract out the assignments in consultation with the government.

- UNDP should strengthen monitoring and evaluation of its AIDS-related work in Namibia by helping institutions put such systems in place. UNDP should then facilitate their use. Among other matters, it should conduct an assessment study to evaluate the impact of its HIV/AIDS-related training. It should also facilitate the evaluation of the effectiveness of the decentralization of the HIV/AIDS response to regions and sub-regions.

ANNEX 1. ACRONYMS AND ABBREVIATIONS

AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
CO	Country Office
MDG	Millennium Development Goal
MoHSS	Ministry of Health and Social Services
MTP	Medium Term Plan
NABCOA	Namibia Business Coalition on AIDS
NACP	National AIDS Control Programme
NDP	National Development Plan
NGO	Non-governmental Organization
NPC	National Planning Commission
PLWHA	People Living With HIV/AIDS
UNV	United Nations Volunteers

ANNEX 2. REFERENCES

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ANNEX 3. PEOPLE INTERVIEWED

GOVERNMENT OF NAMIBIA, CIVIL SOCIETY AND OTHER

Dr. Norbert Foster, Under Secretary, MoHSS
Professor B. Otaala, University Focal Person for HIV/AIDS Task Force
Tara Shaanika, CEO, Namibia Chambers of Commerce and Industry
Moderata Shaduka, AMICAALL
Vekondja Tjikuzu, Deputy Director in NPC
Peter van Wyk, NABCOA
Inge Zaamwani, President of Namibia Chambers of Commerce and Industry

UNDP

Tamba Baldeh, Deputy Resident Representative
Melanky Farmer, HIV/AIDS Workplace Programme Officer and Accountant
Melinda Maasdorp, Head, HIV/AIDS and Poverty Unit

BILATERAL DONORS

Rushmann, UNICEF Programme Officer
Salvador, UNAIDS Country Representative
United Nations Population Fund, Country Representative

ANNEX 4. FINANCIAL RESOURCES FOR HIV/AIDS RESPONSE

TABLE A1. GOVERNMENT AND UNDP FUNDING OF HIV/AIDS PROGRAMMES IN NAMIBIA

	2002/3	2003/4	2004/5	2005/6	2006/7
Government of Namibia	NAD 4,506,000	NAD 4,729, 000	NAD 645,959,773	NAD 716,888,083	NAD 765,638,389
UNDP	USD 340,000 for three years				

Source: MTP II, 1999 and MTP III, 2004-2009.

TABLE A2. UNDP COUNTRY OFFICE HIV/AIDS PROGRAMME

Expected Outputs	Responsible Partner	Source of Funds (USD)	Amount of Funds (USD)	Gap (USD)
Socio-economic impact study conducted	Government	TRAC	160,000	
Capacity built at national and sub national level	Government	TRAC	70,000	
Support to decentralized response strengthened	Government	TRAC	5,000	
Support and build academic institutions capacity	UNAM	TRAC	25,000	
Private sector capacity built	NABCOA	TRAC	40,000	
Total			**340,000**	**40,000**

TABLE A3. POVERTY REDUCTION PROGRAMME

Expected Outputs	Responsible Partner	Source of Funds	Amount of Funds (USD)	Gap (USD)
Measurement of policy and programme performance in the reduction of poverty	**NPCS**	**UNDP**	**309, 920**	
		TTF	70,000	
		ORC	15,000	
			394,920	
Improvement in overall capacity in achieving its priority development and poverty reduction	**NPCS**	**UNDP**	**130,000**	
Enhancement of the capacity of the Ministry of Lands, Resettlement and Rehabilitation to implement an effective land valuation; acquisition and estate management system	**MLRR**	**UNDP**	**139,080**	**113,600**
Identification of gaps in the creation of enabling environment for private entrepreneurship	**Replaced by Vision 2030 formulation at NPCS**	**UNDP**	**18,000**	
Other project support activities		**UNDP**	**28,000**	
		UNDP	12,000	
		ORC	40,000	
Total			**722,000**	

Notes: Under the HIV/AIDS budget, the money assigned to assist University of Namibia was never given to the institution at all up to the day of evaluation (2004). Although the overall budget seemed very small, it was also not fully utilized for the programme as assigned. At the same time, however, the budget was not adequately earmarked for HIV/AIDS. In addition, the current programme cycle was only expected to end in 2005 and all funds were expected to be disbursed accordingly by the end of the cycle

TABLE A4. ENVIRONMENT PROGRAMME

Expected Outputs	Responsible Partner	Source of Funds	Amount (USD)
Sustainable land management	MET in collaboration with MLRR and MAWRD	TRAC GEF	40,000
Conservation and sustainable use of biodiversity	MET	TRAC GEF	40,000
Frameworks and strategies for sustainable development	MRLGH	TRAC TTF EU	10,000
Frameworks and strategies for sustainable development	MET	TRAC GEF	5,000
Cross cutting	NNF	TRAC GEF	5,000
Total core funds			**100,000**

Source: UNDP report 2002-2005.

SOUTH AFRICA COUNTRY STUDY

HIV/AIDS

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

By Shaun Samuel and Sulley Gariba

The authors thank the UNDP Country Office South Africa for the invaluable help it provided.

SOUTH AFRICA

CONTENTS SOUTH AFRICA COUNTRY STUDY

Boxes, tables and figures

1. INTRODUCTION AND COUNTRY BACKGROUND

1.1 METHODOLOGY

This report is the synthesis of the key findings and recommendations of the country-level assessment of UNDP's contribution to the national response to HIV/AIDS in South Africa. The key findings are grouped according to the following themes: governance, capacity building, leadership, partnership coordination for development results, and mainstreaming HIV/AIDS in poverty reduction and development efforts.

The evaluation included country case studies that assessed UNDP's experiences and encouraged stakeholders to reflect on outcomes and lessons learned as a result of UNDP's support for programming in HIV/AIDS. The report was also informed by the views and contributions of the international team that visited South Africa for a week in January 2005 to assist in processing and validating the key findings through a series of interviews with select respondents and site visits. Finally, a validation workshop was held with key stakeholders that further shaped the findings, analyses and conclusions in this report.

The international team visited South Africa to interview key members of the government, donor agencies, non-governmental organizations (NGOs) and civil society groups in order to enrich the national consultant's work on assessing UNDP's role in the HIV/AIDS response in South Africa. The team also supported the analysis and validation of the evaluation's key findings, and provided feedback to the UNDP Country Team and guidance to the national consultant in completing the assignment. The validation workshop, where findings and conclusions were processed and refined, involved key stakeholders of the UNDP. Annex 2 to this chapter indicates the list of references used, and Annex 3 indicates the list of the list of informants used.

1.2 COUNTRY BACKGROUND

South Africa is a country rich in diversity. Its people, their cultures and traditions, and its natural beauty and wildlife constitute some of the aspects that make it a 'rainbow country' in the true sense of the word. Democracy (as young as it is) has seen South Africa redefining itself as an African country and not a colonial outpost. This has resulted in the country supporting important initiatives such as the New Partnership for Africa's Development and the formation of the African Union. It has also seen major cities, such as Johannesburg, recognizing the important role that South Africa plays in the region and preparing themselves to be major regional trading and service hubs.

The past 10 years of freedom in South Africa demonstrate significant changes and improvements in the lives of South Africans. The legacy of apartheid was indicative of a society divided along racial lines and the social exclusion and neglect of the majority as a matter of state policy. Ten years later,[1] significant improvements are evident—notwithstanding the fact that South Africa still has a long way to go to adequately address the needs of the majority. For example, social grants that were formerly allocated on a racial basis have been extended to all who are in need and eligible, and beneficiaries have increased from 2.6 million in 1994 to 7.9 million in 2004. Primary healthcare has expanded with free healthcare for children under the age of six years and women. The integrated nutrition programme that reached 89 percent of the targeted recipients in 1994 now reaches 94 percent, or 4.58 million children. Government policies have freed resources for social expenditure by reducing the interest on debt. The country has a Gross Domestic Product (GDP) of USD 130 billion and a per capita GDP of USD 3,160—ranking South Africa as a lower middle-income country.[2] The budget deficit fell from 9.5 percent in 1993 to 1 percent in 2002-2003, and public-sector debt fell from 60 percent to 50 percent. Investment has been low (16 to 17 percent of GDP) compared with successful developing countries, but it has begun to improve in the last three years.

Despite the improvements, there are still significant challenges facing the country. The World Bank suggests that South Africa is really two societies in one: a largely white society constituting 13 percent of the total population that is First World in every sense; and an overwhelmingly African society constituting 53 percent of the population that is living in conditions of abject poverty.

1 Government of South Africa, "Towards Ten Years of Freedom, 2003" available at: http://www.10years.gov.za/.

2 Human Sciences Research Council (HSRC), "South Africa, 2003" available at: http://www.hsrcpublishers.co.za/user_uploads/tbl/PDF/1924_04_Financing.

According to the 2003 Human Development Report,[3] approximately 48 percent of the South African population of 46 million people falls below the national poverty line. Income distribution remains highly unequal, with a Gini coefficient of 0.635 in 2001. The human development index declined from 0.73 in 1995 to 0.67 in 2003. The economy provided 11.56 million jobs for 16.81 million economically active South Africans in March 2003—resulting in 5.25 million unemployed people or a 31.2 percent unemployment rate. The 2003 Human Development Report introduced the Service Deprivation Index, which measures the backlog of deprivation in several dimensions of basic services. This index shows that the number of households deprived of access to good basic services between 1996 and 2001 increased from 5.68 million to 7.24 million. This implies that 65 percent of the total population was deprived of access to good basic services during the period of 1996 to 2001.

South Africa faces the same challenges as other developing countries in achieving economic growth and poverty alleviation without environmental degradation. Access to resources such as water, energy, proper sanitation and waste removal are critical to development. This was clearly recognized in the Reconstruction and Development Programme that was adopted by the African National Congress in 1994 as a policy framework to guide it in transforming South Africa from a divided society to one that provides equal opportunities for all its citizens. However, current poverty and inequality are reflective of strong spatial and racial biases.

South Africa is yet to produce a progress report on achieving the Millennium Development Goals (MDGs). The MDGs were put on the national development agenda at the time the government was compiling its Ten-Year Review in 2003. The Review was seen as a priority over the production of a MDG report.[4] In March 2004, Statistics South Africa was nominated as the lead agency responsible for producing the MDG report. The processes have been slowed by weak capacity of the lead agency, plus the tensions created between the UNDP and the Government of South Africa by the release of the 2003 Human Development Report. Despite these difficulties, eight baseline MDG reports (through the assistance of the UNDP) are currently being synthesized, forming the basis of the first national MDG report, scheduled for completion by June 2005.

Unofficially, according to a report released by the government's Social Sector Cluster, "South Africa is well on its way to meet all of the Millennium Development Goals (MDGs) and targets ahead of 2015."[5] The published article notes progress with reference to addressing extreme poverty through the social grant system. Social grants increased from ZAR 10 billion in 1994 to ZAR 37.1 billion in 2004, now benefiting 7.9 million people (as opposed to 2.6 million). The proportion of households with access to clean water increased from 60 percent in 1995 to 85 percent in 2003, while access to sanitation increased from 49 percent in 1994 to 63 percent in 2003. With reference to housing, 1.74 million units were built between April 1994 and March 2005. In the case of universal primary education, a steady increase in enrolment of boys and girls has been noted between 1999 and 2002, increasing from 150,000 to 280,000. There has been a significant increase in state funding to fight HIV/AIDS and the adoption of a treatment plan that is possibly the largest in the world.

The confidence in declaring that the targets may be met ahead of time comes from the fact that the new government set targets (immediately post 1994) similar to those in the 2000 Millennium Declaration. Despite this and the noteworthy gains, the reporting on MDGs obviously depends on the quality, coherence and interpretation of existing data. The Minister of Health Dr. Tshabalala-Msimang was quoted as saying, "while the immunization rate for the country stood at 82 percent, certain districts in the Eastern Cape and KwaZulu Natal has [sic] coverage rates as low as 40 percent." This problem of national averages masking provincial and intra-provincial variation is a problem faced by each goal area of the MDGs.

2. HIV/AIDS SITUATION

HIV/AIDS in South Africa was first identified among gay white males in 1983. The number of infected was less than 1,000. In 1990, the first survey

3 UNDP South Africa, "South Africa Human Development Report, 'The challenge of Sustainable Development: Unlocking People's Creativity'," Oxford University Press, 2003.

4 UNDP, "MDG Processes in South Africa, Briefing Notes: March 2004 – January 2005."

5 "South Africa on course to meet MDGs target," published 05/09/2005, available at: http://www.sagoodnews.co.za/search/benchmarking/480682.htm

was carried out to establish HIV prevalence in the South African population, and 0.8 percent of women attending the state antenatal clinics were HIV positive. According to a 2002 survey, 26.5 percent of pregnant women tested were HIV infected.[6] However, the accurate estimation of the impact of HIV/AIDS in South Africa is highly contested. Figures generated by the 2002 Antenatal Clinic survey suggest that there were 5.3 million infections by the end of 2002. This is a higher estimate than the 2002 population-based survey done by the Human Sciences Research Council that found that 4.69 million or 11.4 percent of South Africans over the age of two years were living with HIV. This discrepancy has been the subject of much contention—detracting from the fact that South Africa faces a major crisis and challenge in fighting the epidemic.

National indicators for 2004 were released by the Centre for Actuarial Research at the University of Cape Town in conjunction with the Burden of Disease Research Unit of the Medical Research Council and the AIDS Committee of the Actuarial Society of South Africa.[7] These indicators suggest the following:

- Five million, or 11 percent of a total population of 46 million people, are infected with HIV. A further breakdown of this statistic shows the following regarding HIV prevalence:
  - 18.1 percent of those infected are adults aged 18 to 64 years
  - 10.8 percent are youth aged 15 to 24 years
  - 1.7 percent are children aged zero to 14 years
- Of a total estimate of 701,000 deaths in 2002, 310,000 or 41 percent were due to AIDS.
- In the absence of antiretroviral therapy, deaths will rise to half a million by 2010.
- Life expectancy is currently 50 years.
- There are more than one million orphans under the age of 18 years.
- At least half a million people infected with HIV/AIDS are in desperate need of antiretroviral therapy.

In addition to the above indicators, the same report reflected indicators of prevention and treatment. The following were noted:

- 33,000 people are currently receiving treatment in the public sector.[8] This falls short of the government's projected target commitment of 53,000 by the year 2005.
- 302 million male condoms and 190,000 female condoms were distributed by the Health Department during 2003.
- The percentage of facilities providing prevention of mother to child transmission has increased from 20 percent to 52 percent in 2003.
- The numbers of people counselled for testing in the public sector has risen from 413,000 in 2002-2003 to 691,000 in 2003-2004.

Outcomes of the Nelson Mandela/Human Sciences Research Council study of HIV/AIDS[9] concur that approximately five million people are infected with HIV, that South Africa has a serious HIV/AIDS epidemic, that accurate information and a comprehensive understanding of the epidemic is needed to deal effectively with the problem, and that it is critical to understand the social, cultural, political and economic context that contributes to vulnerability to HIV infections.

An area of major contention refers to the attribution of AIDS to the death toll in South Africa. Researchers backed by the Medical Research Council have discovered that most AIDS deaths are misclassified because of the stigma attached to the disease. Death certificates seem to omit any mention of AIDS as the cause of death, implying that the death toll of 310,000 deaths could be nearly three times the official government statistic. This figure is close to the estimate provided by the Actuarial Society report and in line with the UNAIDS estimate as well. In support of the aforementioned, the media in South Africa is currently carrying a number of stories and reactions under headlines such as 'AIDS deaths spiralling out of control'.

The above factors are all contested and have become highly politicized, especially in relation to the

6 Whiteside A, "Economic and Development Issues Around HIV/AIDS," Presentation at the 50th Anniversary Conference Reviewing the First Decade of Development and Democracy in South Africa, School of Development Studies, KZN, October 2004.

7 Dorrington RE, Bradshaw D, Johnston L, Budlender D, "The Demographic Impact of HIV/AIDS in South Africa. National Indicators for 2004," South African Medical Research Council and Actuarial Society of South Africa, Centre for Actuarial Research, Cape Town, 2004.

8 According to the new Head of the AIDS programme in the National Health Department, Dr. Nomonde Xundu, http://iafrica.com/news/sa/424802.htm.

9 Nelson Mandela/HSRC Study of HIV/AIDS, "South African National HIV Prevalence, Behavioral Risks and Mass Media Household Survey," 2002.

government's response to the epidemic. This has clouded the urgency of the epidemic and delayed implementation of anti-HIV/AIDS measures.

3. COUNTRY RESPONSE

3.1 NATIONAL RESPONSE

The South African political response to the epidemic has been the subject of much criticism and anger. It seems the post apartheid government failed to respond to HIV/AIDS effectively because it was overwhelmed with restructuring and developing new policies and programmes. Under the leadership of the then President Mandela (in the first five years post 1994), HIV/AIDS was a priority as a Presidential Lead Project but no impact was made on the epidemic. Under President Mbeki, the government's response has been characterized as one of denial, and there has been reluctant acceptance of the need to act decisively in the fight against the epidemic.

The protracted response by the government has created much confusion, especially with reference to policy on HIV/AIDS and programmatic responses at all levels in the country. This prompted a civil response led by the Treatment Action Campaign to pressure the government into acknowledging the impact of the epidemic and to respond through the adoption of relevant policy and the deployment of public and other resources. Despite the political position taken by the President, budget allocations have increased and the national response has intensified, although many argue that this has occurred rather late. A brief historical account of the national response is articulated below:

- At the institutional level, the National AIDS Coordinating Committee of South Africa developed the first coherent National AIDS Plan. This plan was adopted as the National HIV/AIDS Strategy in July 1994. During this time, the AIDS Advisory Group was established to advise the National Department of Health on the implementation of the AIDS Strategy but was disbanded when it opposed the department on a number of its proposals

- In 1997, a national review of South Africa's response indicated that there was a lack of coordination among various departments and sectors. The recommendations that were adopted included ensuring political leadership by the Deputy President Jacob Zuma, who provided a broader portfolio for HIV/AIDS (away from the Ministry of Health), and strengthening inter-departmental and inter-sectoral responses. An Inter-Ministerial Committee was established, comprised of Cabinet Ministers and their deputies, to discuss issues relating to HIV/AIDS. This committee was disbanded and replaced with the South African National AIDS Council (SANAC).

- The HIV/AIDS Strategic Plan for South Africa: 2000-2005 was drafted in July 1999. The primary goals of the plan are to reduce the number of new infections and the impact of HIV/AIDS on individuals, families and communities.
  - The Plan called for the establishment of SANAC in 2000. SANAC is made up of 33 persons: 16 from the government and 17 from various sectors of civil society. There are four technical task teams including Prevention, Care and Support, Social Mobilization, and Legal and Human Rights. Its members completed their first term of office in February 2003.
  - The Plan also made provision for the establishment of Provincial AIDS Councils (PACs) that would coordinate the provincial multisectoral approach focusing on districts, local councils and local communities. Not all provinces currently have functional PACs.
  - Inter-departmental committees were also established representing a forum for public servants to coordinate their respective departmental HIV/AIDS programmes, to develop workplace HIV/AIDS programmes, and to ensure the allocation of resources to HIV/AIDS
  - In November 2003, the Cabinet approved an operational plan for HIV/AIDS treatment and care titled 'Operational Plan for the Comprehensive HIV/AIDS Care, Management and Treatment'. This plan provides for antiretroviral therapy, treatment of opportunistic infections, support to families affected by HIV/AIDS, a massive prevention campaign, and a sustained education and community mobilization programme, among others. The Plan is likely to be the world's largest comprehensive AIDS treatment plan and will involve a massive training and infrastructure

overhaul, at a cost of ZAR 12 billion during the next three years (2004-2005 to 2008-2009). Among other things, the Plan provides for antiretroviral therapy in the public health sector as part of the government's comprehensive strategy to combat the epidemic. As a result, HIV/AIDS received special attention in the 2004-2005 national budget as resources were earmarked for the funding of the Operational Plan. A total of ZAR 1,439 billion is allocated to HIV/AIDS in the national budget in 2004-2005.[10] Over the medium term (2004-2005 to 2006-2007) ZAR 5.505 billion will be dedicated to HIV/AIDS, which includes antiretroviral funds and the transfer of grants to provinces, specifically to finance community and home-based care programmes.

The Department of Health is instrumental in directing the national response to HIV/AIDS. The department is driven by a strong sense of responsibility for national public policy, has invested considerable time and resources in coordinating the national response, and is very sensitive towards ceding any of this leadership to other agencies, seen mainly as supporting the national response.

An identified area of weakness concerns the AIDS councils. Most provinces do not have functional AIDS councils. SANAC is considered disorganized and ineffective in mobilizing a multisectoral response to the epidemic, although the representatives of SANAC argue that their role is essentially advisory and that critics are conferring roles that are not within their mandate. SANAC contends that they are neither a coordinating body nor do they deal with programmes, but are instead a broad-based government/civil-society partnership that provides a forum for partners to interact on HIV/AIDS issues. However, legitimate criticisms point to the fact that SANAC has not formed strategic alliances with other organizations, donors or sectors outside of SANAC. In addition, SANAC is not truly multisectoral, as it is dominated by government representatives (49 percent of all representatives) and has not succeeded in developing a broad-based coalition to respond to the epidemic. For example, almost all of South Africa's leading HIV/AIDS experts are excluded, key NGOs are not represented, and the medical profession (apart from traditional healers) has not been invited to participate. In a similar vein, most of the provincial and district AIDS councils are not functional because they have inadequate mechanisms for achieving multisectoral responses and collaboration among stakeholders.

Much debate has centred around understanding the essence of government denial. Some argue that the general invisibility[11] of the epidemic is the issue. Others argue that political interference has impeded the civil-service response to the epidemic and that the policy response by the government has been exceptionally poor. This is despite the fact that the government had plenty of information to act on, through studies done by its own agency, Statistics South Africa, and the 2002 Nelson Mandela/Human Sciences Research Council survey, which showed that 1 in 10 people were infected with the virus.[12]

Given the financial investment and commitment by the government through its treatment plan, the above debates seem less relevant, as the primary imperative is the implementation of the treatment plan. In his Annual State of the Nation Address in 2005, President Mbeki confirmed that with regard to HIV/AIDS, "the government's comprehensive plan, which is among the best in the world, combining awareness, treatment and home-based care is being implemented with greater vigour." However, he acknowledged that the target of 53,000 people receiving free antiretroviral drugs through 113 state accredited health centres by March 2005 was not met. This reinforces the urgency for appropriate and intensive capacity building of government operatives, the effective management of delivery and rollout, and a concerted multisectoral drive that must coordinate the efforts of all relevant institutions and stakeholders to realize the government's comprehensive plan.

3.2 UNDP RESPONSE

UNDP's interventions in the country were defined in collaboration with strategic national partners including

10 The Institute for Democracy in South Africa,"HIV/AIDS Expenditure in the 2004/5 Provincial Budgets:Trends in the Budget Allocations and Spending," Budget Brief no. 147, 19 October 2004.

11 The invisibility of the epidemic was argued by Professor Alan Whiteside, Director of Health Economics and AIDS Research Division. His argument focused on the invisibility of the disease until the onset of opportunistic infections. Also AIDS deaths are spread across the country and therefore do not have the cumulative impact on the South African population. He was using these arguments to explain the denial by government of the impacts of the epidemic. Cited in AIDS: Crisis and Resistance. A review by Mandisa Mbali, February 2005 available at: http://www.nu.ac.za/ccs/default.asp?11,22,5,238.

12 Argued by Mark Heywood of the Treatment Action Campaign.

the National Treasury and the Department of Foreign Affairs. Other stakeholders, such as civil society organizations and bilateral partners, also made their contributions. The key imperative was ensuring that a people-centred approach informed policy frameworks and initiatives aimed at reducing poverty and inequality. The formulation of the programme areas in the first Country Cooperation Framework (CCF) in 1997 was informed by the experience the country office (CO) acquired during the period 1994 to 1997. The focus was on the reduction of poverty and inequality within a broader framework of democratic governance, peace, security and stability in South Africa. The second CCF, covering the period 2002 to 2006, focused on national efforts to reduce poverty and inequality with a greater emphasis on delivery and implementation by supporting four key programmes: Integrated Sustainable Rural Development, Transformation for Human Development, Holistic Response to HIV/AIDS, and the Interface Between Development and Environment.[13]

As a precursor to the development of the United Nations Development Assistance Framework (UNDAF) 2002-2006, the Common Country Assessment (CCA) in October 1999 noted that "South Africa is experiencing one of the most rapidly progressing HIV epidemics in the world. Approximately 3 million people are currently HIV positive with over half being women. There are 1,500 new infections daily with young Black women experiencing rates only seen in high risk sex worker occupations."[14] In the UNDAF 2002-2006,[15] three themes identified by the government converged with the priorities argued in the CCA, particularly the emphasis on HIV/AIDS. The three themes included: Regional Integration, Integrated Sustainable Rural Development, and HIV/AIDS. The overall goal, therefore, of UN assistance to South Africa for the period 2002 to 2006 was defined as "to achieve a higher state of basic human rights encompassing sustained levels of human development to alleviate poverty and inequality and reduce the impact and spread of HIV/AIDS." The South African government requested that three specific objectives be addressed in stemming the HIV/AIDS pandemic:[16]

1. Contributing to South Africa's efforts to reduce the rate of new infections
2. Assisting in the creation of an enabling environment for the protection, care and support for the infected and affected, with emphasis on women and children (in particular, orphans)
3. Reducing the overall impact of HIV/AIDS on socio-economic development.

HIV/AIDS was identified as the major programme focus area for UN support to South Africa because it is integrally linked to all the other national priorities. The integration of HIV/AIDS into existing and planned programmes was dealt with in the context of a joint work plan of the UN Theme Group on HIV/AIDS. The CCA 2002-2006 defined the response to HIV/AIDS as "the Holistic Response to HIV/AIDS and Poverty where, through the UN Theme Group on HIV/AIDS, the imperative of developing holistic provincial HIV/AIDS and poverty strategies and building institutional and human capacity to implement the strategies would be realized." This included reinforcing the principle for the greater involvement of people living with HIV/AIDS (GIPA).

The Resident Coordinator (RC) system played a role in attempting to convene a collaborative inter-agency approach to realizing the key imperatives of the UNDAF, but this proved to be difficult, given different agency modalities, budgetary processes and interests. Compounding the problem was the consistent lack of dedicated human resource capacity in the RC system to help ensure a more synergized UN response to the national challenges facing the South African government.

In the context of the response by the UNDP, the 2003 National Human Development Report was released and was met with strong negative reaction by the government of South Africa. In the African National Congress Daily News Briefing, dated 6 May 2004, the response said that "overall, the report's findings were in line with recent assessments of the performance of government during the first decade of freedom. However, some of the statements and conclusions

13 Ohiorhenuan J, "Not by Bread Alone: Official Development Assistance in South Africa," Valedictory lecture, 2005.
14 "Common Country Assessment South Africa," October 1999.
15 "United Nations Development Assistance Framework, 2002–2006, South Africa," 30 August 2000.
16 UNDP South Africa, "Enhancing an Integrated Response to HIV/AIDS and Poverty to Reduce the Impact of Human Development in KwaZulu Natal, Eastern Cape and Northern Province," Programme Support Document, December 2001.

TABLE 1. UNDP PLANNED SPENDING ON HIV/AIDS PROGRAMMES IN SOUTH AFRICA

Project	2003 Budget (USD)	2004 Budget (USD)
Integrated response to HIV/AIDS and poverty	1,900,880	3,013,000
National database	97,577	36,294
GIPA	37,156	52,922
Involving youth in HIV/AIDS	429,610	250,231
Total programme spend	**2,465,223**	**3,352,447**

Source: UNDP country office, 2005.

contradicted other researches on sustainable development issues, and the context that informed the analysis and conclusions were not sufficiently explained." The government disagreed with many of the analyses, conclusions and data contained in the report. According to representatives in National Treasury and the Department of Foreign Affairs, it was felt that the UNDP could no longer be trusted, which soured relations between the government and the UNDP. Despite this reaction, it seems the work of UNDP at sub-national levels remained unaffected by the controversies.

At present, the CO response to addressing HIV/AIDS is guided by the following key programmes (as outlined in the CCF 2002-2006):

- Enhancing an integrated response to HIV/AIDS and poverty in order to reduce HIV/AIDS infections and mitigate its impact on the poor. The main components of this programme include:
  - Leadership for Development Results (LDR) that build leadership at all levels in society for an effective response to the epidemic
  - Development planning with an emphasis on mainstreaming HIV/AIDS into Integrated Development Plans (IDPs)
  - Community Capacity Enhancement Project (CCEP) that facilitates community conversations and galvanizes action at the local level in addressing HIV/AIDS
- GIPA recognizing that people living with and affected by HIV/AIDS should take the lead in responding to the epidemic
- Involving Youth in HIV/AIDS—a joint programme between UNDP, UNICEF and UNFPA and funded by the United Nations Fund for International Partnerships (UNFIP); the UNDP component of the programme trains HIV-positive youth to enhance their potential for employment
- Model communities that demonstrate an integrated approach to HIV/AIDS and poverty, and are designed to mobilize and strengthen efforts of communities in prevention, care, support and mitigation of HIV/AIDS
- Developing and maintaining a National Database aimed at promoting good governance of philanthropic investment and activities aimed at prevention and mitigation of HIV/AIDS in the country.

UNDP interventions through the above programmes have been geared more towards the sub-national levels in the country, focusing specifically on province, district and community levels. This seems to be in response to the fact that the South African government does not require upstream policy support and has taken the responsibility for coordination as part of its national response. UNDP budget for the above mentioned programme components are noted in Table 1.

The total budget by the UNDP for the 2004-2005 period is USD 5,817,670 or ZAR 35,429,610 at current prices.[17] This represents a tiny percentage of the budget by the government for the same period, clearly arguing that UNDP is operating in South Africa in a context where the problem is not money but rather the lack of capacity to creatively deploy available resources to address the scale of need in the country.

3.3 DEVELOPMENT PARTNERS' RESPONSE

The South African government enjoys significant official development assistance (ODA) support by a number of key donors including the UN system. UNAIDS, in particular, has provided technical support to national HIV/AIDS programmes in various sectors. In addition to the funds that have

17 Based on a 25 April 2005, exchange rate of 6.090.

been budgeted for by the South African government, a number of bilateral and multilateral agencies have pledged their support to help the government realize its comprehensive HIV/AIDS plan.

A number of agencies that were interviewed confirmed their support, such as the Danish International Development Agency (DANIDA),[18] which has made available to the UNDP more than USD 5 million to deliver the programmatic interventions as described above. The Department for International Development (DFID)[19] has earmarked GBP 30 million over a five-year period to prioritize prevention and mother to child transmission in three priority provinces (Eastern Cape, Limpopo and KwaZulu Natal). The European Union (EU)[20] has pledged EUR 43 million, with 50 percent devoted to national and provincial government and 50 percent to civil society healthcare providers. An additional EUR 25 million has been set aside to directly support the government's comprehensive plan with an emphasis on developing the human resource pool, medical regulatory systems and health promotion. The Swedish International Development Cooperation Agency (SIDA)[21] has also invested in HIV/AIDS, focusing on mainstreaming of HIV/AIDS, facilitating dialogue in the country and direct programme support. The United States Agency for International Development (USAID)[22] has earmarked USD 106 million for 2005, focused on supporting the comprehensive plan but with an emphasis on primary healthcare as well. This is in addition to the President's Emergency Plan for AIDS Relief (PEPFAR), which is now calling for proposals of between USD 1 million to USD 30 million for addressing different aspects of the epidemic. Approximately USD 70 million in allocated funds was spent in South Africa during 2004.[23] This is notwithstanding the contestations related to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which according to its Web site, has approved more than USD 65 million (ZAR 425.5 million) over a two-year period for South Africa, of which a little more than USD 16.6 million (ZAR 108.6 million) has been disbursed.[24]

18 Interview with Lone Spanner of DANIDA, January 2005.
19 Interview with Tim Martineau, Senior HIV/AIDS Advisor, DFID, Southern Africa, January 2005.
20 Interview with Ian Ralph of the EU, January 2005.
21 Interview with Ria Schoeman of SIDA, January 2005.
22 Interview with Dr. Melinda Wilson of USAID.
23 Sengwana M, "A policy brief on the Review of 'The President's Emergency plan for AIDS Relief' (PEPFAR)," Health Economics and HIV/AIDS Research Division, August 2004.
24 UN Integrated Regional Information Networks, 28-05-2004.

All donors confirmed that their funding is directly supporting the government's comprehensive HIV/AIDS plan. While it has not been easy to work in the country context where ODA is approximately 1 percent of the South African national budget, they have nonetheless forged good relationships with the government and other key stakeholders. The Donors Forum convened by the National Health Department is a case in point. While many of the donor representatives felt that the Forum was not fully effective (as it was not easy to get consistent government representation at the meetings and therefore a clear sense of progress), it still represented an important forum for critical reflection and conversations on HIV/AIDS in the country.

4. OUTCOME OF UNDP CONTRIBUTIONS AND SUPPORT

The outcomes of the UNDP contributions in South Africa are captured under five distinct thematic headings:

- Mainstreaming of HIV/AIDS in development
- Governance
- Capacity development
- Leadership
- Partnership coordination

4.1 MAINSTREAMING

While there has been increasing emphasis on addressing HIV/AIDS in a multisectoral response, the mainstreaming of HIV/AIDS issues is not yet pervasive at the national level and is not evident in most departmental mandates or across departments. This is despite a conscious shift from a bio-medical approach and the articulated need for government departments and stakeholders to join forces across sectors in the fight against the epidemic. Despite efforts by the UNDP (albeit limited at the national level) and other stakeholders in the country, effective mainstreaming of HIV/AIDS in the government is yet to be realized.

While the services of many departments indirectly support an HIV/AIDS response, only two departments outside the Social Cluster have allocated funds for the year 2004-2005: the Department of Public Service and Administration (which has allocated ZAR 27 million) and the Department of Science and

Technology (which has allocated ZAR 50 million). This represents a positive shift in departmental responses, although on a limited basis. Other national departments—such as the departments of Labour, Correctional Services, and Defense and the South African Management Development Institute—provide HIV/AIDS plans and services but do not have budgetary line items to reflect their financial commitment.[25]

Similar challenges face the departments that form part of the Social Cluster of departments. For example, the Department of Social Development appears ready to provide leadership in the more social dimensions of the HIV/AIDS response. Operating within the Social Cluster in the national response, this potential has been insular in the grand scheme of the national response. A recent shift in paradigm of the social development process from welfare towards a more integrated development approach could enhance impact on HIV/AIDS. Because this shift is still evolving, UNDP has the opportunity to engage in more horizontal alliances with central government agencies by providing assistance in conceptualizing the shift and developing implementation models.

Currently, harmonization of methods among the various clusters (such as the Governance and Administration Cluster; Economic, Investment and Employment Cluster; and the Justice, Crime Prevention and Security Cluster) that are implementing the national response is weak. The prospect that this will be strengthened under current institutional arrangements for HIV/AIDS coordination is low.

What the government lacks is a functional framework that provides practical guidelines, not just the discourse for a multisectoral and inter-departmental response to the epidemic. Making a budgetary provision is a good indication of the commitment to address HIV/AIDS, but it is not sufficient to guarantee an integrated and synergized response to the epidemic. In fact, the government has always struggled to sustain inter-departmental collaboration. Furthermore, given the weakness of SANAC in not creating a consistent space for multisectoral and multi-partnership engagements about HIV/AIDS, departments have little assistance in participating in collaborative responses.

UNDP efforts through the LDR, CCEP and HIV/AIDS mainstreaming workshops have started to influence local government and IDP planners to mainstream HIV/AIDS in their IDPs. However, IDPs in South Africa are still relatively young and need time to mature. The complexities of integrated development planning are apparent and there is a dearth of skills and expertise in this regard. For example, how does integrated development planning diminish an environment that enhances vulnerability to HIV infection, and to what extent does the planning undermine capacities of individuals and institutions to cope with the impacts of HIV infection, illness and death?[26] The key challenge is the polemic of planning for HIV/AIDS where the objective is to consciously respond to the epidemic (prevention, treatment, care and impact mitigation) as opposed to development planning that focuses on other development objectives within which HIV/AIDS needs to be subsumed. As a result of UNDP interventions, there exists a general understanding of the need for mainstreaming and acknowledgement that integrated planning is complex, multi-faceted and calls for more intensive capacity building and support. A similar challenge faces the Provincial Growth and Development Plan (PGDP), an integrated development planning instrument at the provincial level, where it is more difficult to reflect HIV/AIDS as integral to all the sectoral programmes than it is to reflect it as a stand-alone programme or project.

The national, provincial and district AIDS councils, which represent a broad range of stakeholders engaged in the fight against HIV/AIDS, have largely remained inactive. Their centrality in defining mechanisms and coordinating actions has not yet manifested. Supporting efforts at mainstreaming HIV/AIDS into departmental mandates is a key opportunity for the UNDP, although in general, the government does not recognize the value offered in this.

UNDP is currently undertaking two projects with two different approaches to mainstreaming. On one side, UNDP's HIV/AIDS and Poverty Reduction Programme has developed innovative tools for community engagement, using a rights-based approach to assess community needs for livelihoods,

25 The Institute for Democracy in South Africa,"HIV/AIDS Expenditure in the 2004/5 Provincial Budgets: Trends in the Budget Allocations and Spending," Budget Brief no. 147, 19 October 2004.

26 UNDP Regional Project on HIV and Development,"Understanding the Link between Development Planning and HIV/AIDS in Sub Saharan Africa," Concept Paper 2, July 2003.

security, safety and social services. The entry point for such analysis is the subject of HIV/AIDS and its ramifications for poverty, community rights and self-generated community development. Conversely, the Sustainable Livelihoods Programme uses a composite livelihoods approach to engage poor communities, but expects to integrate HIV/AIDS towards the middle of the project, according to the project workplan.

Despite UNDP efforts at mainstreaming HIV/AIDS in the national response, lack of HIV/AIDS mainstreaming is pervasive within the UNDP itself. UNDP's reflection on how to mainstream HIV/AIDS in poverty reduction initiatives is insular to the programme on HIV/AIDS. The concept of mainstreaming will only have value when other practice areas that deal with poverty directly—such as governance, decentralization, environment and livelihoods—begin to integrate HIV/AIDS. A case in point is the UNDP Sustainable Livelihood Project in the Limpopo Province. This project is located in the Office of the Premier, while the UNDP HIV/AIDS project is located in the Department of Health. There is no common framework that defines the integrated nature and linkages between HIV/AIDS and sustainable livelihoods, nor is there any real programmatic collaboration at the practical level. This is not only the fault of the projects at the provincial level, but also indicative of the disparate and silo nature of the programmes of the CO. The various programme areas within the UNDP seem not to have dedicated time to finalizing an integrated HIV/AIDS response, as there is no evidence of a coherent framework to this effect. How the governance and environment programmes reflect HIV/AIDS in their offerings is not being harnessed to enrich UNDP's overall strategy in addressing HIV/AIDS.

This contradiction of the UNDP advocating a multisectoral response to HIV/AIDS with its counterparts while not defining and driving its own internal synergies, indicates a lack of a corporate response to addressing HIV/AIDS. Leaving planning and development to the specific responsible units serves only to reinforce the silo effect. A corporate response must redefine the nature of internal planning commensurate with a clear analysis and understanding of the multi-dimensional nature of the epidemic.

4.2 GOVERNANCE

Government leadership of policy and programming for HIV/AIDS is strong, having developed a comprehensive plan funded substantially from government budget allocations. The consequence of this has been a less visible and discernable influence on government policies and programmes by the UNDP. This poses frustrations for donors, such as the UNDP, that are accustomed to exerting considerable influence in public policy elsewhere in the developing world.

The UN system and other multilateral and bilateral donors must recognize the fact that the South African government has taken the lead in developing its own policies and implementation plans. The Health Department, for example, has assumed the role of coordinator at both the national and provincial levels in the national response to HIV/AIDS. Added to the robustness and confidence of the government is the budget and revenue base of the country, in which ODA accounts for only 1 percent of the total national budget. The budget set aside by the government for HIV/AIDS is significant relative to the budgets offered by most of the donor agencies. When understanding the limited contributions by the UNDP in comparison to the budget by the government and other agencies, the UNDP has to fight much harder to position itself as a partner with comparative advantages beyond funding.

Given the above, the government extends invitations to specific resources it deems appropriate and able to assist, and it is clear that UNDP has not been considered such a resource. Although UNDP has some national recognition and sanctioning by virtue of the role played by the Minister of Health as Chair of the National Steering Committee, UNDP presence and offerings have been very limited and not exploited by government. This is attributed to the lack of understanding of the value that UNDP can offer, and perhaps the lack of resolve by UNDP to more aggressively position its comparative advantages. The challenge to UNDP is how best to position its value to an able government that will not cede roles such as coordination in the national response but is calling for more implementation support and capacity building at the sub-national levels.

UNDP has not played a leadership role in the development 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 multisectoral response, the shift by the Department of Social Development from welfare to social development, and the many departments that are beginning to embrace HIV/AIDS issues. While UNDP may have engaged the issues in the Steering Committee and HIV/AIDS Theme Group, this was not at the heart of the processes that finalized the plan or that called for departmental compliance in addressing HIV/AIDS in budgets and programmes. Yet the coordination of the shift to a multisectoral response remains a critical and ongoing challenge to the government and represents a key opportunity for the UNDP.

Coordination is critical for effective governance to unfold, especially in government. SANAC, for example, has not been consistent in marshalling a multisectoral response to the epidemic as a multi-stakeholder body (despite its argument that its role is advisory). A number of key stakeholders are currently excluded from participation in SANAC. Inter-departmental collaboration at the national and provincial levels is not effective, as departments battle their over-subscribed development agendas imposed by specific mandates. The UNDP is not recognized as a coordinating or convening body and has not been allowed to offer its assistance in this regard. Even in the priority provinces, there is limited evidence of a concerted and driven multisectoral and inter-departmental response to HIV/AIDS. The mainstreaming of HIV/AIDS in IDPs, for example, is generally not linked to the conversations communities have through the CCEP. This limits the synergy between community conversations and planning instruments such as the IDPs and provincial level PGDPs. UNDP has offered some interventions that encourage synergy and coordination from community conversations to IDPS through to provincial level PGDPs, specifically in the Eastern Cape. However, there is a need to scale up this practice throughout the provinces so that vertical and horizontal convergence is achieved in the mainstreaming of HIV/AIDS and poverty.

A significant challenge to government response to HIV/AIDS has been the civil disobedience campaign by the Treatment Action Campaign, under the banner 'Dying for Treatment'. The Treatment Action Campaign directly reacted to government delay in responding to the epidemic, launching what is arguably the most successful advocacy movement since 1994. The Campaign argues that government delays result in immense suffering and loss: "It is also creating new inequalities in SA. Members of Parliament have access to ARVs (antiretrovirals). People with medical aid have access to ARVs. Parastatals such as Transnet and Eskom provide employees with ARVs. The South African National Defense Force is designing an ARV programme. It is only the poor, those employed in the informal sector and small and medium sized enterprises, and the unemployed—those who are totally dependent on the public health service—who, as a matter of policy are denied these medicines."[27]

The consistent lobby activity of the Treatment Action Campaign, in concert with the key national labour unions, NGOs and media support, has gone a long way in influencing government policy and thinking. Good examples include the Treatment Plan and Cabinet directives to the Health Department to implement the Plan.

UNDP has not played any noticeable role in the delicate debates between the government and civil society organizations, and has not been visible in supporting civil society responses to government inaction and delays. While civil society is not the direct target group defined by the UNDP, notwithstanding the risk of being seen as anti-government, UNDP has failed to effectively engage at this level. Civil society represents the recipients of government and ODA offerings, and it is not enough for UNDP to engage in community conversations locally without strongly advocating for the needs of these communities at a higher level.

Local government response to addressing HIV/AIDS has been characterized as late, probably because the ongoing transformation of local government has left it with little capacity to implement HIV/AIDS programmes. Local government is at the interface with communities and its planning instrument, the IDP, is the ideal tool for implementing the multi-sector response advocated in the HIV/AIDS Strategic Plan. Some of the key constraints faced by the local government include insufficient funding for IDPs, funding historically organized and disbursed on a sectoral basis, and lack

27 Available on the Treatment Action Campaign Web site at: http://www.tac.org.za/Documents/CivilDisobedience/briefingdocument.html.

of skills at the local level.[28] UNDP interventions at the district and local council levels recognize the critical role councils need to play in ensuring adequate service delivery to constituents and in addressing the impacts of the HIV/AIDS epidemic. The LDR and the CCEP processes have sensitized a cadre of leaders nationally and at the district and local council level to the multi-dimensional nature of the epidemic, while community conversations have reinforced the fact that local communities must be the focal points in the response to the epidemic. The emerging HIV/AIDS responses by municipalities are indicative of UNDP's efforts in laying the groundwork for more concerted and formalized responses to the epidemic at the local level.

Local community conversations through the CCEP methodology have brought the government closer to the people and reinforced the fact that communities have to be involved and take the lead in setting their own development priorities. This includes declaring their needs and aspirations, mobilizing their resources to address those needs, demanding support from the local government, ensuring that these are factored into the IDPs of the local and district councils, and holding local government accountable in terms of delivery. The intended result of the CCEP process—to allow communities to develop the confidence to make demands on the government—is important as communities mobilize themselves in the fight against poverty and HIV/AIDS. Conversations on HIV/AIDS have become entry points for critical reflection on the impact of poverty and the actions needed to fight both poverty and HIV/AIDS. The conversations have demonstrated that communities have the capacity to assume responsibility for addressing the different dimensions of HIV/AIDS and the links with poverty and sectoral concerns—providing that there is a supportive social, political and economic environment. It is this supportive environment that is critical to galvanizing community energy and action for their development. UNDP has been instrumental in facilitating these conversations at the community level and helping participants achieve a broader understanding of the pervasiveness of poverty at the local level, using HIV/AIDS as the entry point. This, in turn, is building a renewed confidence at the local level to hold the government and itself (as a community) accountable for local action needed to address development imperatives (see Box 1).

BOX 1. FEEDBACK ON COMMUNITY-LEVEL HIV/AIDS CONVERSATIONS

"What I liked most about these conversations is the fact that nurses from the local clinic, the police, officials from the Department of Welfare, Health and Home Affairs come to these meetings to address us and tell us more about their work and what to expect from them, like the shortage of personnel, funds or facilities. These initiatives enabled people to understand their government better and its shortcomings. I have seen many of our youth volunteering their time in police stations and offices of the Department of Health and Welfare. It is really good."

Source: Human Sciences Research Council, "A Journey Towards Change--Starting where the People Are," An impact assessment report of the Community Capacity Enhancement Programme, October 2004.

4.3 CAPACITY DEVELOPMENT

UNDP's capacity development efforts have facilitated a greater awareness of the multi-faceted and multi-dimensional nature of the HIV/AIDS epidemic and how it impacts the fabric of life in the country. There is also an increased understanding by key development planners at the provincial and local levels of the need to mainstream HIV/AIDS issues, with a few councils beginning to mainstream HIV/AIDS in their IDPs.

Through UNDP's national and local interventions, the importance of mainstreaming has been effectively reinforced. This has been facilitated through various interventions such as the PGDP for the Eastern Cape, the PGDP for KwaZulu Natal, and the mainstreaming workshops that were held for local government stakeholders in each of the priority provinces (Limpopo, Eastern Cape and KwaZulu Natal). However, the increased understanding of the need to mainstream has not translated into the technical capacity needed to effectively mainstream HIV/AIDS in IDPs at the provincial and local levels. In the case of formulating IDPs for councils, consultants are still widely used. This represents a missed opportunity for UNDP to make human and knowledge resources available when it comes to mainstreaming HIV/AIDS into local development imperatives.

28 Ngwena C, "Strengthening Local Government and Civic responses to the HIV/AIDS Epidemic in South Africa," Department of Constitutional Law & Centre for Health Systems Research, University of the Free State, no date.

The dynamic of how HIV/AIDS impacts poverty and how poverty, in turn, impacts HIV/AIDS is not immediately understood in planning terms. This speaks to the need for more intensive capacity building and support.

Another key area of weakness is the lack of proper analysis of the impact of HIV/AIDS on key development sectors at the local level, hence the difficulties in developing a feasible multisectoral response. The challenge is to develop a practical framework that helps municipal planners and communities with proper analysis and effective development planning. UNDP's HIV/AIDS mainstreaming workshops have mainly focused on raising awareness of the complexities of integrated planning including the development of multisectoral responses. This represents a good start—albeit just the beginning of what is needed at all levels of governance, particularly local. The interventions, however, in capacitating councils to mainstream HIV/AIDS in their IDPs represent a critical move to build local governance and to encourage communities to make demands and hold government accountable. Few councils have responded by reinforcing HIV/AIDS as cross cutting and a core element of their plans. However, for those that have responded, it can be argued that the new levels of understanding set the foundation for improved integrated development planning—where district and local councils assume a more holistic and local response to the epidemic. Even in the absence of the capability to technically mainstream HIV/AIDS, there is sufficient understanding that will encourage members to at least advocate for a holistic response to HIV/AIDS. One particular council will not adopt their IDP during the annual reviews if HIV/AIDS is not meaningfully reflected. This speaks to the success of the mainstreaming efforts of the UNDP.

One of the key challenges facing the councils is managing the consultants who are contracted to draft IDPs, and who may not appreciate the urgency to mainstream HIV/AIDS into the IDP. This represents a real opportunity for the UNDP to make expertise available to district and local councils through the UN Volunteer System.

UNDP interventions at the grassroots level through the CCEP conversations and local/district integrated planning are a powerful strategy in the fight against HIV/AIDS. They reinforce the clear links between poverty and HIV/AIDS as communities reflect upon the reality of unmet needs and marginalization from key governance processes. This rights-based approach, in which communities have the right to make demands and hold the government accountable, is critical in reinforcing sound governance. In addition, focusing on the community's own resource capabilities and building on organic strategies reinforces a more comprehensive response that is bottom up. Building on the aforementioned, the localized response is also captured in the IDP processes for legitimate government response and action.

Capacity-building efforts, notably at the community level through community conversations, have also shown evidence of changes in knowledge, attitudes and practices of community leaders (see Box 2). Approximately 161 facilitators have been trained and are active in the three priority provinces in facilitating such changes.

BOX 2. AFFECTING KNOWLEDGE, ATTITUDES AND PRACTICES THROUGH COMMUNITY CONVERSATIONS

A woman from Musina in Limpopo said: "Community conversations have raised awareness among traditional healers of the importance of sterilizing surgery instruments when they are re-used. This protects thousands of people who consult them from contracting HIV, including our boys who attend initiation rites."

Another woman in the Eastern Cape said: "I am really thankful to our local facilitators. Through community conversation I gained more knowledge about services offered in our area. I also know where to go for what. I gained confidence to speak to the police, nurses and welfare officials. I used to be so scared to approach them when I had problems…"

Source: Human Sciences Research Council, "A Journey Towards Change--Starting where the People Are," An impact assessment report of the Community Capacity Enhancement Programme, October 2004.

By engaging community leaders to analyze causes of poverty linked to HIV/AIDS, these leaders are initiating self-help efforts for community development, forming committees to channel their demands to municipalities, and engaging in dialogue with service providers regarding what they need and how services can be improved (see Box 3).

BOX 3. PROJECTS EMERGING FROM THE LEADERSHIP FOR DEVELOPMENT RESULTS (LDR) TRAINING PROCESS

Some of the projects that emerged out of the LDR training process include the following:

- The Letaba Change Group investigated prevailing opinions and experiences on issues of disclosure of HIV status by members of the Provincial Legislature in Limpopo. Leaders were encouraged to lead by example in matters relating to HIV/AIDS.
- The Impact Change Group identified a life skills development project at Sehlaku High school (grades 8 and 9) in the Sekhukhune District, Greater Tubatse Municipality. Meetings were held with 67 parents and scholars.
- The African Gladiators group decided to investigate the possibility of providing capacity for home-based care givers. Twenty-three home-based care givers from Mkhuhlu were trained in home-based care, stress management, project management and financial management. Dynamic enquiry interviews were conducted at Mkhuhlu and Ha-Musha communities.

Source: Human Sciences Research Council, "A Journey Towards Change--Starting where the People Are," An impact assessment report of the Community Capacity Enhancement Programme, October 2004.

The LDR process that drew champions from across different sectors has sensitized leaders to HIV/AIDS—its dimensions, links with poverty, and personal impact, among others. The assumption is that these leaders will translate their new perspectives into institutional and community value by impacting budgets, strategies and programmes aimed at addressing HIV/AIDS. As a result of the training, some of the graduates have initiated projects that may offer value to communities, but these projects are only at inception stages. While the psychological changes and benefits are evident, definitive community and institutional value is yet to be seen.

The essence of building community capacity for social action is that it represents the foundation of a successful and sustained national response to HIV/AIDS and poverty. National and provincial policies will have limited success if communities do not rise to the challenge of dealing with HIV/AIDS. UNDP conversations are a direct contribution to building the foundation for sustained and organic community action, which is the one key hope of success in the fight against the epidemic.

4.4 LEADERSHIP

Across institutions and sectors, leaders are addressing HIV/AIDS in a more comprehensive manner. The LDR Programme has influenced a cadre of leaders who have a higher consciousness about their analytical capacity, are developing a composite vision about the connection between HIV/AIDS and poverty, and are eager to acquire the tools for mainstreaming HIV/AIDS into every facet of development leadership.

Through the LDR initiative, graduates developed the ability to analyze complex inter-relationships pertaining to HIV/AIDS and poverty. Approximately 235 leaders from government, the private sector and civil society have participated in the LDR Programme. Participants developed a shared analysis of the context and nature of the causes of HIV/AIDS and a corresponding clear vision about the multi-faceted responses needed to: mitigate the impact of the disease among those already infected; tackle the root causes of the pandemic by systematically alleviating poverty; and enlist the partnership of a multisectoral institutions at the national, provincial, district and municipal levels.

The impacts of leadership development have been particularly strong at the sub-national (provincial and municipal) levels, where managers who went through the programme are seeking to influence decision making in their respective departments. Municipalities are placing demands on themselves and are responsive to demands from communities to re-visit their IDPs with a view to integrating HIV/AIDS. Applying this vision to strengthen their organization's engagement in the national response remains the next challenge, for which UNDP has a critical and catalytic role to play.

The deployment of fieldworkers (people living with HIV/AIDS) into corporate environments in private business, parastatal organizations and government departments has successfully reinforced the imperative that people living with HIV/AIDS should lead the response to the HIV/AIDS epidemic (see Box 4). This is done through the GIPA workplace model as part of the campaign to broaden the response to the epidemic. The GIPA experience has demonstrated successes in transforming the imperative into reality, especially in corporate and parastatal companies and government departments. The principle of people living with HIV/AIDS taking the lead in the

BOX 4. EMPOWERING PEOPLE LIVING WITH HIV/AIDS

"Thandeka (not her real name) touched many of us when she revealed her status in the presence of everybody who attended the community conversation that day. She told us how badly people treated her in the past and how she got help, and strength to remain this strong and healthy (she has been living with the virus for more than eight years). She encouraged everyone to check their status so that they can get help before it is too late…. Many people were encouraged. She soon got employed by the Regional Offices of the South African Police Services to promote awareness campaigns among members of the police service."

response to HIV/AIDS must be extended to other development arenas as well, so that the influences extend beyond corporate policies to programme development and delivery. The results of GIPA, while innovative and successful, have been localized, given the limitations of the project. The key opportunity for the UNDP is to scale up this project as the bedrock of a campaign that must situate people living with HIV/AIDS as crucial resources and leaders in the fight against HIV/AIDS.

4.5 PARTNERSHIP COORDINATION FOR COUNTRY RESULTS

The preponderance of the Government of South Africa in determining policy directions and programming priorities in HIV/AIDS, allocating substantial domestic resources, and directing donors to areas commensurate with their comparative advantages has resulted in UNDP's (and other donors') limited convening role in coordinating donor spending and exercising leadership in addressing HIV/AIDS.

The National Health Department plays a lead role in the national response to HIV/AIDS in the country at all spheres of governance. At the national level, UNDP is not recognized as a coordinating agency of donor activities and spending. In addition, the extent to which UNDP has exercised intellectual leadership in defining policy and programme responses to HIV/AIDS in the country has been limited. The Expanded Theme Group on HIV/AIDS and the National Steering Committee bring together government, agency and civil society representatives, but these do not pivot around sanctioned coordination roles of the UNDP nor do they recognize its resources to influence programme content.

Most of the donor agencies confirm that UNDP has a low profile in the national response to HIV/AIDS and does not have a recognized coordinator function in the country. Many have commented on the lack of UNDP presence in the donor forum (coordinated by the National Health Department) and other forums on HIV/AIDS. Donor agencies including SIDA, EU and USAID confirm that they interact more with the Regional Service Centre than with the UNDP CO simply because the UNDP CO is not visible and because they derive value in their interactions with the regional resources.

Yet at the sub-national levels, there are examples of UNDP playing a coordinating role. At this level, the success of UNDP interventions is based on its status as an impartial agency with no agenda other than addressing development challenges. This was evident in the Eastern Cape, where UNDP helped mediate conflicting agendas during the development of the PGDP, which assisted in the mainstreaming of HIV/AIDS issues. The coordination of stakeholders at the community levels (especially interfacing with government) and at the IDP mainstreaming workshops demonstrates UNDP's ability to mobilize key resources and stakeholders for social action.

Currently, interface between community demand and government resource allocation is still in its infancy in South Africa. Resources earmarked for accelerated development, including some for HIV/AIDS, are therefore not being disbursed fast enough to meet the looming needs. In order to achieve a level of convergence between the government and community, there is a need for a neutral broker and partner, such as the UNDP.

5. CONCLUSIONS AND RECOMMENDATIONS

The Department of Health is instrumental in directing the national response on HIV/AIDS and is driven by a strong sense of responsibility for national public policy. Moreover, the miniscule contributions of donors, especially UNDP, render their role marginal in shaping the national response. While the Department of Health appears to have functioned credibly and is committed to the basic tenets of the

national vision that links HIV/AIDS to poverty and sustainable livelihoods, the fact remains that the shift from a bio-medical response to one of a multisectoral, poverty-related response has not yet occurred in substance.

The government currently faces several challenges in addressing the HIV/AIDS crisis. For one, community initiatives in raising awareness and generating demands on decentralized and centralized institutions of government are slow in pace and limited in scope. These initiatives, mainly coordinated through the department of social services, are focused primarily on welfare services, and are struggling to transform their strategies to a more developmental approach. Another challenge is the interface between community demand and government resource allocation, as funds are not being disbursed fast enough to meet needs. The National Treasury and the government are very concerned about this, and are challenging those working with communities to fabricate the "mid-stream methods and tools to enhance the interface between community needs and governmental response."

Unfortunately, the apparent diplomatic hiatus of UNDP vis-à-vis the Government of South Africa has made it difficult for the UNDP CO to claim the space of convener, partnership broker and facilitator of development assistance normally occupied by UNDP. This state of affairs has affected the level of the UNDP CO's engagement with national institutions in positioning UNDP to respond to HIV/AIDS at the country level. Consequently, a major missed opportunity has been the limited knowledge of, and influence over, the South African government's strategic responses to HIV/AIDS.

Greater potential for harmonization exists at the provincial, local government and community levels, but this needs an 'honest and neutral broker' such as the UNDP. For UNDP to be positioned as a credible facilitator of this harmonization and sharing of best practices, the agency must harmonize its activities at the provincial, district and community levels.

In terms of UNDP's role, it has not positioned its comparative advantages sufficiently for it to be recognized as a key resource in the HIV/AIDS landscape. Even in the donor community, UNDP has a low profile and is not recognized as a coordinator of donor activity. Yet all donors acknowledge that what South Africa needs is capacity building and support—not money. This creates the opportunity for UNDP to position its comparative advantages to address these challenges, even though donors argue that the comparative advantages of global good practice and sourcing of expertise is not unique to the UNDP. The focus on sub-national interventions through capacity building and support has emerged as the key value offering of the UNDP. Sub-national capacity building and support is of fundamental importance to the government, which is realizing that community resolve and capacity to fight HIV/AIDS in concert with local government structures are key to winning the battle. This presents an important opportunity for the UNDP to further assert its value and contributions.

Two salient comparative advantages became evident when engaging respondents for this evaluation. They include the following:

- *UNDP as an impartial and neutral broker.* UNDP is recognized by leadership at the national, provincial and local levels as an impartial resource that does not feed into party political agendas, is driven by international norms and conventions, and is focused on the poor and marginalized—regardless of race, gender, creed or political orientation. The rights-based approach espoused by the UN system underpinning the meeting of key development imperatives and priorities of government earns the UNDP the trust of many in leadership positions. There is however, a feeling that this role should focus primarily on the provincial, municipal and community levels, where government sees a substantial need in improving the poor's access to services and rights. UNDP's role at the national level appears less necessary due to a high level of coordination of policy and programming processes by government itself.

- *UNDP as the gateway to global best practice.* The UN is regarded by most as the gateway to global best practice and expertise, and therefore, there is expectation that the UNDP will bring knowledge, lessons and resources to bear on national and local development efforts. While donor agency counterparts argue that global best practice and expertise can be sourced and bought by any of them, this still remains the comparative advantage of the UNDP especially

in its (neutral) partnership relationship to government counterparts.

5.1 KEY LESSONS

- Government ownership and leadership of national response to HIV/AIDS in the country is a reality and a given. It is not easily ceded to any other stakeholder.

- Local government cannot make a meaningful contribution unless its capacity to mainstream and implement HIV/AIDS programmes is considerably augmented.

- Unless there is concerted effort and coherence in the organization and management of HIV/AIDS programmes at the local community level, the programmes will not reach the communities for which they are intended.

- Individuals and communities have the ability to be responsible for addressing the different dimensions of HIV/AIDS provided there is a supportive and empowering social, political and economic environment.

- Democratic governance and proper coordination of government interventions are essential to developing effective responses to HIV/AIDS.

- The lack of a corporate planning approach to addressing HIV/AIDS at the UNDP will render interventions disparate and less effective.

- Constructive conversations at the local level on matters directly affecting communities are powerful vehicles for mobilizing social action.

5.2 RECOMMENDATIONS

- **UNDP has the distinct opportunity to work at all levels within the country through its programmatic interventions with communities, local government, and provincial and national structures. It is therefore incumbent on the UNDP to drive vertical and horizontal convergence and synergy in the programmatic responses to HIV/AIDS.** The greatest impact on addressing HIV/AIDS is at the local level where communities are mobilized and galvanized into action and have developed the confidence to make demands on the government and hold it accountable. Synergizing the aforementioned with the effective mainstreaming of HIV/AIDS into the IDPs of local government structures will account for a more holistic response to the epidemic and a greater chance of success. Interventions such as the community conversations and the mainstreaming of HIV/AIDS into IDPs must continue but with a greater emphasis on synergistically building capacity for effective integrated development planning at the local level. Considering the vertical integration of plans from local community aspirations to IDPs to PGDPs of provinces can provide the basis for influencing national developments and policies.

- **Coordination of the multisectoral response to HIV/AIDS in the country remains the most critical challenge in marshalling all available resources. The UNDP must aggressively position its comparative advantage of being a neutral broker for the effective coordination of a multisectoral response to HIV/AIDS.** Experience has shown that the key comparative advantage of the UNDP is its status as a neutral broker in the development arena. This has been established in the development of the PGDP in the Eastern Cape and even bridging the political divides at the community level in KwaZulu Natal. Capacity to implement and bridge conflicting interests and agendas are the greatest challenges facing any integrated responses at the sub-national levels (not funding). The biggest problem area is the coordination of an effective multisectoral response to HIV/AIDS. This is needed at all levels within the country but more so at the provincial, district and local levels, where interventions need to translate into real benefits and changes at the community level. What is lacking is a neutral broker in the development arena and in the national response that mediates conflicting interests, reconciles community need with national policy, and efficiently links resources to need. The UNDP has the profile of a neutral broker and must use this to maximum effect.

- **The dynamic relationship and linkages between HIV/AIDS and poverty is, at best, academically understood but is generally not effectively translated into practical, multi-sectoral programmatic responses needed to**

fight the epidemic. This is an opportunity for UNDP to lead the process of enabling persons and institutions to understand the nexus between poverty and HIV/AIDS, and more importantly, develop interventions and approaches that will advance the fight against the epidemic. The discourse of the relationship between HIV/AIDS and poverty is familiar to most in the development arena. However, this does not translate into practical interventions that address the dynamics and inter-relationships between poverty and HIV/AIDS. What is needed is the translation of the theoretical discourse and concepts into strategy, interventions and instruments that concretely address the challenges. UNDP is particularly well-placed to do this and must double its efforts at offering all key stakeholders in the country the requisite capacity and practical modalities for effective and results-based programming.

- **There is mounting pressure in the country for feasible and sustainable solutions to addressing HIV/AIDS at the community level. UNDP must harness its experience and strengths of sub-national, community-driven processes of empowerment that target the vulnerable and poor. The CCEP, LDR and the mainstreaming of HIV/AIDS intervention pilot processes are increasingly seen as potential contributors to national policy and strategy on HIV/AIDS.** The government is anxious to tap experience and interventions that focus on empowering the poor at the grassroots level for a more organic and local response to HIV/AIDS. However, the plethora of policy provisions and budgeting of resources do not easily translate into the kinds of responses that will win the fight against HIV/AIDS. Communities have to rise to the challenge of addressing HIV/AIDS on all fronts, starting with their own households. This is the only hope of winning the battle. The UNDP has acquired experience in this regard and its pilot interventions hold tremendous promise in influencing national policy and strategy.

- **HIV/AIDS is a multi-faceted and multi-dimensional challenge and deserves a mainstreamed and corporate approach to planning and execution. The thematic and collective programmatic strengths within the UNDP must be galvanized as the response to HIV/AIDS.** UNDP's siloed approach to interventions compromises impacts that can be achieved at the stakeholder level. In defining an integrated response to HIV/AIDS, UNDP must assume a corporate approach to programming that marshals its collective resources for a more defined and effective intervention at the community level. This implies moving away from having an HIV/AIDS-specific (or unit specific) programme that is distinct from other thematic areas, such as governance and environment. The four thematic areas of the UNDP must be mobilized as the HIV/AIDS response of the UNDP.

- **UNDP needs to drive a UN response, rather than a UNDP response, to HIV/AIDS in the country—marshaling the entire resource base of the UN system including UN Volunteers and the Regional Service Centre.** The UNDP CO must marshal all the relevant technical resources at its disposal to help the Government of South Africa, including the Regional Centre. UNDP is well placed to play this coordinating role that seeks a united UN, inter-agency strategy and intervention framework as a response to the multi-dimensional challenges posed by HIV/AIDS and poverty in South Africa. More specifically, the local government is, by now, accepted as the key level of governance that impacts directly on communities with reference to HIV/AIDS but is in dire need of capacity development. Capacity development and support has to extend beyond the training workshop as an approach and must include more sustained elements of support in the form of coaching and mentorship. The UN Volunteer Programme, for example, can make an important contribution to decentralized and more hands-on support and capacitation of local government structures, as UN Volunteers can be deployed to the local levels for periods of time.

ANNEX 1. ACRONYMS AND ABBREVIATIONS

CCA	Common Country Assessment
CCF	Country Cooperation Framework
CCEP	Community Capacity Enhancement Process
CO	Country Office
DFID	Department for International Development
EU	European Union
GDP	Gross Domestic Product
GIPA	Greater Involvement of People Living with HIV/AIDS
IDP	Integrated Development Plan
LDR	Leadership for Development Results
MDG	Millennium Development Goal
NGO	Non-Governmental Organization
ODA	Official Development Assistance
PAC	Provincial AIDS Council
PGDP	Provincial Growth and Development Plan
SANAC	South African National AIDS Council
UNDAF	United Nations Development Assistance Framework
ZAR	South African currency, rand

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ANNEX 3. PEOPLE INTERVIEWED

GOVERNMENT OF SOUTH AFRICA

Dr. Connie Kanaka, Chief Director, Department of Social Development, Department of Health
Paula van Dyke, National Treasury

UNDP

Gift Buthelezi, HIV/AIDS Programme
Dr. Mothomang Diaho, National Programme Manager, HIV, AIDS and Poverty Programme, UNDP and Department of Health
Elizabeth Duku, GIPA Work place field worker
Aloma Foster, Assistant Residence Representative
Julia Hill, GIPA Programme Manager
Reckson Luvhengo, M&E Specialist, Sustainable Livelihoods Programme, UNDP Project Management Unite (PMU) at the Limpopo Provincial Premier's Office, Polokwane
David Mathanhire, HIV/AIDS Focal Person
Dumisane Mgadi, Assistant Resident Representative
Mokgadi Ntsoane, Program Manager, Sustainable Livelihoods Programme, UNDP Project Management Unit (PMU) at the Limpopo Provincial Premier's Office, Polokwane
Thabo Thobejane, Provincial Programme Coordinator, UNDP Provincial Office, HIV/AIDS and Poverty Programme Limpopo Province

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Lone Spanner, Counsellor, Royal Danish Embassy, Pretoria
Melinda Wilson, USAID

NON-GOVERNMENTAL ORGANIZATIONS

Rob Allan, Treatment Action Campaign, Johannesburg
Zwelli Dlomo, Love Life, Johannesburg
Gillian Gresak, Anglo Platinum
Njogu Morgan, Treatment Action Campaign, Johannesburg
Sesupo, SANAC
Botha Swatz, Love Life, Johannesburg

SWAZILAND COUNTRY STUDY

HIV/AIDS

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

By Dumisile Shabangu

The author thanks the UNDP Country Office Swaziland for the invaluable help it provided.

SWAZILAND

CONTENTS SWAZILAND COUNTRY STUDY

Boxes, tables and figures

1. INTRODUCTION

The Evaluation Office of UNDP commissioned independent consultants to undertake an outcome based evaluation of UNDP's role and contributions in the HIV/AIDS response in 10 countries in Africa—Angola, Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia, Zimbabwe and Ethiopia. A team of four international consultants was assembled to undertake the evaluation exercise in partnership with local consultants in all 10 countries. This is the country report for Swaziland.

1.1 METHODOLOGY

The first part of the evaluation involved interaction between the international and national consultants at a workshop in Johannesburg, South Africa in October 2004. The workshop briefed national consultants on their expected tasks. An outline of the tasks to be undertaken by national consultants included: conducting an inventory of UNDP programmes at the country level; outlining the methodology used; and developing research instruments for use in consultations with stakeholders, the main evaluation report format, deliverables, and individual work plans, which also included the joint scheduling of international visits. Consultants were introduced to the principles of the proposed conceptual framework and the approach for the outcome evaluation, which was intended to assess UNDP's contributions in the response to HIV/AIDS in Southern Africa and Ethiopia.

The second part of the evaluation took place at the individual country level during November 2004. National consultants were engaged in consultations with the identified stakeholders using the pre-designed instruments, which identified the three categories of groups of people to be consulted. Consultation differed among stakeholders: For the senior policy level, all consultations were one-on-one interviews; for UNDP staff, meetings were held with several officers attending different meetings; at the community level, focus group discussions were held with Chiefs, their Inner Councils, youth, members of non-governmental organizations (NGOs) and specific participants in UNDP activities at the community level, for example, people living with HIV/AIDS (PLWHA) and satellite villages.

1.2 COUNTRY BACKGROUND

Swaziland is a landlocked country of 17,364 square kilometres that is divided into four regions. It is surrounded by the Republic of South Africa and Mozambique. The 1997 Census found a de facto population of 930,000,[1] a dejure population of 980,000, and a population growth rate of 2.8 percent. Seventy seven percent of the population lives in rural homesteads and approximately 70 percent is engaged in subsistence agriculture and animal husbandry. Women make up 53 percent of the population, with those in the reproductive ages of 15 to 49 years contributing 23.1 percent; 44 percent of the population is less than 15 years of age.[2]

1.2.1 Economic and human development

With a gross domestic product (GDP) per capita of USD 4,726 in 2005, Swaziland is classified as a middle-income developing country. However, economic performance has been declining, with growth rates falling from 10 percent in the 1980s to 2 percent in 2000 and 2.9 percent in 2003.[3] This means that economic growth has struggled to keep up with population growth. The government's fiscal position has also deteriorated as rapid increases in expenditure have led to unsustainable deficits. The national debt has reached 6 percent of GDP, about twice the size considered healthy for the country's small economy.[4]

Since 1997, the Government of Swaziland (GOS) has initiated reforms and policies to ameliorate the declining macro-economic and fiscal situation. The National Development Strategy (NDS), also known as Vision 2022, was launched in 1999. It has three thematic priorities: the economy, good governance, and social and human development. Its key strategies include: governance, economic and public sector management, agriculture and rural development, education, population health, social welfare, and gender and disadvantaged groups. The Economic and Social Reform Agenda's priority areas include enabling private-sector development and maximizing income to improve social services. The Internal Structural Adjustment Programme entails restraining growth in government expenditure and structural reforms.

In the 2004 Human Development Report (HDR), Swaziland ranked 137 out of the 187 countries. Its ranking declined to 147 in the 2005 HDR. Poverty is

1 Government of Swaziland, "1997 Swaziland Population and Housing Census Report," Central Statistics Office, Swaziland.
2 Ibid.
3 UNCT, "Common Country Assessment," United Nations Country Team, 2000.
4 Based on IMF Reports from December 2004.

TABLE 1. INDICATORS FOR SWAZILAND

Indicator	Value	Year
Population	929,718	1997
Area	17,364 km^2	
Annual population growth rate	2.90%	1997
Life expectancy at birth	32.5 yrs	2003
GNP per capita	USD 1,350	2000
External debt as a percentage of GNP	18.80%	2004
Poverty ratio	69%	2001
Proportion of rural population in poverty	75%	2001
Proportion of urban population in poverty	49%	2001
Proportion of underweight children (less than 5 years of age)	10%	1995-2003
Net primary enrolment	70.10%	1998
Ratio of girls to boys in primary education	88:95	1998
Under five mortality rate (per 1,000)	122	2002
Maternal mortality rate (per 1,000)	229	2002
HIV prevalence among pregnant women	42.60%	2004
Adult literacy	81.30%	2000
Adult literacy: male	80.40%	2000
Adult literacy: female	78.10%	2000

Source: UNCT, "Millennium Development Goals: Swaziland," December 2003; 2005 HDR for the life expectancy at birth and proportion of underweight children; Central Bank of Swaziland for the external debt (as of September 2004); and SHIES for the poverty ratio.

a major problem for Swaziland despite its middle-income country status. Wealth and incomes are concentrated in a small proportion of the population. According to the 2005 HDR, the richest 10 percent of the population control 50.2 percent of total income, while the poorest 10 percent control only 1 percent of total income.[5] Poverty is endemic in Swaziland, where approximately 70 percent of the population contributes to the agricultural sector's modest 10 percent share of GDP. Table 1 shows key development indicators for Swaziland. Approximately 66 percent of the Swazi population lives below the poverty line of SZL[6] 128.60 (USD 24) per month. That rate climbs to approximately 84 percent in rural areas. Unemployment is currently estimated at 29 percent[7] and the 2000 Priority Action on Poverty Reduction estimated that 40 percent of the poorest are unemployed.

The continuing drought, which the country has experienced since the early 1990s, has seriously affected large areas of the country. The combination of high levels of household vulnerability, drought and economic slowdown precipitated a crisis for many Swazi communities. Many households are unable to sustain viable livelihoods in the face of cumulative shocks. It was estimated that 217,000 vulnerable people in 2005 needed food assistance, and UN agencies and NGOs played key roles in alleviating the crisis. The government response has been aimed at providing policy and structures that enable multisectoral approaches to the crisis.

However, a more ominous paradigm is emerging: chronic and deepening food insecurity among particular population groups, much of it caused by and contributing towards, HIV/AIDS.[8] The epidemic is having a major impact on nutrition, food security and agricultural production, prompting a need to focus on the chronic problems of poverty and HIV/AIDS.

Swaziland has endorsed the Millennium Declaration and the Millennium Development Goals (MDGs).

5 UNDP, "Human Development Report 2005."

6 Currency: Lilangeni (SZL); Exchange rate: South African Rand: E1=R1; USD 2002 — End of Period: USD1 = E 7.4295; Period average: USD1 = E 7.911

7 Government of Swaziland, "Swaziland Household Income and Expenditure Survey 2000-2001."

8 WFP, "Protracted Relief and Recovery Operations, Southern Africa Region 10310, 2004-2007, Assistance to Populations Vulnerable to Food Insecurity/High HIV/AIDS Prevalence Areas in Southern Africa, World Food Programme, 2005-2010."

The first report on the MDGs was made jointly by GOS and UNDP in 2003. The report identifies challenges to success that include economic growth rates, HIV/AIDS, unemployment, gender and governance. The MDG Report acknowledges the far-reaching impact of HIV/AIDS, which affects every sector. The major challenge in Swaziland is to address both health and wider development-related causes for the high rates of HIV infection. Some of the reasons for the high prevalence rate include the high rate of sexually transmitted disease, multiple sexual partners, migrant labor, poverty, and the breakdown of traditions and power relations between men and women. The MDG Report concluded that it is unlikely that Goal 6, aimed at combating HIV/AIDS through the reversal of the spread of HIV/AIDS and other diseases by 2015, will be met.

For Swaziland, the MDGs represent an opportunity to operationalize the NDS Vision 2022, which has poverty reduction as one of its major goals and dovetails well with the MDGs. The main objective of the draft Poverty Reduction Strategy (PRS) is to reduce the incidence of poverty by more than half to 33 percent by the year 2015. As poverty affects women more than men, GOS has adopted a strategy for a rapid acceleration of economic growth based on broad-based participation—empowering the poor, especially women, to generate income and equitable distribution of the benefits through pro-poor public expenditure.[9] It is estimated that the economy needs to grow by 9 percent per annum for Swaziland to be able to reach the 50 percent poverty reduction target by 2015. But the goal can be achieved at lower growth rates if income distribution improves significantly.

2. HIV/AIDS SITUATION

HIV/AIDS reached Swaziland later than many other sub-Saharan African countries. The first case was diagnosed in 1986, but now Swaziland is experiencing a severe and escalating epidemic. The HIV-positive rate among pregnant women ages 15 to 49 years attending ante-natal clinics increased from 3.9 percent in 1992 to 38.6 percent in 2002[10] and 42.6 in 2004.[11] This made Swaziland the country with the highest rate of infection in the world. All four regions of Swaziland, and urban and rural areas, have shown similar trends in the epidemic. The 25 to 29 age group has the highest prevalence in urban areas, followed by the 20 to 24 age group. Prevalence rates among pregnant adolescents (15 to 19 years) was 32.5 percent in 2002[12] but dropped to 29.3 percent in 2004.[13]

It is estimated that there are about 220,000 people living with HIV/AIDS in Swaziland. Women are not only infected with HIV more frequently than men, but they also become infected at younger ages. The vulnerability of women is increased by their marginalized status: most are unable to negotiate safer sex and they face many other socio-economic and cultural factors that make them more vulnerable. Women are also more indirectly affected by the epidemic, as they tend to have more responsibility for caring for the sick and dying.

The number of orphans is estimated to be around 60,000 and is projected to increase to about 120,000 by 2010. Children already head 10 percent of households in the country and elderly-headed households are increasingly prevalent as younger parents die of HIV-related illnesses.[14]

The effects of HIV/AIDS are felt at every level of society and in every sector of the economy: the household, the health system, the education and agricultural sectors, as well as the general economy in terms of the eroded capacity and lost productivity due to ill-health and premature death.

3. COUNTRY RESPONSE

3.1 NATIONAL RESPONSE

Swaziland initially responded to the HIV/AIDS epidemic as essentially a health issue. The Ministry of Health and Social Welfare (MOHSW) had sole responsibility for addressing the epidemic.

In 1999, His Majesty King Mswati III declared HIV/AIDS a national disaster and a new multisectoral approach was introduced. A Crisis Management and Technical Committee was established, which included stakeholders from different sectors of society and produced the HIV/AIDS Strategic Plan 2000-2005. In 2000, the Committee was replaced by the National Emergency Response Committee on HIV/

9 UNCT,"Millennium Development Goals: Swaziland," December 2003.
10 "8th Sentinel Sero-surveillance Report," Kingdom of Swaziland, 2002.
11 "9th Sentinel Sero-surveillance Report," Kingdom of Swaziland, 2004.
12 "8th Sentinel Sero-surveillance Report " Kingdom of Swaziland, 2002.
13 "9th Sentinel Sero-surveillance Report:," Kingdom of Swaziland, 2004.
14 UNCT,"Millennium Development Goals: Swaziland," December 2003.

AIDS (NERCHA) in the Prime Minister's Office. NERCHA became a parastatal council in 2003.

NERCHA is comprised of representatives of all key sectors. Its role is to coordinate the country's response under one governing body and accelerate the multi-sectoral roll out of programmes. As a coordinating body, NERCHA's mandate is to secure funding and ensure that partners deliver appropriate community-level services for prevention, care, support and impact mitigation in a coordinated and effective manner. NERCHA has accelerated its activities, and expenditure rose from SZL 15 million in 2003 to SZL 42 million in 2004. NERCHA receives technical and financial assistance from the government. Stakeholders feel that NERCHA has been efficient in its coordination role. However, it has faced ongoing challenges. These include: limited capacity, difficulties establishing optimal working relationships with partners such as MOHSW, and limited monitoring and evaluation systems for itself and funded projects.

The HIV/AIDS Policy developed by the MOHSW in 1998 was more focused on the health sector, while the HIV/AIDS Strategic Plan 2000-2005 is more holistic. The Strategic Plan is now being reviewed by NERCHA and stakeholders. One of the critical gaps identified during interviews is that the Strategic Plan was not translated into a National Plan of Action with clear targets, benchmarks, coordination points, and responsibility for monitoring and evaluation of the implementation of the Strategic Plan. However, UNDP and other stakeholders have recently participated with NERCHA in finalizing the National HIV/AIDS Multi-sectoral Policy, National Strategic Plan and Action Plan.

In an attempt to take a more holistic approach to the epidemic, the GOS is targeting different levels and different sectors of society in its attempt to come up with an integrated package response that enables individuals and families to find new skills, generate income, and maintain home-based care and institutional support within the community. This is based on the premise that, despite erosion of the extended family system by HIV/AIDS, the community and its customary practices are still the most appropriate point of entry for any development to take place.[15]

At the chiefdom level, NERCHA has engaged chiefs in all 55 *Tinkhundla* areas to aggressively deal with the issue of orphans and vulnerable children (OVCs) to ensure that affected children remain within their communities. In these chiefdoms, chiefs and the communities have identified OVCs and allocated land and farming assistance in order to feed OVCs. NERCHA, in collaboration with other agencies like the United Nations Children's Fund (UNICEF), has provided input ranging from construction of the feeding centres, food, seeds, books and monitoring of the centres. Community-based organizations, such as Lihlombe Lekukhalela[16] and the National Women's Movement, Lutsango LwakaNgwane, provide psychosocial support.

His Majesty King Mswati III has been personally involved in mobilizing resources within the country and internationally to combat HIV/AIDS. The *umcwasho* traditional rite[17] was revived in 2000 to promote chastity among girls, but ended in August 2005 as it is usually done for a period of not more than five years at a time.[18] Her Majesty the Queen Mother has also launched a project to fight teen pregnancy and HIV/AIDS among youth.

3.1.1 Response by government sectors

The increased incidence of AIDS-related illness and death is rapidly transforming the core mandate of many sectors. In light of this, the Ministerial HIV/AIDS Workplace Programme was launched in mid 2004. The public service HIV/AIDS policy is being finalized and three ministries (Agriculture, Education, Labor and Public Service) have undertaken impact studies on HIV/AIDS. The Ministry of Economic Planning and Development has considered HIV/AIDS in the new PRS.

The MOHSW continues to have a large mandate in the national response. The Swaziland National HIV/AIDS Programme (SNAP) under the MOHSW was established in the 1980s and covers sentinel surveillance, health education, sexually transmitted infections, voluntary counseling and testing (VCT), prevention of mother to child transmission, laboratory testing

15 Swaziland has maintained community oriented traditional values and a parallel traditional system of government based on customary practices and law through the *Tinkhundla* system. *Tinkhundla* are both centres for development activities and electoral centres where parliamentarians are elected. Each of the 55 *Tinkhundla* is comprised of 5 or more chiefs.

16 Literally translated, this means 'a shoulder to cry on'. A group of women volunteers are trained within communities to offer care and psychosocial support to OVCs.

17 All girls are required to wear woolen tassels on their heads as a sign of chastity and are required to abstain from sex for the duration of the traditional rite, which is approximately five years.

18 Traditionally, Umcwasho lasts for a period of five years in honour of a specific princess.

and home-based care. SNAP is now offering antiretroviral therapy (ART). By the end of 2004, there were approximately 6,000 people on free ART. This number is expected to grow to 13,000 people on ART by the end of 2005. The government has also introduced the prevention of mother to child transmission in the major hospitals and clinics, as well as post exposure prophylaxis. The MOHSW is working with the World Health Organization (WHO) to review the health sector human resources base.

The Ministry of Education is now engaged in a national exercise to determine the numbers of OVCs who need assistance to continue schooling. Since 2003, the government has pledged to pay school fees for all children. The Schools Health and Population Education in the MOHSW has targeted school children with information on HIV/AIDS and prevention, and has recently introduced a broader multimedia programme to target youth.

Total government spending on HIV/AIDS programmes is not easy to quantify as HIV/AIDS is being mainstreamed in most ministries but is not generally reflected in separate budget items. Nevertheless, there has been a significant rise in HIV/AIDS spending. Overall investment in health, however, has declined from approximately USD 70 per capita in the late 1980s to approximately USD 24 in 2006. On average, the government has been spending approximately 9 percent of its budget on health for the last 10 years.[19] The health budget for 2005-2006 has increased by 41 percent, mainly to cover higher salaries to retain health staff and some increase in HIV/AIDS spending.[20]

3.1.2 Non-governmental responses

Community based organizations (CBOs), faith based organizations, NGOs, and the private sector have been prominent in Swaziland's national response—working both with the government and development partners. The organizations offer a range of interventions, including youth and prevention, and a variety of treatment, care and support services. Some NGOs and CBOs deal exclusively with HIV/AIDS issues.[21] Others are mainstreaming HIV/AIDS within their core programmes.[22] The Churches United Against HIV/AIDS in Eastern and Southern Africa Ambassadors of Hope Programme is one faith based initiative that seeks to establish PLHWA support groups within churches. At the municipal level, the Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) and NGOs are involved in initiatives that have resulted in the formation of youth organizations.

One prominent development is that more PLWHA organizations are being established. The first organization formed by and for PLWHA, the Swaziland AIDS Support Organization, was established in 1993. Other organizations that have been formed since 2002 include Swazis for Positive Living (SWAPOL), Women Together, and Imphilo Isachubeka (Life Goes On). In 2004, the International Community of Women Living with HIV opened a regional office in Swaziland. An umbrella organization for PLWHA called Swaziland National Network of People Living With HIV and AIDS (SWANNEPHA) was formed in 2004.

On the workforce front, many companies have either established, or are in the process of establishing, workplace programmes. In December 2001, the Swaziland Business Coalition Against HIV/AIDS under the Federation of Swaziland Employers and Chamber of Commerce, launched the 'Our Company Cares' Initiative. In addition, NERCHA, the Ambassadors of Hope Programme, the Business Coalition Against HIV/AIDS, and the Swaziland National Association of Journalists have all had activities to stimulate media involvement in the national and private-sector workplace responses.

3.2 UNDP RESPONSE

Since HIV/AIDS was declared a national disaster, UNDP assistance has moved from traditional development issues to focusing on HIV/AIDS as part of joint programming of the United Nations Country Team (UNCT). UNDP's Programme Support Documents (PSDs) on Capacity Building for Democratic Governance and Gender Mainstreaming and the PSD on Poverty Reduction and HIV/AIDS

19 "8th Sentinel Surveillance Report: A Nation at War With HIV/AIDS," Kingdom of Swaziland, 2000.

20 Government of Swaziland, "Budget Speech 2005," Minister for Finance to the Parliament of Swaziland, 9 March 2005.

21 These include The Aids Support Centre, Swaziland AIDS Support Organisation (SASO), and Hospice at Home.

22 For example, World Vision, Save the Children Fund, Lutheran Development Services, Africa Cooperative Action Trust, Caritas, Council of Swaziland Churches, Baphalali Swaziland Red Cross, Swaziland Action Group Against Abuse (SWAGAA), Umtapo Women's Resources Centre and Save Our Souls to mention a few.

Mainstreaming, which have been developed within the context of the UNDP Country Cooperation Framework 2001-2005, have been refocused in response to the humanitarian crisis.[23] Prior to 2002, UNDP activity was limited to joint UN programming.[24] However, since 2002, UNDP has prioritized HIV/AIDS activities, leading to allocation of a total of approximately USD 370,000 to its HIV/AIDS programme spending for the period 2002-2004.[25]

UNDP support has focused on translating international conventions and UN declarations into activities at the country level, and on promoting an integrated approach to poverty and HIV/AIDS. In terms of the MDGs, UNDP, through the UNCT, has led efforts to help Swaziland integrate the MDGs into national development frameworks, policies, strategies, ministry priorities and budgets. This thrust has been consistent with the NDS, which acknowledges that HIV/AIDS is among the key development challenges facing the country.

In 2002, as part of the UN Theme Group and joint programming, UNDP was tasked with the responsibility to hold donor roundtable conferences to fundraise for HIV/AIDS activities and to coordinate UNCT programming. UNDP partnership strategy identifies GOS, primarily Ministry of Economic Planning and Development, as the main interlocutor for aid coordination in view of the inter-linkages between poverty and HIV/AIDS.

The UNDP's corporate strategy on HIV/AIDS focuses on the following five services offered to developing countries:[26]

3.2.1 Advocacy and policy dialogue

Advocacy activities have aimed at education and creation of public awareness of HIV/AIDS-related issues, such as gender focused responses, ethics, human rights, and involvement of parliament, local authorities, communities and civil society in the national response. UNDP has assisted in promoting leadership at all levels and coalition building among stakeholders, including parliament, local government, chiefs, the youth, churches, NGOs, CBOs and the private sector. The goal is to ensure that stakeholders beyond the health sector engage in policy dialogue on challenges and important issues for an effective response to the pandemic.

One area of support is a synergistic set of advocacy and policy dialogue interventions, under the Leadership for Results (L4R) Programme. Leadership development programmes have been designed to transform leadership at different levels in the government, private sector, communities, civil society, individuals, youth, the arts and the media. In 2002-2003, UNDP facilitated 'emotional leadership'[27] among stakeholders. Leaders and potential leaders were trained to design teams that can work together to influence critical policies and responses to HIV/AIDS within their organizations and communities. This approach is based on the premise that an organization or community is successful because the leadership is people-oriented and develops a 'can do' attitude.

The country office (CO) established a Human Development Forum (HDF) in 2000 to bring major stakeholders together to discuss topical issues. The UNDP CO has convened and co-chaired monthly meetings, coordinated all the activities of the Forum, and provided technical and financial support for Forum events. There are 15 HDF co-sponsors. They include professional bodies, NGOs, University of Swaziland, a Poverty Reduction Task Force, the Employers Federation and Trade Unions. The British Council funds some Forum activities. The Forum promotes advocacy efforts to stimulate policy dialogue for good governance and poverty reduction. It engages stakeholders from the government and other sectors to promote their full participation and contribution towards consensus around priority issues, policies and actions. In the year 2003, the HDF chose culture and HIV/AIDS as the themes around which all Forum activities were to be developed. The intention was to come up with recommendations for the HDR that the government will adopt. Two studies on Culture and Gender Focused Responses to HIV/AIDS were made and the theme for the HDR for 2003 was Culture and HIV/AIDS. The study on culture revealed that some cultural practices impact the spread of HIV/AIDS,

23 UNDP, "Poverty Reduction and HIV/AIDS Mainstreaming," UNDP Project Support Document, April 2003.

24 Other UNDP actions may have occurred, but this could not be ascertained due to high CO staff turnover.

25 This includes PAF funds. HIV/AIDS programme spending declined from approximately 40 percent of total UNDP programme spending in 2002 (due to high expenditure on L4R training) to 18 percent of spending in 2004. 2005 HIV/AIDS programme expenditure is estimated to have increased to USD 150 ,000.

26 UNDP, "Draft on Leadership for Results: Best Practice Area in Swaziland," UNDP, 2004.

27 A term coined by UNDP for this particular initiative.

while the study on Gender Focused Responses to HIV/AIDS have kick-started special initiatives that focus on gender as a key entry point in efforts to deal with HIV/AIDS.

3.2.2 Capacity building

The GOS has been greatly concerned by capacity depletion in the country due to HIV/AIDS, the brain drain and migration. To assist GOS, UNDP adopted a participatory and multi-institutional mechanism to decentralize the response to HIV/AIDS in 2003, by involving a wider cross-section of society at different levels. UNDP implemented multisectoral strategies to limit the spread of HIV/AIDS and mitigate its social and economic impact. A major entry point was through capacity development for local authorities, in order to develop and strengthen leadership skills for mainstreaming HIV/AIDS at the national and local level. UNDP also offered advice and support to develop policies in key areas of human rights

At the national level, UNDP assistance to GOS has aimed at strengthening NERCHA's role in the development of a multisectoral policy on HIV/AIDS and a review of the National Strategic Plan. UNDP has helped NERCHA develop a monitoring and evaluation system for the national response.

In addition, UNDP in conjunction with WHO, assisted government ministries such as MOHSW in developing human resources planning for health programmes in order to assess the skills gap due to HIV/AIDS. UNDP further assisted in the development of institutional capacity for coordinating and managing the national food crisis. A Disaster Management Unit was recently established within UNDP to coordinate all disaster issues beyond drought and food security.

At the individual, institutional and society level, UNDP has strengthened capacity to cultivate leadership and communities that will generate appropriate local responses that will link to national development plans in combating HIV/AIDS.

UNDP has supported training and capacity building for government, NGOs, the private sector, organizations of PLWHA, and CBOs (including churches and Lutsango Lwaka Ngwane).[28] Traditional healers, youth and journalists have also been trained to strengthen their capacity to plan, fund, lead and manage national and community level responses to the epidemic. In 2002, UNDP adopted the Community Capacity Enhancement (CCE) through Community Conversations (CC) methodology. The CCE has a set of tools and approaches to generate CC aimed at designing community-driven plans for fighting HIV/AIDS. A number of organizations and individuals have participated in CCE including Red Cross, Family Life Association, the AIDS Information and Support Centre, Council of Swaziland Churches, Swaziland Action Group Against Abuse (SWAGAA), Siphila Nje Drama Society and AMICAALL.

Since 2001, UNDP has also assisted local authorities and municipalities in planning and implementing prevention, care and support, and mitigation activities. Since UNDP had already worked with such institutions under AMICAALL, UNDP continues to assist them in integrating their activities into the wider national response. AMICAALL adopted CC as a tool and is now using it in all urban communities to develop community-driven HIV/AIDS response plans. In 2004, Ezulwini town facilitators trained in CCE/CC engaged community members and youth to identify the most important issues surrounding HIV/AIDS. Some of the issues identified include: difficulty in accepting an HIV-positive status, acknowledging having infected someone else, the stigma attached to HIV-infected people, importance of *lobola* (dowry) in marriage, the role of church leaders in supporting people with HIV/AIDS, and promiscuity and HIV.[29] Other issues that were deemed important but not integral included: HIV transmission, HIV infection equaling death, factors fuelling the spread of HIV/AIDS, and cultural beliefs. They also emphasized the importance of community commitment to change, especially of behaviour.

In 2003, UNCT started a youth intervention in Shiselweni region, which has high HIV/AIDS prevalence, high population growth, and is the poorest and most drought-prone region. UNDP has provided technical support to this multifaceted United Nations Fund/International Programme (UNF/UNFIP) project, which aims to strengthen the capacity of organizations to provide preventive services, to promote behavioural change, and to

28 This is the National Women's Movement commissioned by Their Majesties to undertake a number of activities at the forefront of which is the protection of the culture of Swaziland.

29 *The Swazi Observer News,* 'Ezulwini Town Board and HIV and AIDS,' 15 December 2004.

provide mitigation services to PLWHA and OVCs. Specific activities have included increasing awareness of behavioural change among chiefs, NGOs, key government officials, nurses and the youth, in particular. Six clinics have established Youth-Friendly Corners to supply information and condoms. The programme has so far been able to train at least 15 peer educators per community and reach a total of 42,878 youth within the Shiselweni region. There is also Lihlombe Lekukhalela,[30] established by UNICEF, where youth can report abuse cases. WHO has provided support for home based care, established an ART clinic in Hlatikhulu and is implementing post exposure prophylaxis. The Hlatikhulu Youth in Action Against HIV/AIDS, an umbrella organization for four community groups within Hlatikhulu, was established in 2004 as a direct result of the UNF/UNFIP project training and motivation of youth. Imphilo Isachubeka (Life Goes On) was formed by PLWHA with assistance from nurses and counselors at the VCT centre.

UNDP conducted training workshops for 55 chiefs from the Shiselweni region and engaged them in CC on the impact of HIV/AIDS, and the role of chiefs in taking care of OVCs at the community level. The chiefs decided to change the name 'orphans', which they think stigmatized the OVCs, to *Bantfwana Bendlunkhulu* or 'Children of Chiefs Kraal', meaning they belong to the community.

Working with the Deputy Prime Minister's Office, UNDP has also opened the way for a series of nationwide dialogues involving rural local communities and *Tinkhundla*[31] structures. In 2004, CCE facilitators engaged more than 70 percent of the chiefs in Swaziland in three-day CC. Lutsango Lwabomake (the national women's movement) has been asked to be responsible for psychosocial response for OVCs. Youth are holding their own CC and developing community responses to HIV/AIDS. This initiative will now be scaled up to include faith based organizations and the Deputy Prime Minister's Office has requested that this activity also include teachers.

30 Local women are trained to be counselors who offer psychosocial support mainly to abuse victims, orphans and others, and monitor the welfare of children in their communities and report cases to police and other relevant organizations like SWAGAA.

31 *Tinkhundla* are traditional administration/community development centres that are also used as electoral centres. Swaziland is divided into 55 *Tinkhundla* centres, each comprised of approximately three to five chiefdoms.

In 2004, UNDP initiated the Swaziland Capacity Initiative. The main objective of this initiative is to enable GOS and its key partners, from national down to community level, to respond in a systematic way to the challenges posed by human and institutional capacity erosion.[32] There are four entry points to operationalize this initiative.

1. **Enhanced service delivery.** This aims at strengthening GOS decentralization efforts to facilitate efficient service delivery to improve the quality of life of citizens. UNDP identified four demonstration projects at *Tinkundla* level to tackle HIV/AIDS in Swaziland in 2004 and had engaged with two of them by mid 2005.

2. **Capacity stabilization.** This anticipates placing 65 UN Volunteers (41 national, 24 international) over a four-year period in key government institutions. Six international volunteers are already in place.

3. **Policy support in five key ministries.** These are: public service and information to strengthen the skills and human resources base and multi-skilling; education; Deputy Prime Minister's Office on the development of a National Multisectoral HIV/AIDS Policy amongst others; health and social welfare, with WHO, to support the 3 by 5 Initiative and operationalize the Human Resources for Health project; and Economic Planning and Development to operationalize the NDS and prepare the Poverty Reduction Strategy Paper (PRSP).

4. **Demand for new skills.** An assessment was undertaken in key government ministries to identify potential and existing skills gaps. The government's main concern is the continuing brain due to the migration of skilled people from the government and the country. HIV/AIDS compounds this brain drain.

Multisectoral committees at the regional level have been put into place to guide the technical implementation of the Swaziland Capacity Initiative.[33] However, it is too early to evaluate the outcomes of this intervention. Some UNDP activities that are still in the pipeline include support to the development of policies and legislation that are necessary to enhance the response towards the HIV/AIDS epidemic in the country.

32 UNDP, "Operationalization of the Swaziland Capacity Initiative," UNDP, 2003.

33 Ibid.

3.2.3 Mainstreaming

UNDP assistance to GOS has emphasized mainstreaming HIV/AIDS in all national activities. It aims at providing policy guidance on integrating HIV/AIDS priorities into the core of national and sub-national development planning, domestic resource allocation processes, poverty reduction strategies, and sector plans to manage the socio-economic impact of HIV/AIDS. This includes policy development in key ministries like Agriculture and Ministry of Economic Planning and Development through the formulation and implementation of the Agriculture Policy, the Food Security Policy, and the PRSP. There are also technical and other support to strengthen the mainstreaming of HIV/AIDS in all development plans and programmes.

In 2000, an assessment of the impact of HIV/AIDS on the education sector was carried out by GOS with UNDP assistance. In 2002, another was carried out in agriculture. In 2003, one was conducted in the public service sector. These served to highlight the implications of HIV/AIDS for the sectors' capacity to deliver services, new needs for services arising from HIV/AIDS, and specific areas that require responses.

3.2.4 Human rights

UNDP has promoted perspectives on human rights, discrimination against PLWHA, and gender in all aspects of the national response—legislative, policy, research and the community level. Since launching the Gender Focused Response to HIV/AIDS in 2003, UNDP has been promoting a gender sensitive human rights approach that includes introduction of anti-discriminatory laws to protect PLWHA and address gender inequalities that fuel the epidemic.

3.2.5 Information and multimedia technology

UNDP has contributed toward the development of a national communication strategy that builds on lessons learned in previous Information, Education and Communication (IEC) interventions and employs multimedia techniques including information technology. The initiative aims to promote development of national capacity to implement broad public information campaigns on HIV/AIDS using innovative approaches and multimedia technology.

Under the Development Support Communications Programme, two 'digital villages' were set up as pilot sites at Ekukhanyeni and Mankayane. Internet cafés enable local residents to access information on HIV/AIDS, among other uses. Both digital villages are no longer operational due to difficulties between the communities and government after UNDP's exit. A Youth Centre has recently been completed in Nhlangano with plans for a library to provide information on HIV/AIDS to the youth, counseling, an IEC component, training personnel and information on what Nhlangano youth are doing to respond to the crisis.

Other UNDP activities have included the following:

Resource mobilization. Since the 1990s, UNDP has emphasized resource mobilization activities, promotion of partnerships with other development agencies, and playing a catalytic role. With the advent of HIV/AIDS, and funding that limits its own activities to local initiatives such as L4R and a few pilot projects, UNDP has continued this emphasis. A specific mechanism that UNDP has used aggressively has been organizing thematic roundtables to mobilize resources for HIV/AIDS activities.

HIV/AIDS and poverty. In addition to the policy support to the PRS and the PRSP, UNDP supports PLWHA organizations in developing their capacity to provide high-quality services to their members and to the communities within which they live, and in addressing poverty related challenges. A programme aimed at alleviating poverty among PLWHA and those affected with HIV/AIDS was established in 2002. A special porridge product called e-pap was brought into the country to make it available to PLWHA as a food supplement and an income-generating resource.[34] Another initiative in the fight against poverty was started by GOS and UNDP in 2000 called the Export Production Villages for Mushroom Growing. This aimed to help communities grow and market mushrooms in order to increase income, particularly among women, the rural poor and disadvantaged groups. UNDP has subsequently exited from the e-pap and mushroom projects.

Decentralization. Other UNDP activities in Swaziland include assisting GOS with decentralization. UNDP focuses on policy support, strengthening capacity and providing institutional support for constitutional and legal reforms, decentralized

34 e-pap is made from precooked maize meal, soya, vitamins and minerals.

government, administration of justice, and management of development. It also supports national dialogue to raise awareness and popular participation in human development, governance and gender issues.

New UNDP initiatives for enhancing the response to HIV/AIDS in the country include the HIV/AIDS Care Policy and the HIV/AIDS Policy. These are impact and mitigation policies that deal with the workplace environment, employer/employee relations, employee benefits, and treatment and drug policies.

3.3 DEVELOPMENT PARTNERS' RESPONSE

Swaziland is a very small country, which has recently been criticized for its human rights and governance record. As a result, there is limited bilateral donor engagement and UN agencies have a relatively high profile in the donor community response to HIV/AIDS. Those bilateral donors that do work with Swaziland—Department for International Development (DFID), European Union, Italian Cooperation, American Embassy, German Council, Chinese Embassy, and until recently, the British High Commission—often tend to have regional rather than country programmes serving Swaziland.

Several UN Agencies—UNDP, WHO, UNICEF, United Nations Population Fund (UNFPA) and UNESCO—have organized themselves into a UN Theme Group on HIV/AIDS. With the establishment of United Nations HIV/AIDS Programme (UNAIDS) and World Food Programme (WFP) in 2000, the UN Theme Group was expanded to include other donors including DFID, European Union, Italian Cooperation, American Embassy, German Council, Chinese Embassy, British High Commissioner and Federation of Employers/Chamber of Commerce.

The UN Theme Group on HIV/AIDS supports capacity building and institutional strengthening for the government, local authorities, NGOs, CBOs, private sector, and organizations for PLWHA. The UN Theme Group has supported the government in the following activities: development of the National Strategic Plan, advocacy activities, training and capacity building, research and policy formulation, strengthening VCT, and home-based care and prevention activities.

Joint UN programming has been a marked feature of support in Swaziland. In 2000, the UN Theme Group, through UNAIDS, jointly undertook a UN/UN Fund for International Partnership project that targets adolescents in the country, particularly in the rural areas and the Shiselweni region. The project focuses on: capacity development among youth so that they can generate income; provision of youth-friendly services, such as youth centres and youth-friendly areas in clinics; orphan care; support for PLWHA; community mobilization; and encouragement of NGO support to engage communities in activities that will mitigate HIV/AIDS. UN agencies involved in this project are UNDP, UNICEF, WHO, and UNFPA, each of which undertakes activities that are in line with their corporate mandates and, in the process, mainstreaming HIV/AIDS.

Individual UN agencies have also undertaken other work within their mandates. UNICEF has established neighborhood care points,[35] school feeding and school fees for OVCs, and the African Girls Education Initiative and HIV/AIDS Pilot Project. It recently released a toolkit on 'What Religious Leaders Can Do About HIV/AIDS' that is expected to be a resource when UNDP commences the planned initiatives with religious leaders. UNICEF's Community Action for Child Rights Programme, in partnership with the Deputy Prime Minister's Office and stakeholder NGOs, mobilizes and empowers communities to fight HIV/AIDS. The programme has expanded coverage to 55 communities.

Under the new Protracted Relief and Recovery Operation (PRRO), WFP is complementing the 3 by 5 Initiative by providing nutritional support to PLWHA as part of a comprehensive care package that covers home-based care projects and patients on tuberculosis and ART.[36,37] The WFP-PRRO will work in neighborhood care points to provide food to orphans, vulnerable children and elderly-headed families, as well as link with initiatives to support crop diversification. The project is estimated at

35 Neighbourhood care points have been established by the communities with UNICEF assistance to take care of orphans and vulnerable children within those communities. Common feeding facilities are constructed where the children come to eat and these are now also offering other services (education, psycho-social support etc.) for the children. These are run by volunteers from the communities. There are more than 300 of these throughout the country.

36 "Swaziland PRRO 10310: Swaziland Year One Implementation Plan," 2004.

37 WFP, "Protracted Relief and Recovery Operations, Southern Africa Region 10310, 2004-2007, Assistance to Populations Vulnerable to Food Insecurity/High HIV/AIDS Prevalence Areas in Southern Africa, World Food Programme, 2005-2010."

USD 259 million for the period 2004 to 2007. UNFPA is also training communities, especially women and WFP Relief Committees, on leadership, gender and HIV/AIDS.

WHO has a project with the Italian Cooperation to strengthen the National Blood Transfusion Services, the continuum of care for PLWHA, and access to quality VCT with total funding for 2001-2003 of USD 533,000. The International Labour Organization, funded by the United States Department of Labor, is focusing on implementing comprehensive work-place programmes involving the Business Coalition Against HIV/AIDS and trade union federations.

A variety of other initiatives has started during the period under review by this study. Peace Corps Volunteers returned to Swaziland in 2002, and there are now approximately 50 in rural communities, working with UN agencies and the government to develop an integrated approach in education, youth outreach, community development, health and HIV/AIDS, agriculture and environment, business development, and information technology. A regional pilot project launched in 2004, Strengthening Coordination of the Health Sector Response to HIV/AIDS and the Involvement of PLWHA, was adapted from the Southern Africa Development Community DFID project. This project aims to strengthen the institutional and technical ability of PLWHA organizations for greater involvement in management of HIV/AIDS programmes and improved care for their members.

Although the government contributes a substantial amount of HIV/AIDS related funding in Swaziland, development partner funding, particularly from the Global Fund to Fight AIDS, TB and Malaria, has been critical to key aspects of the national response. In 2004, NERCHA received SZL 26.5 million from GOS for HIV/AIDS, and USD 29.6 million for HIV/AIDS and USD 0.98 million for malaria from the Global Fund.[38] The DFID funded programme, Support for International Partnerships Against AIDS in Africa, donated SZL 0.4 million, the United States Embassy contributed SZL 0.1 million, and the African Development Foundation has granted SZL 1.6 million. The World Bank has granted approximately SZL 3.4 million towards the Capacity Building and Monitoring and Evaluation of HIV/AIDS Programmes for 2004-2005, and an additional USD 400,000 from the Development Marketplace was awarded to a variety of participating stakeholders.[39] In addition, technical assistance has been provided by the Italian Cooperation, DFID/ Support for International Partnerships Against AIDS, UNAIDS, and the World Bank.

38 National Emergency Response Council on HIV/AIDS,"A Nation At War, Annual Report 2004," Swaziland, 2004.

39 Projects are from Gone Rural, New Life Homes, Swaziland Boy Scouts Association, CAIDS, Swaziland Business Coalition Against HIV/AIDS, Swaziland Olympic and Commonwealth Games Association and the Church of the Nazarene.

4. OUTCOME OF UNDP CONTRIBUTIONS AND SUPPORT

PSDs developed by UNDP identify several planned programme outcomes. These include: increased use by decision makers of sustainable human development concepts in policy formulation and implementation; strengthened capacity for management development; policy statement and strategies incorporating gender equality as a specific objective; national poverty reduction strategies to address the impact of HIV/ AIDS on development and poverty eradication through participatory multi-institutional mechanisms; and institutional capacity to plan and implement multisectoral strategies to limit the spread of HIV/ AIDS and mitigate its social and economic impact.

In many areas, it is too early to assess final outcomes and impact of some interventions due to limited time and uncertainties about sustainability. However, UNDP intervention has led to positive outcomes in several areas discussed below.

4.1 GOVERNANCE

4.1.1 Changes in policy and more effective planning related to HIV/AIDS

UNDP advocacy, policy support and advice on planning were important contributors to a policy environment that is more receptive to the HIV/ AIDS epidemic. They have also markedly improved national strategic planning and programming aimed at reducing the impact and consequences of HIV/AIDS and meeting MDG and UNGASS goals. UNDP has been, and continues to be, a key catalyst in this area, and has contributed to the adoption of a broad-based, multisectoral and multi-

level national response to the pandemic that includes mainstreaming in key sectors and plans.

UNDP's involvement with GOS in key aspects of national planning, in the form of policy support and capacities strengthening, has strategically positioned UNDP to be effective in ensuring that the fight against HIV/AIDS and the reduction of human and income poverty are addressed as major issues in macro-economic and development policies. UNDP has had these opportunities by being an important partner to GOS in operationalizing the NDS, the PRS and the development of the Prioritized Action Programme for Poverty Reduction. A contributing factor to the changes in planning appears to be that UNDP's programmes in Capacity Building for Democratic Governance, Gender Mainstreaming, and Poverty Reduction and HIV/AIDS Mainstreaming have been consistent with national development policy and acknowledge links between poverty and HIV/AIDS. These programmes have therefore facilitated UNDP's ability to assist GOS in identifying strategies for empowering vulnerable groups on poverty and HIV/AIDS. This has helped the PRSP identify vulnerable groups—such as women, children (especially orphans), and the elderly—so that specific strategies be employed in reducing the impact of poverty and HIV/AIDS on vulnerable households.

UNDP has also increased use of the MDGs and UNGASS commitments to influence policy formulation, prioritized planning, budgeting and implementation. The newly produced PRS is nationally owned and reflects MDG development strategies and policies. The PRS has incorporated them into national budgets, ministerial priorities, development activities and other assistance frameworks.

UNDP financial and technical support to GOS as well as information and awareness raising from sectoral impact studies, have increasingly begun to be reflected in political and policy commitment and leadership across sectors to the fight against the pandemic. Examples include the Royal Initiative to Combat HIV/AIDS, support for AMICAALL, and support for NERCHA in its appointed role of coordinating organizations focusing on the HIV/AIDS response. HIV/AIDS has been placed more centrally in national and sectoral planning and budgets, and planning has led to sector-specific and multisectoral initiatives at various levels. The Draft Poverty Reduction and Action Plan for example, is proposing multisectoral approaches to poverty, gender and HIV/AIDS, which are seen as interlinking issues. The draft HIV/AIDS Policy currently being developed, and the ministerial HIV/AIDS Focal Teams, are approaching ministerial mandates through multisectoral initiatives and mainstreaming HIV/AIDS in their sectoral activities. One of the key outcomes is that all government ministries have begun to mainstream HIV/AIDS and develop specific action points to be addressed by their various ministries.

Despite this progress, however, it is uncertain how well the new awareness, policies and plans will translate into action on HIV/AIDS. There has been some difficulty in implementing responses, and there is likely to be a need for ongoing support to consolidate and sustain outcomes. Informants noted that UNDP had previously missed important opportunities to translate strategies into actionable plans. In particular, stakeholders felt that ability to operationalize a more sustained and effective response required translation of the National Strategic Plan on HIV/AIDS into a National Action Plan. UNDP and stakeholders have only recently begun to address this gap as part of finalizing the National HIV/AIDS Multisectoral Policy, National Strategic Plan and National Action Plan to lead to stronger action.

4.1.2 Strengthened stakeholder participation to influence policy decisions

UNDP has contributed to enhanced stakeholder ability to influence HIV/AIDS policy by facilitating stakeholder participation. According to stakeholders, one of the significant UNDP interventions was enabling stakeholders from different sectors, including the private sector and civil society, to participate at the HDF. The HDF presented an opportunity for stakeholders and implementing partners to stimulate national dialogue on advocacy and communication about the HIV/AIDS pandemic. It also helped identify priority interventions in the fight against HIV/AIDS. For example, the Gender Focused Responses to HIV/AIDS has raised awareness on the importance of identifying those elements of culture that fuel the spread of HIV/AIDS and those that assist in preventing the spread of HIV/AIDS, so that positive cultural practices are encouraged and the negative ones discouraged. The Gender Focused Responses to HIV/AIDS encouraged policy makers to adopt a gender and human rights approach to the fight against HIV/AIDS.

The HDF has also assisted in building the capacities of participating organizations in articulating issues related to development, particularly HIV/AIDS, which has been at the forefront of the discussions. It has also fostered partnerships between the public and private sector and encouraged national dialogues on thematic issues like HIV/AIDS. The HDF is also felt to have strengthened private sector involvement in HIV/AIDS policy dialogue, which might otherwise have been very limited. In addition, involvement seems to have strengthened action within the private sector. For example, the Business Coalition through the Federation of Employers/ Chamber of Commerce has helped members put into place HIV/AIDS workplace policies and activities, and mainstream HIV/AIDS in other private-sector activities. They have also forged links with the media, through the Swaziland National Association of Journalists, to ensure information about HIV/AIDS in the workplace is disseminated to the public.

A number of stakeholders reported that their participation in HDF has enabled them to develop HIV/AIDS policies within their own institutions. They also hope that government policies will be influenced by recommendations made in the HDR. However, as the report has not been finalized, the Forum has not engaged with GOS fully to promote its adoption.

One area in which UNDP has not been fully successful in encouraging participation has been in arts and media interventions. Due to lack of financial resources, UNDP has not been able to continue with activities in this area.

4.1.3 Strengthened public debate and consideration of gender and HIV/AIDS

UNDP advocacy, policy support, training, and focus on gender and culture in the HDF and research studies were influential in triggering public debate on the link between culture and HIV/AIDS. This has resulted in greater prominence of gender issues in HIV/AIDS responses in Swaziland. A critical issue addressed is the vulnerability of women to HIV/AIDS because of women's legal and cultural impediments. Involvement and empowerment of women (and men, who had previously not been engaged in discussions on HIV/AIDS) was also seen as an important outcome, especially by communities engaged in CC. These have led to community-level recognition and discussion of gender issues related to HIV/AIDS.

Nevertheless, it is clear that complex challenges still remain in addressing the contribution of gender and cultural factors to the severity of the epidemic in Swaziland. UNDP is committed to undertaking further research into the roles of socio-cultural and gender factors in the high HIV/AIDS prevalence to inform the National HDR.

4.1.4 Increased recognition of PLWHA rights and increased rights-based approaches to HIV/AIDS

There are indications that rights-based approaches[40] to deal with the epidemic are being adopted within communities, private sector organizations, institutions and national policy. There has also been a reduction in HIV/AIDS stigma and greater involvement of PLWHA in making decisions about HIV/AIDS issues through their organizations and support groups. More companies and organizations are enacting rights-based workplace policies. Communities and traditional leaders are also giving more voice to PLWHA and allowing them access to resources that were previously unavailable to them.

UNDP contributed to these changes through various activities. These include: technical support and advice to PLWHA organizations, advocacy, national and workplace policy support, engagement with media and journalists, and community-level interventions. However, the extent of UNDP's contribution is not completely clear and it appears that more still needs to be done to reduce stigma and discrimination.

4.1.5 Enhanced credibility of NERCHA's coordination role

UNDP assistance has helped to enhance NERCHA's credibility and ability to coordinate the national multisectoral response. At inception, there was no funding for NERCHAs activities. UNDP helped by funding consultants to write proposals to the Global Fund. However, limitations still exist, including the need to strengthen coordination with the MOHSW.

4.2 LEADERSHIP DEVELOPMENT

UNDP support through L4R has enhanced leadership on HIV/AIDS at a number of levels. Various people who participated in the training have made striking changes in management and their communities. Resulting policies, plans and work practices have,

40 Human rights approaches to dealing with HIV and AIDS to ensure the rights of infected and affected persons are respected and promoted.

within a short space of time, changed responses to HIV/AIDS in the workplace and in communities. Stakeholders confirm that the leadership capacities to effectively respond to the epidemic have been enhanced in government, civil society and the private sector—including development partners, communities, traditional leaders, individuals, and the arts and media. The HDF convened by UNDP also seems to have contributed to stronger leadership in influencing critical policies and responses within government, organizations, the private sector and communities.

A number of examples of improved leadership due to L4R are listed below. A recent evaluation of L4R supported this change in leadership and indicated that the potential 'reach' of the interventions was wide. Nevertheless, it was difficult to establish the proportion of L4R trainees who have gone on to use their skills and the outcomes of their efforts. Thus far, it is not clear whether leadership 'breakthroughs' have had an impact, or how sustainable they may be.

4.2.1 Development of leadership on HIV/AIDS in government and the private sector

L4R has affected changes within a number of institutions with respect to practices to reduce and mitigate the effects of HIV/AIDS. Boxes 1 and 2 give some of the examples of success stories emanating from the leadership intervention facilitated by UNDP in 2002-2003.

4.2.2 Mobilization of traditional leaders for an effective community-level response

UNDP's L4R intervention has increased community mobilization for an effective response to HIV/AIDS

BOX 1. ENHANCED LEADERSHIP ON HIV/AIDS WITHIN THE POLICE FORCE

The Assistant Commissioner of Police attended the UNDP training in 2003. Upon completion, he initiated a number of interventions that represented major changes in the response of the police force to the HIV/AIDS pandemic. A Committee on HIV/AIDS has been set up in the force to initiate, coordinate and monitor activities aimed at addressing HIV/AIDS. In all four regions of the country, the police force has initiated awareness and education training for police officers. Training of police counselors was undertaken so that police can counsel all officers, irrespective of whether they are infected, affected or unaffected, on various aspects of the HIV/AIDS issues. The Assistant Commissioner confirms that, although the counselors have been well trained, most police officers are unwilling to attend counseling unless they are already sick. However, awareness on HIV/AIDS and the importance of testing is steadily increasing and according to the Assistant Commissioner, "more and more healthy police officers are beginning to test for HIV." Other initiatives include: attempts to address the increasing numbers of orphans within the police community and their welfare, as well as the development of a police HIV/AIDS Policy for the police force. This Policy has to await the development of the national policy. However, the Assistant Commissioner feels that if GOS is taking too long to formulate a national policy the police might be forced to go ahead and formulate theirs because people are dying. Police stations now have condom dispensers and senior police officers are encouraged to use them so that the junior officers can emulate them.

BOX 2. ENHANCED LEADERSHIP ON HIV/AIDS IN THE PRIVATE SECTOR

Ms. Phindile Weatherson is employed by Standard Bank and runs the autonomous HIV/AIDS Employee Wellness Programme. She attended the UNDP L4R training. While Standard Bank had a policy on HIV/AIDS, the L4R training was able to take Standard Bank management beyond the development of policies to enhanced workplace practices. Ms. Weatherson found that employing the UNDP methodology, particularly communication strategies that involved discussion teams using Emotional Intelligence, has produced more results than previous approaches. Under the programme, HIV/AIDS conversations are held at the workplace. Group discussions revealed that more staff members are discussing HIV/AIDS-related issues more freely, both before and after testing for HIV. Staff members are also more prepared to live with the consequences of the results of an HIV test and are more calm about it. This has greatly enhanced the existing HIV/AIDS interventions in the Bank. The programme's strengthened communication strategy has translated to more information available to the Bank's customers as well. Customers are free to call the programme for more information and sometimes they request condoms. A number of banks in Swaziland are now participating in HIV/AIDS Corporate Social Investment, which guides the companies' behavior when taking into consideration the social, environmental and ethical dimensions of their business practice and promotes a combination of concrete policy and action. Standard Bank was a pioneer of corporate social investment and other banks have followed its example.

using local traditional leadership structures that are respected by the communities. The majority of chiefs in the Shiselweni region was taken through the L4R Programme under UNF/UNFIP Programme, and a recent unpublished internal evaluation of L4R found that more than 70 percent of local chiefs have been reached by the intervention.[41]

Interventions targeted at the chiefdom level have led to a shift in perceptions and involvement of traditional leaders. Many chiefs now understand that HIV/AIDS is a national problem, that all citizens need to contribute towards combating it, and that the first and most important step is to get communities to develop local solutions. During the L4R three-day training for Shiselweni, the chiefs made certain resolutions for their communities. The first was a commitment to initiate responses within their communities to combat HIV/AIDS. Another commitment was that orphans should not be removed from their communities and that strategies must be designed to keep them within their communities and to meet their basic needs. The chiefs also decided to change the name 'orphans', which they felt stigmatized the OVCs, to *Bantfwana Bendlunkhulu* roughly translated to mean 'Children of Chiefs Kraal', meaning they belong to the community. Chiefs also agreed that children who have already been sent to orphanages should not lose links with their homes. Consequently, chiefs and SOS village[42] management are in dialogue on mechanisms that can be developed to do this.

A number of other commitments and direct responses by chiefs are examples of the success of L4R. Of the eight chiefs interviewed in this evaluation, all have called community meetings specifically to generate discussion on what the communities see as critical issues around HIV/AIDS. A number of communities had reached further stages in mapping out community action plans on how to tackle the pandemic. Several chiefs have allocated land for use in community activities aimed at fighting HIV/AIDS, such as planting maize and beans for OVCs, the elderly, and other people affected by HIV/AIDS. Some chiefs banned funeral feasts, because the huge amounts of food prepared sometimes leave orphans with no money for their upkeep. At Lavumisa, the chief has initiated a number of community projects aimed at economic empowerment of the community to increase resilience to HIV/AIDS and other threats to local development. At the forefront is the proposed construction of a hotel and a game reserve spanning Swaziland and South Africa under the Lubombo Spatial Development Initiative. The community has apparently received assurances of funding from the Development Bank of South Africa.

One chief interviewed was very pleased that they as chiefs were the first to be contacted and trained before the programme interacted with the communities. Past efforts by other entities, especially NGOs, tended to ignore chiefs. This is a comparative advantage of UNDP—more effective process management and better ability to involve key stakeholders than many other role players. This is important in that whatever future initiatives are proposed and undertaken by the communities in combating HIV/ AIDS, they will have the highest support from the local leadership.

4.2.3 Increased PLWHA involvement, leadership roles and development of role models

The UNDP L4R training programme has led to greater PLWHA involvement in assuming leadership roles within their communities. It also created role models of PLWHA within the communities. By training PLWHA, more people are being encouraged to find out their HIV status, join in the fight against HIV/AIDS and poverty, and to live positively. More PLWHA are coming out openly to discuss HIV/AIDS and forming support groups. There is a growth of youth associations and support groups both in rural and urban areas, particularly in the Shiselweni region where L4R has been part of the UNF/UNFIP and UNAIDS pilot project.

One example of the effects of L4R is provided by the HIV/AIDS support group, Imphilo Iyachubeka (Life Goes On) in Hlatikhulu. This group was formed after individuals attended L4R training. It has expanded its services beyond offering support and training to members to advancing plans for income generation. Imphilo Iyachubeka has secured three different plots of land from three different chiefs. One plot will be used to grow beans, cow peas, garlic and vegetables for their own consumption to improve their nutritional status. The other two will be used to cultivate commercial crops. Having observed the group, youth in four different communities within Hlatikhulu (who could not join it because they had not tested for HIV) came together and

41 Poppleton 2005.

42 SOS villages have been taking care of all the needs of orphans and vulnerable children throughout the Kingdom for decades.

formed the Hlatikhulu Youth in Action Against HIV/AIDS as an umbrella body for their community youth associations. They have also been given access to four pieces of land by the chiefs and they intend to plant herbs for export, maize and vegetables, and farm chickens. They have also won the support of a local businessman who has given them 12 months rent-free access to his property in town. This is used as offices and contains a counseling room, a car wash, hair salon, and activities such as welding and sewing to generate income to pay utilities and other running expenses.

Imphilo Isachubeka members expressed the following views in a focus group discussion:

- "Most of us can now talk freely about HIV/AIDS."
- "We can now admit that HIV/AIDS is now in our homes."[43]
- "Neighbors are now calling on members to assist and talk to sick relatives."
- "More people are now visiting the VCT centre[44] and we have now made many friends with whom we can share experiences."
- "There is still a lot of stigmatization."
- "Our biggest problem is that we do not have the necessary knowledge on how to involve the whole family of the PLWHA to be supportive."

4.2.4 Increased involvement and leadership among youth in responding to HIV/AIDS

UNDP intervention through the UNF/UNFIP project has facilitated youth mobilization for community projects and action aimed at mitigating HIV/AIDS and poverty. In addition to Hlatikhulu Youth in Action Against HIV/AIDS, another example is from Kwayiweni, where the chief went for L4R training under the UNF/UNFIP Programme. When he came back, he convened community meetings that identified the critical issues facing the community, including unemployment (especially among the youth), poverty, increasing crime and teenage pregnancies. The Kwayiweni Youth Association was established as result, with the aim of fighting unemployment. The Association plans to build a youth centre, start income generating projects, and assist HIV/AIDS orphans with profits from the income generated. The same strategy was adopted by the community at Manyiseni umphakatsi. The youth approached the Chief and the Inner Council for assistance in setting up a poultry project. The Chief and the community are now fundraising for a youth centre that will incorporate computer studies, craft work, sewing, upgrading a high school and a community hall.

While the chief and the youth group interviewed had knowledge about HIV/AIDS, they felt that the majority of the community still lacks sufficient knowledge on HIV/AIDS. The proposed projects will be undertaken with assistance from the Community Development Officers and the Rural Health Motivators who address HIV/AIDS in all their activities so that more and more members of the community will be reached.

According to informants, the response from the youth on the UNF/UNFIP project is very positive. Stakeholders also agree that the Peer Education Programme has multiplier effects in that the peer educators are reaching both youth and adults. Although statistics to show effects were not available, nurses and peer educators reported that youth attendance at most clinics in pilot areas has increased dramatically and that there have been fewer teen pregnancies. More youth are going for VCT, and youth now report sexually transmitted infections and go to the clinic to pick up condoms. They reported that before the intervention, most youth would only go to the clinic when they were already very ill or when traditional healers or chemists could not help them.

UNDP also enabled some youth to attend the Pan African Youth Summits in 2003, 2004 and 2005, aimed at breeding a new type of tomorrow's leaders focused on MDGs and with a component of HIV/AIDS. No clear outcomes of this were reported so far.

4.3 CAPACITY DEVELOPMENT

4.3.1 Local capacities for a decentralized response

Through CCE/CC, UNDP has increased the capacity of local institutions, including traditional structures, NGOs and CBOs, to provide the necessary external push factor that has strengthened the competencies of communities and organizations to take action on causes and impacts of HIV/AIDS.[45]

43 Before, most residents thought of HIV/AIDS as something that only happens in far away places and could not admit that what was killing them was HIV/AIDS.

44 On the day of the interviews, at least 115 people attended VCT at the Hlatikhulu centre.

45 CCE/CC was piloted in 2002 with participating partners including Swaziland AIDS Support Organisation (SASO), Red Cross, Family Life Association, The AIDS Support Centre , Council of Swaziland Churches, AMICAALL, Swaziland Action Group Against Abuse (SWAGAA) and the Siphila Nje Drama Society.

Through the CCE/CC tools and approaches, targeted communities have been able to reflect on HIV/AIDS issues and design local solutions to the causes and effects of the pandemic, in that way effectively decentralizing the response. Many communities have then been able to draw up response plans that are community driven.[46] Although no clear outcomes of these plans could be identified so far, CCE/CC has increased awareness of HIV/AIDS at chiefdom leadership level, and the chiefs now take a leading role in mobilizing communities to combat community challenges including HIV/AIDS. Chief Mzweleki of the Shiselweni region had this to say: "On several occasions, we brought our community together to strategize on HIV/AIDS. It became clear to us that issues like crime, drug abuse, poverty and prostitution have a direct bearing on the spread of HIV/AIDS in our community."

The CCE/CC has also increased capacity of institutions in the private and public sectors to upscale their responses to HIV/AIDS. This has been exemplified by the strategies undertaken by the police force, Standard Bank (see case studies above) and some other private sector companies.

However, the final outcomes and effects of CCE/CC are not completely clear. For example, AMICAALL has conducted CC in all main towns. These CC have identified, amongst other issues, the importance of addressing discriminatory laws and practices against PLWHA as well as the gender inequalities that have tended to fuel the pandemic. AMICAALL feels that town residents have better awareness about HIV/AIDS than those in rural areas as a result of initiatives like the CCE/CC (and initiatives by other stakeholders). However, such awareness appears not to have yet been translated into sexual behavioural changes, or other actions that are likely to have reduced impact of the epidemic.

The UNF/UNFIP project coordinated through UNDP has also trained PLWHA and members of PLWHA organizations. As illustrated in the discussion of leadership outcomes, this has helped to establish support groups and other capacity for more effective involvement in activities aimed at fighting HIV/AIDS.

46 Of the sampled chiefs, three-quarters of those interviewed have at least initiated community discussions and drawn plans on what their individual communities can do at the local level to fight HIV/AIDS while at the same time embarking on income generation activities.

4.3.2 National level response capacity

At the national level, L4R has developed individuals' leadership skills, attitudes and affected institutional changes that have enhanced HIV/AIDS responses within national ministries.

Several informants reported that the institutional capacity of key government ministries has been enhanced for planning, coordinating and managing appropriate programmes in critical areas of the HIV/AIDS response, including the area of linking national development plans with the HIV/AIDS response. This was made possible through the Capacity Building and Policy Support Programme provided by UNDP. The Programme combines multisectoral HIV/AIDS support and joint review of HIV/AIDS programmes and assists GOS in reviewing the efficiency of the civil service for better service delivery. An example of a process that has resulted is that the MOHSW, in conjunction with WHO, has been able to develop a Human Resources Planning for Health Programme to assess the skills gap due to HIV/AIDS. Further UNDP contributions to national level capacity have occurred through strengthening leadership skills for mainstreaming HIV/AIDS, and advice and support to develop policies in key areas of human rights.

UNDP assistance and support has enhanced NERCHA's role in coordinating efforts aimed at combating HIV/AIDS and in strengthening the development of multisectoral policies and activities to combat HIV/AIDS. Through UNDP technical and financial assistance, NERCHA has also been better able to mobilize resources for agents at the different levels of society. UNDP has also contributed to NERCHA's capacity to monitor and evaluate the national response by developing its monitoring and evaluations systems.

4.3.3 Strengthened capacity of key civil society organizations

UNDP has built capacity of CSOs through involvement in L4R and CC, as well as other support. This has helped to stimulate NGO and CSO activity on HIV/AIDS, as well as enhance their leadership and delivery capacity. A more strategic, holistic response to HIV/AIDS has been facilitated through UNDP training and support to well-placed network NGOs, as well as through direct support and specific engagements to enhance activities and networking of role players at national and other levels.

At the community level, informants reported that there is strengthened capacity of key CSOs, especially those formed by PLWHA, to respond and participate effectively in combating HIV/AIDS. UNDP, in collaboration with UNAIDS, facilitated support to Swaziland AIDS Support Organization to get them off the ground. They have also facilitated the formation of the umbrella body for PLWHA (SWANNEPHA) and also given technical assistance to SWAPOL. In addition to building institutional capacity, there have been positive effects in other areas of support to PLWHA, such as providing information and materials such as brochures.

UNDP further facilitated the establishment of AMICAALL and continues to support some of their activities, such as those funded under the UNF/UNFIP L4R. AMICAALL's activities in LDP are reported to have successfully contributed to leadership capacity development.

Some of the CSOs are now getting funding from the Global Fund to Fight AIDS, TB and Malaria through NERCHA and are engaging in income generation so that they do not rely on external assistance. However it is still too early to assess the sustainability and longer term effectiveness of UNDP's support to CSOs. Some stakeholders also expressed concern at the absence of a strategy by development partners, including UNDP, which promotes decentralized responses in peri-urban areas. They argue that while specific interventions target youth groups and PLWHA in the urban areas, the poverty stricken and vulnerable peri-urban areas are ignored, and that this could negate other efforts being made to combat HIV/AIDS.

4.3.4 Increased media capacity to contribute to the HIV/AIDS response

UNDP developed a strategy of using arts and mass media for social transformation using role models and leaders from different constituencies. Under the Leaders of the Southern Africa Editors Forum, HIV/AIDS has now been included in their programmes. The Swaziland editors benefited from training and, during the World Press Freedom Day, UNDP and UNAIDS organized a workshop for the Swaziland Editors Forum, the Swaziland National Association of Journalists and the Media Women's Association to discuss HIV/AIDS and the role of the media. In recent years, UNDP has also helped to revamp Swaziland National Association of Journalists by providing office space for them to work in and training on gender-sensitive reporting and HIV/AIDS issues.

Although improved media coverage of HIV/AIDS is reported, changes are still limited and there is a need to strengthen the media response. A series of training workshops for the media are in the pipeline to ensure more positive reporting on HIV/AIDS by journalists and to ensure a gender dimension to reporting since the majority of PLWHA are women.

4.4 MAINSTREAMING OF HIV/AIDS, MITIGATION OF IMPACT AND POVERTY ERADICATION

4.4.1 Multifaceted response to HIV/AIDS and mainstreaming into development plans

GOS and development agencies are integrating HIV/AIDS into the core of development planning and seem to have been influenced to do this by UNDP policy support and capacity enhancement programmes. Mainstreaming is reflected in the NDS, the draft PRS, the draft PRSP, and sector plans that have been developed. The Ministry of Labor and Public Service is engaged in that initiative to ensure that all ministries mainstream HIV/AIDS. UNDP has provided advocacy, technical and financial assistance to these planning processes. However, the PRS had not been finalized at the time of this evaluation, and it is difficult to assess as yet how effectively plans have mainstreamed HIV/AIDS. A major challenge for GOS is to ensure that budgets also mainstream HIV/AIDS effectively.

Through initiatives to develop capacity of local authorities, UNDP has also developed and strengthened skills at the national and local level for mainstreaming HIV/AIDS at a decentralized level, although it was not possible to fully assess the nature, number and effects of local HIV/AIDS plans and actions developed at local levels.

4.4.2 Viable models of VCT services piloted

An important outcome of UNDP assistance has been the piloting of a viable model of VCT services. In the first year after the establishment of the Hlatikulu VCT in 2003, 1,208 people had been tested for HIV and 1,002 came for post-test counseling. The local Imphilo Isachubeka Support Group helps counselors in educating clients on positive living and the benefits of testing. Client numbers are reported to be

increasing following visits to communities by counselors and members of the support group. However, this success has also created challenges for the service, which is reported to be short staffed. To cater to increasing client numbers, UNDP is having to renovate a wing of the hospital for VCT to replace the one room that is currently used. This intervention has the potential of bringing on board other development partners with different components of assistance to PLWHA. For example, WFP is now able to assist food insecure patients on ARTs and their families with food rations. And after depletion of UNDP funds, WHO pays the salaries of three of the counselors.

4.4.3 Reducing HIV/AIDS stigma

An important outcome of UNDP assistance, in the Shiselweni region especially, is the reduction of stigma around HIV/AIDS. PLWHA confirm that the level of stigmatization is now diminishing. They report, for example, that at first they met with mixed reactions when they publicly presented educational talks in schools, ranging from disbelief about their HIV status to not wanting to associate with them, but responses have become more informed and positive.

4.4.5 Mainstreaming of HIV/AIDS in workplace and other programmes

UNDP support has enhanced mainstreaming of HIV/AIDS in various sectors and development plans, although the outcomes of the efforts are not yet clear. UNDP has also supported mainstreaming in its own programmes and on workplace issues.

An innovative example of mainstreaming was UNDP's two digital villages. These had given communities access to information on HIV/AIDS especially at Mankayane where the community was running the digital villages on their own and generating some income (in the region of SZL 28,000 a year), prior to closing down. Although large numbers of youth come in to use the internet, there is no information on how much of the use is actually related to HIV/AIDS. Neither was it easy to discern whether it was an efficient way to improve knowledge and attitudes. At Nhlangano, the new Youth Centre being constructed as a pilot project by UNDP will have further HIV/AIDS components ranging from counseling services and education on HIV/AIDS, a computer room for information on HIV/AIDS and other activities.

An issue that also remains uncertain is the sustainability of the programme once UNDP funding has ceased. It appears that the exit strategy has not yet been fully defined and there are challenges. For example, the salaries paid under UNDP are much higher than those likely after the project is handed back to the community.[47]

UNDP has had some influence in promoting workplace responses in ministries, the private sector and UN agencies. However, clear and positive outcomes of this were not prominent. The unique We Care Workplace Initiative was discontinued due to limited resources. In particular, financial resources from other UN agencies were not forthcoming.

Other initiatives with uncertain outcomes are the facilitation of access to e-pap for nutritional support and the mushroom project. PLWHA groups confirm that e-pap is very expensive and unaffordable to many PLWHA, and its sustainability and impact may be limited. Similarly, the initiative to grow and sell mushrooms may not be feasible as the cost of mushrooms was too high for many PLWHA and cultivating them cannot generate the levels of incomes needed by producers.

4.5 PARTNERSHIP COORDINATION FOR COUNTRY LEVEL DEVELOPMENT RESULTS

4.5.1 Enhanced coordination of development partners

There are fewer bilateral agencies in Swaziland than in other countries in the region. UNDP has played a key role in bringing the few donor agencies that are there to a roundtable in order to maximize effectiveness of the limited resources in the national HIV/AIDS response.

UNDP has effectively coordinated donor funding and activities on HIV/AIDS to involve under the UN Theme Group on HIV/AIDS all the UN agencies as well as bilaterals and other agencies. Stakeholders consider that UNDP was effective during the period under review in using its mandate to hold donor roundtable conferences. Although the roundtable has ceased to exist, it was reported to be useful in fundraising for HIV/AIDS activities and

47 Ekukhanyeni digital village is also faced with a number of challenges mainly stemming from land disputes and lack of cooperation from some segments of the community.

coordinating UNCT programming as part of the UN Theme Group and joint programming. The UNDP PSD on HIV/AIDS has been used by both GOS and UNDP as a basis from which to solicit funding for programmes on HIV/AIDS.

In addition, UNDP has collaborated with other agencies on a number of other projects that have benefited from UNDP input and seem to have achieved some successes. Examples of improved joint programming include the UNF/UNFIP project in Shiselweni, the Indlunkhulu project with GOS, the UNICEF Neighborhood Care Point concept, and the WFP PRRO intervention. The UNF/UNFIP project was cited by the majority of respondents as a good project, with good intentions and with appropriate targeting. Many considered that it had achieved important results in terms of mobilizing the communities.

However, there are concerns about gaps on the ownership and sustainability of the UNF/UNFIP project and outcomes as implementation partners had not been fully integrated into the implementation process despite involvement of all stakeholders in the project proposal and launch stage. In addition, it was uncertain whether UNDP's input into projects such as UNF/UNFIP represented the most strategic use of UNDP resources and comparative advantages. UNDP's role was also thought to have been compromised by staff capacity limitations and turnover.

4.5.2 Local partnership development, coordination and coalition building

UNDP has facilitated coalition building among a wide range of stakeholders within the communities and nationally, especially through the HDF. In the comprehensive communication strategy for scaling up the response to the pandemic, UNDP adopted a human rights approach that has meant that more members within the communities (such as chiefs, youth, and women) are regarded as important actors. Communities have also been encouraged to involve outsiders in their discussions on critical issues, so that they can assist in translating analysis into action. At the local level, there are further examples of UNDP initiatives leading to effective partnerships between the chiefs, health education officers, women's groups and youth groups, as evidenced through the local HIV/AIDS groups that have received assistance from the chiefs, such as tracts of land for projects.

The HDF has also contributed to better coordination and networking of stakeholders from government, civil society, the private sector and other constituencies. In addition, support for setting up umbrella bodies for NGOs dealing with HIV/AIDS and CBOs, such as youth groups and SWANNEPHA, has also enhanced partnerships and collaboration.

5. CONCLUSIONS AND RECOMMENDATIONS

UNDP contributed to a number of outcomes in terms of a strengthened national response to HIV/AIDS during the period under review. In particular, UNDP policy guidance has been influential in assisting GOS in shifting to a multisectoral and expanded national response to HIV/AIDS that emphasizes the socio-economic context and the interrelatedness of HIV/AIDS with other development concerns, such as poverty and inequality. This has begun to translate into changes in national and sub-national development planning, domestic resource allocation, poverty reduction strategies, sector plans, and strategies to manage the socio-economic impact of HIV/AIDS. These are important changes, although in some areas, such as UNDP policy support on the PRS and the PRSP, sector planning, supportive legislation and media training, it is still too early to judge how effective and sustainable these changes are.

UNDP has also enhanced leadership and capacity for the HIV/AIDS response, particularly at decentralized levels. Support through L4R for the development of leadership at various levels of Swazi society has played a large role in developing capacity for strong leadership at strategic points of both the public and private sectors, as well as capacity to mainstream HIV/AIDS into development programmes.

Awareness and capacity around rights and involvement of PLWHA, as well as gender issues, have also been strengthened. Another outcome associated with UNDP has been enhancement of partnerships at donor, national and lower levels. There is also some suggestion that UNDP support may actually have led to enhanced prevention of HIV/AIDS through greater uptake of VCT in the Hlatukhulu pilot programme and through social mobilization by UNDP programmes like the L4R and CCE/CC.

5.1 COMPARATIVE ADVANTAGES AND MISSED OPPORTUNITIES

UNDP has several comparative advantages in enhancing the response to HIV/AIDS. The most prominent is that most of the programmes designed by UNDP CO conform with international conventions and obligations that Swaziland had signed and or ratified. Other comparative advantages are that UNDP has a good relationship with GOS in assisting it in addressing its priorities, and that GOS relies on UNDP assistance, especially on governance issues. UNDP also plays a more significant role due to the smaller size of the country and economy, and because there are fewer development partners active in the country. In addition, it has tools such as the PRSP, which have greatly improved national strategic planning and programming aimed at reducing the impact and consequences of HIV/AIDS.

UNDP has developed innovative, participatory and multi-institutional approaches for HIV/AIDS responses that can be rolled out by partners with more resources. In particular, L4R and the CCE/CC initiative have broken new ground. They have led to local action, particularly through use of key leaders such as chiefs, media, youth and PLWHA, and served as entry points to reach people within both rural and urban areas, and through AMICAALL, into the peri-urban areas to reach different target groups.

In general, UNDP identified appropriate targets for support. For example, the UNF/UNFIP project is viewed as a key intervention that is targeting the right people: youth are the most susceptible to HIV/AIDS, while chiefs have the power to move their audience and ensure implementation. Targeting a combination of leadership, youth, media and PLWHA seems to have had a synergistic effect of mobilization as well as de-stigmatization, resulting in more people talking about HIV/AIDS and publicly declaring their HIV status. Nevertheless, there were many interventions by UNDP and initiatives with uncertain effectiveness, such as digital villages, which raises questions about whether UNDP has always targeted areas of comparative advantage.

There are *missed or emerging opportunities* for UNDP to achieve outcomes. One case in point is the unmet need to translate the National Strategic Plan into a well coordinated HIV/AIDS Action Plan, although UNDP is now supporting planning processes that could remedy this. Similarly, it is also unclear whether increased awareness of HIV/AIDS and incorporation into other sectoral plans have received adequate follow-up support to translate them into effective action so far. Another example is that the L4R and other interventions have mainly, but not exclusively, focused on the Shiselweni region and some key traditional leaders within communities, such as teachers and faith based organizations, have not been covered thoroughly.[48] Limited plans and resource mobilization for roll out to achieve greater coverage and impacts are in place.[49] A third case in point is that the sustainability of initiatives and organizations supported by UNDP is uncertain without further support for consolidation, and UNDP may need to consider follow-up support and closer attention to exit strategies in order to optimize outcomes.

Important constraints on UNDP seem to be high staff turnover and limited resources. This makes it difficult for it to develop strong enough approaches for follow up and technical support for people/organizations that participate in its programmes to help them plan and implement better.

5.2 RECOMMENDATIONS

1. UNDP should provide more support to operationalizing strategic level plans and interventions. A priority is development of a National Action Plan on HIV/AIDS to follow up on the current National HIV/AIDS Strategic Plan for Swaziland.

2. Having seen the immediate results of the L4R and CCE/CC, UNDP should scale up the intervention and increase its coverage of other regions as well as key traditional, faith based and community leaders. This requires increased efforts aimed at training leadership structures on CCE/CC through trained facilitators.

3. UNDP and its partners should design clear exit strategies from programmes and projects to ensure

48 For example, several traditional structures that are essential links between the government, traditional leadership and communities, and can assist those leaders who have started initiating change within the communities. These include Tindvuna Tetinkhundla and Bucopho BetiNkhundla, who head and run the affairs of constituencies (that include five or more chiefdoms), where all development activities and elections are held, and Lutsango LwakaNgwane.

49 In February 2005, UNDP announced the upscaling of this initiative to include Bucopho BeTinkhundla.

sustainability of outcomes after withdrawal of support. Effectiveness and sustainability also require participation of all stakeholders (UN, donors, government, NGOs, CBOs, etc.) to increase ownership of programmes and support for implementation. In the case of the UNF/UNFIP project, there is a need to build capacity within the Deputy Prime Minister's Office so that they can play stronger coordination roles throughout processes, to clarify roles of NERCHA and SNAP, and facilitate implementation by NGOs and other stakeholders.

5. UNDP should facilitate the development of a strategy that specifically targets the peri-urban areas.

6. UNDP should focus on facilitation and catalytic roles, instead of implementation, in order to achieve coverage of its innovations, particularly services such as VCT. There is a need to strengthen partnership strategies to bring on board other partners who have more resources and/or technical capabilities in such areas.

7. UNDP should continue to emphasize gender and cultural issues in its programming to address these important influences on the severity of the epidemic in Swaziland. In particular, strategies need to be put into place to encourage more men to participate in support groups for PLWHA. Partnerships with WFP can potentially use pilot groups that receive food-aid under the PRRO to involve more men in scaling up the response to HIV/AIDS.

8. UNDP should review CO capacity, resources and turnover rates of CO staff as these seem inadequate for UNDP to fulfill its potential role in Swaziland.

9. UNDP should ensure increased support for the role of UN and Peace Corp Volunteers who are already stationed in the affected rural areas.

ANNEX 1. ACRONYMS AND ABBREVIATIONS

AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ART	Antiretroviral Therapy
DFID	Department of International Development (UK)
CO	Country Office
CBO	Community Based Organization
CC	Community Conversations
CCE	Community Capacity Enhancement
GDP	Gross Domestic Product
GNP	Gross National Product
GOS	Government of Swaziland
HDF	Human Development Forum
HDR	Human Development Report
L4R	Leadership for Results
MDG	Millennium Development Goal
MOHSW	Ministry of Health and Social Welfare
NDS	National Development Strategy
NERCHA	National Emergency Response Committee on HIV and AIDS (later transformed to Commission)
NGO	Non Governmental Organization
OVCs	Orphans and Vulnerable Children
PLWHA	People Living With HIV/AIDS
PRRO	Protracted Relief and Recovery Operations
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Plan
PSD	Programme Support Document
SNAP	Swaziland National HIV/AIDS Programme
SWANNEPHA	Swaziland National Network of People Living with HIV and AIDS
SWAPOL	Swazis for Positive Living
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Testing and Counseling
WFP	World Food Programme
WHO	World Health Organization

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ANNEX 3. PEOPLE INTERVIEWED

GOVERNMENT OF SWAZILAND

Sipho Dlamini, Assistant Commissioner, Police
Dr. Vincent Matsebula, Head of Public Policy Coordination Unit, Prime Minister's Office
Zelda Nhlabatsi, Coordinator, AMICAALL (Hlatikhulu and Nhlangano)
Patrick Nxumalo, Finance Manager, AMICAALL, Ezulwini Town Council

UNDP

Allen Dlamini, Programme Assistant, Gender and Governance
Jabulane Dlamini, Governance Advisor, Gender and Governance
Sibongile Maseko, Programme Officer, HIV and AIDS
Jabu Matsebula, Communications Officer
Sakinah Morris, Programme Associate, Gender and Governance,

UN SYSTEM

Dr. Alan Brody, UNICEF Country Representative
Thembisile Dlamini, Programme Coordinator, UNAIDS
Khanya Mabuza, Programme Coordinator, UNFPA
Mfanawenkhosi Maseko, Coordinator UN/UNFIP
Lolo Mkhabela, Coordinator, UN Disaster Management Office and Assistant to RC
Dr. Thuli Nhlengethwa, Former UNF/UNFIP Coordinator
Sthembiso Hlatjwako, Programme Officer, World Food Programme

NON-GOVERNMENTAL, CIVIL SOCIETY AND OTHER

Chief Cijimpi Dlamini, Acting Chief, Mampondweni, Zombodze
Mfanukhona Dlamini, Hlatikhulu Youth in Action Against HIV and AIDS
Chief Mzweleki Dlamini, Acting Chief, Lavumisa
Chief Samuel Dlamini, Chief, Embabala, Shiselweni
Chief Bhejisa Lushaba, Chief, Manyiseni, Hosea
Gugu Masilela, Secretary, Hlatikhulu Youth in Action Against HIV and AIDS
Ncamsile Matsebula, Swaziland Broadcasting and Information Services
Elphas Mhlanga, Deputy Chairperson, Hlatikhulu Youth in Action Against HIV and AIDS
Mpumi Mhlongo, Chief Counsellor, Hlatikhulu VCT
Chief Mfanawendlela Mkhonta, Chief, Ngonyameni, Zombodze Inkhundla
Chief Magoloza Mkhonta, Chief, Ngwenyameni
Mpumi Mlangeni, Chairperson, Hlatikhulu Youth in Action Against HIV and AIDS
Chief Abel Mntshali, Chief, Ngonyameni, Zombodze
Thulani Ndlangamandla, Youth Representative, Manyandzeni
Gcebile Ndlovu, International Community of Women on HIV and AIDS
Chief Ngome Ndlangamnadla, Manyandzeni Chiefdom
Ms. Thembi Nkambule, Representative, SWANNEPHA
Patrick Shabangu, Chairman, Imphilo Isachubeka (HIV and AIDS Support Group)
Siza Sifundza, member, Hlatikhulu Youth in Action Against HIV and AIDS
Elizabeth Simelane, Member, Hlatikhulu Youth in Action Against HIV and AIDS
Phindile Weatherson, Standard Bank

ANNEX 4. CASE STUDY

SWAZIS FOR POSITIVE LIVING (SWAPOL)

Swazis for Positive Living (SWAPOL) was launched by a group of middle-aged HIV-positive Swazi women and has been supported by UNDP to assist communities with training and formation of support groups for people living with HIV/AIDS (PLWHA). SWAPOL was formed to provide support specifically for women living with HIV/AIDS and to increase priority given to their needs. SWAPOL created a network for women to share information on ways to cope medically and psychologically with HIV/AIDS. It also sought to reach out to communities and address issues like home-based care and aid to the growing number of orphans and vulnerable children (OVCs).

Its current initiative is to establish an agricultural cooperative to raise funds through agriculture for sustaining other activities without reliance on donor support. Although none of its members knew how to run a business, SWAPOL built on the widespread knowledge of agriculture among its members.

"Because we deal with HIV/AIDS in a country where this is such a big problem, and we are well organized, we have been successful getting donor funding. But we are striving for sustainable projects in agriculture. We have not failed, but it is a lot harder," says Siphiwe Hlophe, founding member of SWAPOL.

So far, only a fraction of the group's revenue comes from proceeds from the agricultural cooperative. But SWAPOL is scrutinizing the lessons they have learned in agriculture and is learning about the marketplace.

Hlophe and her colleagues found an empty field they wanted to cultivate, which was on the part of Swazi Nation Land set aside for community service. All the chiefs of the area had to agree to allow SWAPOL to use the land. Initially, they were not supportive, but SWAPOL found an ally in an acting woman chief, who communicated to the other chiefs that SWAPOL was trying to help the chiefs and the community as a whole. The female chief had orphans she had to take care of. The other chiefs were all men, but they had orphan problems in their areas. "She also saw our plans as a way of give jobs to some unemployed youth and to bring assistance to people living with HIV/AIDS", says Hlophe.

Two years ago, at a time when the new organization was setting up its first support centres for PLWHA and training a first batch of community workers and home caregivers, volunteers began to cultivate their 11 hectare field at Mahlangatsha. When the first crops were ready, a formula for proportioning the harvest was devised. "We would sell whatever we grew, and we paid no salaries because everyone had volunteered to work. Half the profits are put back into the field for purchases of fertilizer and tools, 25 percent is shared among the members, and the remaining 25 percent goes directly to assisting people living with HIV/AIDS," said Ellen Hlatshwako, a SWAPOL founding member who supervises operations at Mahlangatsha with another of the five founding members, Nonhlanhla Dlamini.

"Last year, we got a shock. We have no control over markets, and we found maize prices were too low and fertilizer costs were high," said Dlamini. The 2003-2004 harvest resulted in 300 bags of maize. 50 bags were put into storage for emergencies, 5 bags were given to the neighborhood care points where orphans and poor children receive hot meals and rudimentary education, and 10 bags were delivered to area households run by teenagers who had lost parents to HIV/AIDS. The remaining maize was sold for SZL 24,000. "In agriculture, you have to be flexible. We grew maize because it is the Swazi staple food, and everyone grows it. But no more. For 2004-2005 we have planted vegetables, groundnuts, sweet potatoes and jugo beans, which are high in protein. We still grow some maize, not for sale but for the children's consumption," said Hlatshwako.

The chiefs were impressed by the women's ability to bring in two consecutive harvests. The group is seeking a new field in the southern town of Hlatikhulu to meet the needs of orphans and PLWHA there. SWAPOL membership is now 500, and more than 10 percent of members are men. But mortality has also taken its toll. Thelma Dlamini, the architect of the agricultural cooperative, was the second founding member to succumb to AIDS when she died last July. Of the 20 communities where SWAPOL has set up a home based care operation,

the mortality rate for people ill from AIDS has ranged from 2 to 60 percent in some areas. "Having HIV/AIDS is not a death sentence. Our mission is to spread the message of positive living. This is done through healthy diets, involvement with other people, so a sick person is not isolated and depressed, and safe sex," said Hlophe.

A spin-off group, SWAPOL Youth, is being formed in two communities and already has 150 members in Hlatikhulu and 32 members north of the central commercial town Manzini. Some are HIV positive, and those not infected are given the message of protection against HIV. They plan to emulate SWAPOL's development of unused fields to cultivate marketable produce. Donor agencies are also attracted to the organization. While the agricultural marketplace might be fickle, the war chests full of funds to combat AIDS in the country with the world's highest HIV infection rate are being open to SWAPOL.

Last year, the group received SZL 635,000 in grants, half from UNICEF. The Stephen Lewis Foundation provided SZL 238,000, a group from Denmark sent SZL 17,000 and SZL 38,000 came from a Dutch journalist. None of the money goes to SWAPOL members or the agricultural projects, which must be self-sustaining. The donor largesse funds training programmes for caregivers, getting medical attention to children and widows, home-based care, and neighborhood care for OVCs.

This past year, SWAPOL has organized 110 Child Protection Committees in various communities, and stepped up the training and placement of community counselors to assist AIDS orphans, widows, and PLWHA. These activities are coordinated out of a two-room office in Manzini by Siphiwe Hlophe. The two remaining founding members, Hlatshwako and Dlamini, remain in the field supervising the agricultural projects that SWAPOL hopes will one day overtake donor assistance as the group's principal source of income.

Adapted from: Hall J, "AIDS Lifeline: Positive News from Positive Livers," *Times of Swaziland.*

ZAMBIA COUNTRY STUDY

HIV/AIDS

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

By Mukosha Bona Chitah

The author thanks the UNDP Country Office Zambia for the invaluable help it provided.

ZAMBIA

CONTENTS ZAMBIA COUNTRY STUDY

Boxes, tables and figures

1. INTRODUCTION

This is an assessment of the role of the Zambian UNDP country office (CO) to the HIV/AIDS response in Zambia. The period covered is between 2000 and 2004. The evaluation assesses what changes or outcomes have occurred in the national response that can be associated with UNDP programmes and activities.

It is now accepted at the highest political levels that the high rate of HIV/AIDS prevalence is eroding the social-economic structures and foundations necessary for the sustainability of development in Zambia. The response to HIV/AIDS is increasingly organized on a multisectoral level that incorporates religious, cultural and political leaders as well as civil society, the public sector and the private sector.

UNDP has a mandate to facilitate capacity and institutional development to foster sustainable human development at various levels including the government, communities and households. In this regard, UNDP focuses on the formation and implementation of strategies to combat HIV/AIDS that understand the extent to which HIV/AIDS permeates society and evolve over time in response to the epidemic's developmental consequences and effects on society. UNDP's response should therefore be relevant to the overall national response.

This evaluation assesses UNDP's performance in assisting Zambia's progress towards national and international targets necessary for reversing the progression of the pandemic in a sustainable and consistent manner.

1.1 METHODOLOGY

The assessment was undertaken in October and November 2004. The methodology was based on the approach, guidelines and instruments discussed in a workshop of national and international consultants in Johannesburg. Use of these was customized to ensure relevance to the Zambian context. The evaluation used a process of desk analysis, literature review, and field work that included focus group discussions and other interviews of key informants and stakeholders. The sources included personal interviews as well as focus group discussions in Lusaka, Lusaka Province, Mwinilunga and Solwezi in the North-Western Province, and Siavonga in Southern Province.

Preliminary finding were presented at a stakeholder workshop for discussion and validation. Findings were also validated through triangulation of the views expressed by various stakeholders and documents. In accordance with the principles of the UNDP Evaluation Office's Guidelines on Outcome Evaluation, the assessment considered four states in the process of outcome evaluation: outcomes, substantive influences, UNDP contribution, and the ability of UNDP to form strategic and operational alliances towards optimizing resource use and maximizing yields.

1.2 COUNTRY BACKGROUND

Zambia's development situation has regressed in recent decades. The country's human development index has declined from 0.448 in 1975 to the current 0.42 due to increasing poverty and the effects of HIV/AIDS.

Zambia's per capita income has declined from an average of USD 700 in the late 1960s and early 1970s to approximately USD 300 as of today. Poverty is a severe problem, with higher levels in rural areas (Table 1). Recent droughts have increased food insecurity and poverty in the country.

The HIV/AIDS epidemic is impacting Zambia in the context of a weakened economy, increased poverty levels and declining health status of the population. Both external factors and internal factors combine to adversely impact domestic capacity for programme delivery and to exacerbate the effects of emerging and resurging conditions of HIV/AIDS, malaria and tuberculosis (TB).

Key initiatives have been developed to address the socio-economic situation. These include the Transitional National Development Plan (TNDP) 2001-2006 and the Poverty Reduction Strategy Paper (PRSP), which are primarily coordinated by the Ministry of Finance and National Planning and assisted by UNDP and other development partners. The current UN strategy for HIV/AIDS in Zambia has been organized as a coordinated response that

TABLE 1. POVERTY STATUS BY REGION

Region	Overall Poverty	Extreme Poverty
Rural Areas	83	70
Urban Areas	56	36

Source: Ministry of Finance and National Planning, "Poverty Reduction Strategy Paper, 2002-2004," Lusaka, 2002.

TABLE 2. ZAMBIA'S PROGRESS IN ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS

Goal/Target	Assessment	Assessed National Support
Extreme poverty — Halve the proportion of people living in extreme poverty between 1990 and 2015	Unlikely	Weak, but improving
Hunger — Halve the proportion of people suffering from extreme hunger between 1990 and 2015	Unlikely	Weak, but improving
HIV/AIDS — Halt by 2015 and begin to reverse the spread of HIV/AIDS	Potentialy	Fair

Source: Ministry of Finance/UNDP, "Millennium Development Goals: Progress Report 2003."

encapsulates poverty, hunger, and other diseases such as malaria and TB.

The most recent evaluation on the status of the attainment of the Millennium Development Goals (MDGs) in Zambia was released in mid 2004. This is summarized in Table 2.

2. HIV/AIDS SITUATION

HIV/AIDS is one the leading causes of morbidity and mortality in Sub-Sahara Africa. The epidemic has registered the worst indicators in terms of prevalence, morbidity and mortality in the Southern African region, including Zambia.

Since the HIV/AIDS epidemic was first diagnosed in the early 1980s, the rate of infection and consequences have been rapid and catastrophic. HIV/AIDS has been the single most significant threat to life expectancy in recent history and has led to the erosion of developmental gains and fragmentation of social structures. The epidemic also threatens vulnerable groups, especially children, youth and women. Women have been unduly exposed due to traditional and cultural values as well as their economic dependence on the male as head of the household.[1] Young women have often been victims of transactional sex as well as inter-generational sexual relationships, aspects of risky behaviour that have translated into higher infection rates among young women in comparison to their male peers.

TABLE 3. HIV PREVALENCE BY AGE GROUP

Age Category (years)	Women Infected (%)	Men Infected (%)	Total Infected (%)
15-19	6.60	1.9	4.6
20-24	16.30	4.4	11.4
25-29	25.10	15.0	20.4
30-34	29.40	20.5	25.1
35-39	22.26	22.4	22.5
40-44	17.30	20.5	18.9
45-49	13.60	20.2	16.5
50-54	-	7.3	-
55-59	-	11.7	-

Source: Central Board of Health/Central Statistics Office, "The Zambia National Health Demographic Survey, 2001/2002."

TABLE 4. HIV PREVALENCE IN RURAL AND URBAN AREAS

Region	Women (%)	Men (%)	Total (%)
Urban areas	26.3	19.2	23.1
Rural areas	12.4	8.9	10.8

Source: Central Board of Health/Central Statistics Office, "The Zambia National Health Demographic Survey, 2001/2002."

Tables 3 and 4 highlight several aspects of the epidemiology of HIV/AIDS in Zambia. The most recent measurement of adult prevalence at the national level was estimated at 16 percent.[2] This estimate is lower, but comparable, to previous estimates of 19.8 percent, which were based on prevalence measured among pregnant women rather than all adults.[3]

Analysis by age group and gender shows that prevalence is highest among women aged 25 to 34 years, and that levels are lower and peak in older age groups among men. Infection levels are more than three times higher among women in the 15 to 24 year age group than among men of the same age.

The levels of infection are much higher in urban than rural areas, which have consistently demonstrated lower prevalence (Table 4). Currently available data indicate a general stabilization of infection levels.

1 Demographic and Health Survey, "HIV/AIDS Projections, 1997-1999," 2001-2002.

2 Demographic and Health Survey, "HIV/AIDS Projections, 1997-1999," 2001-2002.

3 Ibid.

There are some indications of behaviour change and declining infection levels, particularly among urban and more educated young people. However, infection rates remain at high levels and trends differ between areas of the country.

There are an estimated 700,000 orphans in Zambia due to the death of one or both parents as a consequence of HIV/AIDS.

Understanding the determinants of HIV/AIDS risk is an area that requires further research and analysis in order to refine responses to the epidemic. Nevertheless, available information suggests the following have been important contributors to the severity of the epidemic:

- **High poverty levels in both urban and rural areas.** These put women, in particular, at risk. The prevalence of poverty has been shown in localized studies in border cities and towns (as well as transit towns on busy transport routes) to be a causal factor for transactional sex.
- **Limited knowledge about HIV/AIDS** and methods of transmission and prevention, including condoms.
- **Social and cultural beliefs and practices,** especially those that subject women to subordination and dependency. Unequal status of women in partnerships aggravates the tendency for men to engage in high-risk behaviour away from home and still subject their partners to sexual relationships (as women don't have the option of refusal). Some studies on the Copperbelt have shown that the rate of infection is highest in certain age groups among married (as opposed to single) women. This is thought to be due to their dependency on male partners who may engage in high-risk behaviour.
- **Stigma and discrimination.** This undermines both prevention as well as ability to access services and other support.
- **Mobility.** Long-distance drivers, refugees, migrant workers, fishermen, uniformed personnel and other groups that tend to stay away from home frequently or for long periods appear to be at higher risk.
- **Prison confinement.**

3. COUNTRY RESPONSE

3.1 NATIONAL RESPONSE

The Zambia national response to HIV/AIDS has evolved as perceptions of the nature of the epidemic and priorities have changed, along with available resources and interventions. Table 5 summarizes the evolution of the national response. The initial response was the formation of a National AIDS Prevention and Control Programme by the Ministry of Health in 1986, as recognition of the severity of the pandemic manifested itself and a greater understanding of risk and transmission were developed. During 1988, a four-year programme under the first Medium Term Plan was developed. This represented the beginning of the multisectoral recognition of the HIV/AIDS pandemic. It addressed TB; sexually transmitted infections; counselling; information, education and communication; laboratory support and strengthening; epidemiological research; programme management; and innovative AIDS care through the Home Based Care Programme. The Medium Term Plan was extended between 1994 and 1998.

TABLE 5. EVOLUTION OF THE NATIONAL RESPONSE TO HIV/AIDS IN ZAMBIA

Year	Programme Area
1986	National AIDS Prevention and Control Programme
1987	Emergency short-term plan for safe blood and blood products
1988–1992	First Medium Term Plan (Priorities: TB; leprosy; information, education and communication; counselling; laboratory support; epidemiology and research; sexually transmitted infections and clinical care; programme management; home based care)
1994–1998	Second Medium Term Plan (multisectoral in design, inter-sectoral coordination and collaboration provision included)
March 2000	Cabinet Committee of Ministers to provide general guidelines to government management of HIV/AIDS
2000–2001	Transitional team to develop initial operations and structures
2000	Creation of NAC
2001–2003	Development of National Strategic Framework

Source: National AIDS Council, "Joint Mid-Term Review of the NAC," 2003.

In 2000, the political, economic and social relations of HIV/AIDS, and increasing commitment to the response, were reflected in the forming of the Cabinet Committee on HIV/AIDS and the Parliamentary Committee on Social, Health and HIV/AIDS. The National HIV/AIDS/STIs/TB Council (NAC) was established in 2000.

A draft of the national HIV/AIDS Policy was developed after the formation of NAC in 2000. This elaborates the government principles for a multi-faceted, multisectoral response and has provided the framework for the implementers and other stakeholders in terms of forming and implementing HIV/AIDS responses. The National HIV/AIDS/STI/TB Intervention Strategic Plan, 2002-2005 (Strategic Plan) was formulated and adopted following the formation of NAC. The Strategic Plan has since been revised and a second version is now in use. Implementation has involved partnerships among various stakeholders and is inclusive of all sectors in the private and public sectors, including non governmental organizations (NGOs), faith-based organizations and others.

Recently, there has been increasing recognition that a fundamental prerequisite for a stronger response lies in an efficient and well functioning coordinating mechanism. So far, however, the NAC has made slow progress in assuming this role. Progress has been limited by inadequate human resources in NAC, which has been unable to perform key functions, such as a monitoring and evaluation and technical support to other decentralized structures.

Decentralized coordinating mechanisms at provincial, district and community levels have also developed slowly. District AIDS Task Forces (DATFs) and Provincial AIDS Task Forces (PATFs) for coordinating HIV/AIDS were only formed in 2002. The integration of communities, traditional leaders, key players in the local-level response and programme implementation, started mainly after the formation of the DATFs.

Overall, coordination of a multisectoral response has been extremely weak at all levels of the system. There have been no formal and legal structures to assume a coordinating structure at the district level. This has contributed to a fragmented and weak HIV/AIDS response at the grass-root community level. Responses at the national level have also, to some extent, not been cognizant of cultural and traditional values and lacked essential coverage of communities for effectiveness and efficiency.

3.1.1 Priority programme interventions and goals

The National Strategic Plan outlines the following priority areas for programme intervention:

- Mobilization of a multisectoral response
- Prevention and behaviour change and communication
- Elimination and prevention of stigma and discrimination
- Enhancement and advocacy for resource mobilization
- Enhancement and advocacy for a multisector, coordinated response that incorporates planning, management, monitoring and evaluation
- Improved and expanded community home based care (HBC)
- Improved and expanded antiretroviral therapy
- Improved and expanded prevention of mother to child transmission.
- Mitigation of the social-economic consequences, especially to orphans and vulnerable children (OVC), women and girls
- Strengthened health systems response
- Integration of responses in sector mandates

The framework above formed the basis for the identification of strategic areas and catalytic projects for interventions. These include the following:

- Response to HIV/AIDS in a holistic way from line ministries and sectors
- Development of evidence-based guidelines of best practices
- Identification of ways for expansion of best practices
- Breaking down of communication barriers, taking into account cultural, religious and other issues that may inhibit HIV prevention
- Institutional framework that avails a coordinated response
- A decentralized and community-based community-level implementation process

3.1.2 HIV/AIDS in development and poverty reduction planning

The TNDP 2001-2006 sets out development priority areas and national strategies to address the priority goals. The TNDP includes HIV/AIDS as a cross-cutting issue. The plan provides the context and national framework for development, which then integrates the themes and framework of the PRSP. These plans set out a development policy

framework with the following main themes: sustained economic development, employment creation and poverty reduction.

The PRSP 2002-2004 has specifically recognized the impact of HIV/AIDS. The PRSP notes that poverty levels in the country range between 80 percent in rural areas and 53 percent in urban areas. The PRSP's approach has been to include HIV/AIDS as a cross-cutting issue that is interlinked with poverty and affects the economic well being of individuals and households. In particular, the PRSP recognizes gender relations and how vulnerability due to gender, culture and tradition interact economically and socially. Given the epidemiology of HIV/AIDS, the PRSP makes note of the overall transmission mechanisms, risk factors, sectoral effects, and medical and social consequences of HIV/AIDS. The cost and other impact of HIV/AIDS on the health sector are highlighted in particular. The PRSP addresses the following areas:

- Prevention of new infections
- Expansion of voluntary counselling and testing (VCT) services to reduce new infections
- Reduction and mitigation against the socio-economic impact of HIV/AIDS
- Strengthening and expansion of community HBC
- Improved quality of life of OVC
- Introduction and access to antiretroviral therapy
- Improved and expanded sexually transmitted infection treatment and management
- Expansion and access to prevention of mother to child transmission
- Prophylaxis against TB
- Issues relating to gender and legislation (human rights), to ensure recognition of the gender relations and rights based responses

The linkage to poverty remains the fundamental relationship in terms of risk, vulnerability and security against HIV/AIDS. However, as can be seen above, the responses or interventions that are highlighted in the PRSP tend to focus on clinical responses.

3.1.3 Political will and advocacy for the national response

There has been increasing political commitment, advocacy and mobilization against HIV/AIDS. The current President, First Lady, Vice President and entire Cabinet are now actively participating in the response to HIV/AIDS. The First President has formed a Foundation, Kenneth Kaunda's Children's Foundation of Africa (KKCAF), which addresses issues of care and support, mitigation for OVCs, advocacy and research in HIV/AIDS.

Support and political commitment from the highest level have, in general, had a positive effect on mobilizing the lower levels of the administrative and political structures. In focus group discussions during this evaluation, focal-point persons in various sectors as well as civil servants, NGOs, and traditional rulers who are members of the DATFs, District Development Coordinating Committees (DDCCs), PATFs, and Provincial Development Coordinating Committee (PDCCs) spoke about the 'favourable political will'. However, there were often reports of reluctance among superior civil servants and private sector organizations to facilitate the work of focal-point persons and structures such as DATFs and PATFs.

3.1.4 Budget allocations and requirements for HIV/AIDS

The President, Cabinet and Parliament have played a key role in securing national budget allocations for HIV/AIDS. In the last two years, there have been specific allocations for antiretroviral drugs, line ministry HIV/AIDS responses, and workplace programmes. Between 2000 and 2003, national budget allocations for these rose from less than USD 100,000 to almost USD 2,800,000.

Nevertheless, budgetary shortfalls remain. Zambia's projected resource requirements for HIV/AIDS between 2001 and 2005 were estimated to be approximately USD 560 million. The resource mobilization commitments for the same period have been estimated at USD 115 million (see Annex 4).[4]

3.1.5 Strengthening of health system response programmes

The health system is beginning to be strengthened in terms of training of human resources and procurement of equipment to support the laboratory and diagnostic functions necessary for antiretroviral therapy. Health sector VCT services are developed and the number of facilities engaged in an antiretroviral therapy programme has increased from just 2 of the tertiary institutions during the last two years to almost 15, including all the secondary level facilities.

4 NAC Financial Database, 2004.

TABLE 6. SOURCES OF FUNDING FOR NATIONAL AIDS COUNCIL, 2003

Source	Funding (USD)	Programme Area
Government	3,000,000	Purchase of antiretroviral drugs
	300,000	HBC and awareness
UNDP	1,000,000	Support to NAC provincial and district coordination support (transport, technology equipment), UNVs
DCI	134,000	Support to PDCC and DDCC for coordination
Asian Development Bank	1,000,000	NAC
Norwegian Development Agency	500,000	NAC, VCT
Global Fund	1,300,000	CBoH CHAZ, Zambia National Aids Network (antiretroviral drugs and civil society/private sector response)
	7,818,032	
	443,772	
	425,150	
World Bank	500,000	NAC, line ministries workplace programme, coordination at district level
	215,482	

Source: National Aids Council Database, 2004. Note: HBC indicates home based care; NAC, National AIDS Council; UNV, UN Voluneer; PDCC, Provincial Development Coordinating Committee; DDCC, District Development Coordinating Committee; CHAZ stands for Churches Health Association of Zambia.

3.2 UNDP RESPONSE

UNDP's response to HIV/AIDS in the period assessed (2000-2004) has been distinguished by an approach of working within government-determined priority areas, needs and requirements. However, UNDP's share of resource levels and support to the multisectoral response has been rather limited (as noted in Annex 4). The question of the optimal utilization and strategic nature of UNDP support has therefore been a key issue. UNDP has tended to support areas that other donors have not identified with until recently. These include support for the NAC structures and developing community structures, and facilitating community responses. These structures and systems targeted by UNDP support are considered to be imperative to facilitate an effective national response. UNDP has also attempted to address issues of synergy among its priority areas and justification for programme identification and support.

Collaborating partners in the area of HIV/AIDS, as recorded by NAC, are shown in Table 6.[5] Though data are not complete, they illustrate that UNDP contributed a substantial proportion of NAC structures' core funding in 2003.

3.2.1 UN Resident Coordinator role

The Resident Coordinator is normally the UNDP Resident Representative and acts on behalf of and in consultation with the UN system in the coordination of operational activities for development at the country level. In Zambia, however, the coordinating role for HIV/AIDS programmes within the UN system now rests formally with United Nations HIV/AIDS Programme (UNAIDS). However, UNDP has had other coordination roles, such as chairing the HIV/AIDS Workplace Programme and, more importantly, guiding the Theme Group on HIV/AIDS, where it facilitates the role of the rotating Chair among other UN agencies. The current Chair is the World Bank.

3.2.2 UNDP HIV/AIDS Programme

Until 2000, the Zambian UNDP CO HIV/AIDS Programme was mainly oriented towards HBC and Commercial Sex Worker interventions.[6] The programme received approximately 4 percent of UNDP CO resources. This approach was considered unsatisfactory due to limited focus and the passive nature of the focus on HBC. The emphasis on material support was potentially unsustainable and dependency creating. An approach that boosted capacity of people, institutions and society to generate solutions was considered more desirable.

5 These are, however, only those partners that disburse funds through NAC or submit records to NAC. The monitoring and evaluation system for tracking funding had not been developed by NAC.

6 Lessons drawn from UNDP's home based care intervention were collated in a manual for training and instructions in the provision of home based care in Zambia.

Since then, the proportion of the Programme budget has increased to 35 percent of the CO budget. The strategic focus has shifted to strengthening a coordinating institutional framework and an effective multisectoral response with a community-based bottom-up orientation. The shift in priorities and focus occurred due the following:

- A fundamental review within UNDP acknowledging that HIV/AIDS was a developmental and long-term concern.
- Recognition that, as a key partner of the government, UNDP needed to demonstrate its partnership in the area of HIV/AIDS.
- Recognition that UNDP needed to provide catalytic support for institutional and individual capacity building targeted at strategic and policy areas, which required a shift in support from HBC.

UNDP support on HIV/AIDS has targeted select institutions and programmes, with the goal of facilitating a holistic response through the involvement of all sectors including civil society, the private sector and the private sector. The programme has focused on the following:

- Institutional capacity development of coordinating institutions, such as the PDCCs and DDCCs, and their respective PATFs and DATFs.
- Strengthening of community-based structures from the lowest (village) level, comprising the Resident/AIDS Development Committees and including traditional leadership.
- Strengthening and developing the capacity of the national coordinating mechanism through the NAC.
- Strengthening and developing key coordinating institutions for the private sector, institutions for persons living with HIV/AIDS, and faith-based organizations.
- Direct collaboration in strengthening the capacity of the line ministries through the provision of HIV/AIDS experts (United Nations Volunteers [UNVs]) to assist the HIV/AIDS focal-point persons in the line ministries, which include the Ministry of Finance and National Planning, Ministry of Education, Ministry of Agriculture and Cooperatives, Cabinet Office, and the Ministry of Local Government.
- Support for advocacy and research to promote the issues of behaviour change communication, care and support, VCT, rights-based approaches, and stronger political support for the national response.

Based on the above goals, recipients of Programme Acceleration Funds covered a wide range of organizations and intervention areas, including NAC, districts, religious groups, advocacy to civil society on debt and AIDS, youth organizations, special sub-population groups, workplace programme support, HBC HIV/AIDS, and information, education and communication in general. Key non-governmental organizations supported by UNDP have included the Network of Zambian People Living with HIV/AIDS (NZP+). The role of UNDP in the formation of NZP+ has been instrumental, as UNDP facilitated the initial funding for administrative and operational work, which included the procurement of equipment and office furniture. The funding assisted in the setting up of NZP+'s district and provincial network administrative and operational centres. Other support has been given to Churches Health Association of Zambia and Alliance of Mayors and Municipal Leaders Initiative for Community Action on AIDS Action at the Local Level (AMICAALL). For AMICAALL, UNPD provided the initial support for the recruitment of a full-time professional staff member, as well as other funding for the organization in early phases. Zambia Business Coalition on HIV/AIDS (ZBCA) and KKCAF have also been beneficiaries of UNDP support. ZBCA has been able to commence programmes with the private sector following the support that allowed it to procure computing and other office equipment. KKCAF has continued to provide support to people living with HIV/AIDS (PLWHA), community schools, and research into nutrition sources for feed-supplementation programmes for PLWHAs. This support has been in addition to the organizational strengthening support that has allowed KKCAF to undertake advocacy functions not only at the national level but also in the entire region.

Specific aspects of UNDP support have included providing training and institutional capacity, developing a harmonized monitoring and evaluation process to assist in decision making, and rationalizing resource allocation and interventions across the country and districts.

3.3 DEVELOPMENT PARTNERS' RESPONSE

A large number of multilateral and bilateral development partners have been active in Zambia during the period covered by the review (see Annex 4 for more NAC data on donors and their support). The largest proportion of funding has been provided by the Global Fund to Fight AIDS, TB and Malaria and

World Bank, but a number of bilateral donors, such as USAID and DFID, have also made substantial contributions. Although government budgets for HIV/AIDS have been substantial, donors have provided the larger share of resources.

For some time, donors tended to formulate and support their individual programmes on a vertical basis. This has been discouraged by the government in an attempt to enhance ownership, coverage, access and equity, especially when donor interventions are limited to certain geographical areas. The formation of NAC and the development of the Strategic Plan have allowed for a more coordinated donor response. Donors are expected to focus on the priorities areas identified by them and work within the parameters defined by the strategic plan.[7] There has been some progress towards pooling of donor resources for NAC to allocate on priority intervention areas.

4. OUTCOME OF UNDP CONTRIBUTIONS AND SUPPORT

4.1 PLANNED OUTCOMES

A number of outcomes related to UNDP support are reported in the following sections. Some useful context is provided on Zambia's national HIV/AIDS objectives and outcomes, and the planned outcomes of UNDP programmes. These are shown in Tables 7 and 8.

The national outcomes are either identical or closely associated with other regionally or internationally defined outcomes as may be contained in the UNGASS, UNAIDS, Abuja Declaration, and other bilateral programme support frameworks. The UNDP outcomes are contained in their country

TABLE 7. SELECTED RATIONAL RESPONSE OUTCOME FRAMEWORK

Goal	Outcome	Indicators
Reduction of HIV/AIDS prevalence	Implementation of prevention, treatment and support measures	Reduction of percentage of pregnant women
		Reduction of percentage of adult men
Improvement of health status through increased life expectancy	Multisectoral behaviour change through broad based information, education and communication campaign	Transformation from number of health aspects such as biomedical treatment to social and economic issues such as OVC
		Rights based issues, gender aspects, risks
	Improvements in knowledge, awareness and sensitization on HIV/AIDS	Transmission mechanism of HIV/AIDS, prevention methods, etc.
	Information communication and behaviour change	Condom use increase
		Reduction of multiple sexual partnerships/relations
	Prevention of HIV/AIDS infection	Delay sexual debut
	Number of OVC receiving mitigation support, such as being in school	Number of OVC socialized, beneficiaries to safety net programmes
	Number of institutions benefiting from capacity building, such as mainstreaming, planning, coordination	Use of instruments in application of response of mandates to HIV/AIDS, resource allocation to HIV/AIDS
	National budgetary allocations to HIV/AIDS programmes	Share in budget to HIV/AIDS;
		Type of programme formulation from workplace to multi-sectoral aspects
	Human rights awareness, legislation and implementation in public, private and community structures	Legislation components addressing rights of gender, discrimination in the world of work

Source: National HIV/AIDS/STI/TB Council, Central Board of Health/UNDP/USAID, "Demographic Health Survey, 2001/2002."

7 The government expects partners to formulate and design their response taking the following issues into consideration: national priorities; available resources and rational resource allocation approach; optimization of productivity, outcome and impact; efficiency; coordination and integration of responses and systems; and existence of formal and legal structures to support accountability and transparency.

TABLE 8. UNDP RESPONSE: PLANNED OUTCOMES

UNDP Strategy Area	Outcome	Output	Indicator
Coordinating mechanism capacity functional	1. Institutional capacity developed and strengthened for coordinating agencies/institutions	1. Assessment of capacity for NAC, PDCC/PATFS, DDCC/ DATFS, Programme supported institutions	1. NAC operating within its statutes
	2. A multisectoral response framework developed and integrated into strategies of stakeholders	2. National provincial, district coordinating workshops and training conducted	2. Multisectoral provincial and district interventions being formulated and implemented
	3. Strategic formation of partnerships for enhanced and synergetic response	3. Infrastructure support (IT capacity, office, transport)	3. Other identified coordinating institutions functional
	4. Improved programmatic delivery impacting on household and institutional structures	4. Partnerships developed	4. Type and number of partnerships formed
		5. Policy guidelines for rights based HIV/AIDS responses	5. Number and type of partnerships functional
		6. Private sector/civil society response developed	
		7. Improved coordinated response through strengthened managerial information and management systems	
		8. Enhanced performance of programme delivery through better articulated roles, responsibilities and accountability	
		9. Human resource support for institutions	
Monitoring and evaluation framework functional and integrated into reporting framework	1. An evidence-based system developed	1. Monitoring and evaluation framework in existence	1. Reports generated
	2. Enhanced performance and response to available evidence in decision making, resource mobilization and allocation	2. Orientation and training conducted in monitoring and evaluation for stakeholders	2. Systems implemented
		3. Dissemination of monitoring and evaluation framework	3. Results of use of monitoring and evaluation in decision making and planning
		4. Improved response through strengthened managerial information and management systems	

Source: UNDP, Country Cooperation Framework 2002-2006; National Aids Council, Country Coordinating Mechanism; Global Fund Action Plan Report 2003; UNAIDS, A Guide to Monitoring and Evaluation, 2003.

programme document and outcomes within the UNDAF for 2002-2006 are also referred to. UNDP-related outcomes focus on institutional change and progress towards the development of a multisectoral response. Others include development of human capacity, and institutional and structural change that shifts the focus of HIV/AIDS interventions from the central level to community-based levels. The UNDAF outcomes relate to empowering young people with the knowledge and skills to respond to the adverse effects of HIV/AIDS; developing institutional multisectoral capacity to plan and

implement HIV/AIDS programmes focusing on young people; increasing coverage relating to public awareness of impact, causes, transmission and prevention; and reducing transmission and enhancing capacity for institutional responses in care and quality of life (mitigation).

As this evaluation was not intended to be a programme evaluation, it did not limit itself to exploration of outcomes set out above. Other outcomes that may not have been formally stated in project and programme documents were also reviewed. In addition, possible HIV/AIDS related outcomes of UNDP's non-HIV/AIDS programmes were also investigated. At the same time, some important outputs of UNDP activities may have been under-emphasized because they have not yet had time to manifest as outcomes.

In general, planned outcomes of UNDP initiatives in HIV/AIDS show a high degree of relevance to national outcomes. As subsequent sections reveal, actual outcomes also seem to have been well aligned with national priorities.

4.2 GOVERNANCE

A significant outcome of UNDP support has been a shift in understanding the roles of the central and decentralized HIV/AIDS structures, specifically NAC and DDCCs, PDCCs, DATFs, and PATFs (see Table 9). NAC effectiveness has remained

TABLE 9. OUTCOMES RELATING TO GOVERNANCE

UNDP Associated Outcomes	UNDP Associated Programmes and Activities	Comments
Strategic shift from HIV/AIDS being seen as a health issue to a multisectoral, development issue especially at decentralized levels	Support to: NAC/DATF/PATF, KKCAF, NZP+, AMICAALL, ZBCA, Governance — NA, HRC, UNVs	Challenge of operationalizing shift at district levels still exists
Strategic shift to a decentralized, community-based response to HIV/AIDS and evolution of new institutional arrangements evolved at the national and district levels to articulate shifts	Support to: NAC/DATF/PATF Support for operations, capacity development, tools, resources.	PATF and DATF roles and functions clarified. Community-level priority setting, project development, budgeting and planning developed. District and Provincial Strategic Plans produced and advocacy strengthened.
Strengthened planning to reflect multi-faceted nature of HIV/AIDS	Mainstreaming tools, planning manuals/handbook, training; Strategic planning occurring in DATFs	
Governance arrangements and shift in policy bringing about interface between government, private sector and civil society	Decentralization; traditional leadership; civil society input via strengthening of NZP+ and ZBCA; line ministries strengthening UNDP training, funding of programmes; joint programming and implementation	
Greater recognition of rights and reduced stigma and discrimination	Advocacy by NGOs, especially KKFAC, NZP+, DDCC/PDCC, DATF/PATF	Effectiveness of programme partner organizations. Rights-based approach to NZP+. Workplace programmes through ZBCA. Strong involvement of PLWHA in DATFs noted.
Greater community involvement and influence in HIV/AIDS programme	DDCC/DATFs and UNV support, NZP+	
Greater government and agency awareness and role clarity in relation to MDGs	DHS input, MDG review and advocacy	UNDP driving role
Coordinating roles defined and operationalized with	Create/strengthen NAC, PATFs, DATFs, civil society, private sector, other public sector	

limited throughout the period due to lack of staff. However, UNDP support enabled it to continue to function and develop its organizational role and capacity. The key role of UNDP in maintaining NAC functions is indicated by its relatively large contribution to NAC core finances over the period under review (as discussed in Table 9 and Box 1). UNDP has provided input such as NAC capacity assessment and support, monitoring and evaluation development, UNV capacity, and funding of computers and logistics. Informants considered these critically important to the function of NAC as well as the districts and provinces in which UNDP was involved. UNDP not only sustained these structures at a time when support from other donors had not yet been mobilized, but also helped to be a catalyst for further support, particularly in the case of decentralized structures.

BOX 1. UNDP SUPPORT OF GOVERNANCE: PROGRAMME ACCELERATION FUNDS FOR NAC

UNDP provided funds to NAC during 2000, 2001 and 2002. These funds were meant to help initiate or strengthen identified catalytic projects. The funds were disbursed to different institutions in different provinces and districts in the country, covering a broad range of stakeholders. Eleven districts were supported on a pilot basis. Other support went to the following: NZP+, Girl Guides, faith-based organizations, Youth Alive, special populations (such as commercial sex workers, military, refugees), ZBCA (private sector response), World AIDS Day and HBC. In addition, the funds were intended to support NAC especially in developing a monitoring and evaluation system.

NAC's Director of Programmes commented: "The PAF [Programme Acceleration Funds] funds were the life line 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…In other words, 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 and expertise to monitor, evaluate and ensure accountability be 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… similarly we learnt we should remain focused in what we do and how we do it..."

Important outcomes have also occurred in the development and strengthening of new institutional arrangements at decentralized levels (DDCCs, PDCCs, DATFs, and PATFs), including mechanisms for involvement of communities and traditional leaders. UNDP, through its pilot in North-Western Province, has made a key contribution to an overall change in the recognition of the role of decentralized responses in the HIV/AIDS effort. It has also provided lessons on how to establish and boost decentralized structures and community-level action. Ideas of who should assume leadership in the formulation of strategic frameworks and activity plans, and in prioritization and selection of activities, have changed. Decentralized structures have been able to set priorities, programmes and activities in a more coordinated and coherent manner. UNDP contributions to the formation and functionality of the DATFs and PATFs have also enabled these structures to guide and support community level responses and structures. The inputs of community level stakeholders are becoming more prominent. One important indicator of these positive changes resulting from the UNDP intervention that was widely mentioned was increased flows of funding from sources such as Community Response on HIV/AIDS (CRAIDS) to the community level, although data to quantify this indicator could not be accessed.

Informants noted that due to the development of the PATF and DATFs in North-Western Province perceptions and attitudes have changed. They described the structure as more 'people centred', taking 'innovative' approaches to organizing the HIV/AIDS reponse; and more 'personalized'. This aspect of personalizing the programme also included the formation of Area/Resident Development Committees, which are the lowest organ comprising neighbourhood houses within the villages and are represented by a member of the Chief's staff (traditional leadership).

UNDP was also reported to have had a key role in creating greater awareness of multisectoral HIV/AIDS

issues within the government structures at the district level and within communities. This has reportedly lead to a greater acceptance of the need for multisectoral responses in relation to issues such as more effective prevention, VCT, roles of communities in the care and support of OVC and PLWHA, and stigma and discrimination. However, ongoing challenges in translating this awareness into practice were reported.

An obstacle to greater effectiveness that may represent an opportunity for UNDP support related to governance is the limited formal integration of HIV/AIDS structures into the government at the district and provincial levels. Although decentralization is now officially a policy for the government, only the health sector and the Ministry of Local Government have legal entities with a delegated decentralized structure. Provincial and district-level institutions function within the ambit of their ministry mandates. The existence of HIV/AIDS institutions has remained informal. This may have hampered the ability of donors to provide further support and more effective inter-sectoral coordination. UNDP has begun to address this by supporting the formation of AMICAALL to forge linkages with the local governance and other decentralized structures.

Several informants indicated that UNDP advocacy and support of the MDG review and Demographic and Health Surveys also contributed to more multisectoral and developmental approaches to HIV/AIDS by helping to clarify roles in relation to MDGs.

Support to NZP+ and strong involvement of PLWHA in DATFs has helped to enhance PLWHA rights, visibility and influence in planning and programmes. Other non-governmental organizations supported by UNDP, such as KKACF and ZBCA, have also enhanced recognition of rights of other vulnerable groups such as workers and OVC.

A DATF discussion group noted the import of DATF's role as a coordinating mechanism and means to place community linkages and activities at the centre of processes.

4.3 LEADERSHIP

UNDP's work has resulted in strengthened leadership related to HIV/AIDS—particularly at decentralized levels—through training, community mobilization, advocacy campaigns and other support. DATFs and PATFs, along with various District Commissioners, have begun to play more prominent roles in the HIV/AIDS response due to UNDP training and other support. The influence of traditional Chiefs in the North-Western Province in providing community-based leadership on HIV/AIDS has become much more visible as a result of the training, awareness and information provided by UNDP. This approach has also been supported by other partners such as the Policy Project (USAID) in the Southern region, and has potential for extension to other districts as part of the roll-out of UNV and other district level support.

Civil society leadership in HIV/AIDS, particularly in the areas of stigma, discrimination and human rights has been provided by NZP+ and KKCF. ZBCA has also helped stimulate and maintain private-sector consciousness of the consequences of HIV/AIDS and need for workplace responses. UNDP has provided basic running costs for the organizations. In the case of NZP+, UNDP funding has been consistent and stabilizing since 1996, and UNDP's support has also facilitated development of PLWHA leadership at decentralized levels. However, the degree to which these leadership roles were directly associated with UNDP support could not be ascertained. UNDP provides support at different levels and some changes have been identified, as shown in Table 10.

Further leadership strengthening has been through support to the Ministry of Finance and National Planning in the area of the PRSP, TNDP and Economic Governance. This has facilitated inclusion of HIV/AIDS in key plans, national budget allocations to HIV/AIDS, and an enhanced response from ministries that have health care components, such as Health and Defence and others.

UNDP's other engagements have been in areas such as support to NAC, DATFs, PATFs, NZP+, KKCAF, and ZBCA. Each of these institutions have provided key leadership functions in aspects of the national response. NZP+ is now able to develop and strengthen its structures from the national level to the provincial and district levels. Furthermore, through other capacity building initiatives such as rights awareness and training in areas such as programme planning, NZP+ members are being represented in forums, such as the Country Coordinating Mechanism for HIV/AIDS, TB and Malaria, and are active participants in the planning and budgeting processes.

TABLE 10. OUTCOMES RELATING TO LEADERSHIP

Outcomes	UNDP Programmes/Activities/Outputs	Comments
Community-based leadership in analyzing situation of HIV/AIDS and mobilizing responses has grown substantially	Support to DATFs, PATFs, and NZP+; training of traditional leaders; community mobilization and training; awareness campaigns; support and advocacy strengthening of political leaders; sensitization	
Civil society organizations provide leadership in debates and advocacy for PLWHA, OVC and more effective responses	Collaboration and support to coordinating and advocacy institutions –CHAZ, NZP+, KKCAF, ZBCA, Kara Counseling; strengthening of civil society and broadening of civil society participation	
Enhanced leadership for promoting private-sector responses	Support to ZBCA and NZP+; strengthening of private sector response; awareness of rights, world of work, impact assessments	UNDP played key role in supporting ZBCA. Awareness was raised but effectiveness and reach of responses so far is uncertain.
Strengthened leadership by traditional leaders in community, local and district structures	North-Western pilot project on HIV/AIDS; support to local area structures (DATFs); training in mainstreaming, leadership involvement; AMICAALL formed and strengthened	
Enhanced advocacy for PLWA, OVC	NGO support	

Chief Mumena in the North-Western Province noted that UNDP's support initiatives had developed local ability to provide leadership and direction to HIV/AIDS responses. UNDP support facilitated development of local structures that have been able to act on local knowledge and priorities, for example, in developing strategic plans. He noted, in this spirit, that: "….we do not wish to see stakeholders waste their time on 'discovering' what exists….information is already there (with Area DATFs, DATFs, PATF in the Strategic Plans)…."

4.4 CAPACITY DEVELOPMENT

Positive outcomes of UNDP capacity development at provincial, district and community level are widely reported (see Table 11). Informants stated that the approach of placing Zambian UNVs at these levels

TABLE 11. OUTCOMES RELATING TO CAPACITY DEVELOPMENT

Outcomes	UNDP Programmes/Activities/Outputs	Comments
Strengthened institutional capacity of NAC	NAC capacity assessment and support; monitoring and evaluation TA; computers and logistics	NAC supported flexibly when other support very limited; capacity still very limited but collapse avoided
Strengthened institutional capacity of DDCCs, PDCCs, DATFs, and PATFs	UNVs; members trained and oriented; development/strategic challenges disseminated; logistical support; strategic planning supported	Improvements in functional planning and coordinating mechanisms widely recognized by stakeholders. Scaling up occurring, and extension to all provinces being supported by DCI.
Coordination of community-initiatives into a broader district strategy and work-plan	Support to NAC/DATF/PATF through training, resources, and UNVs; members trained and oriented; development/ strategic challenges disseminated; implementation planning support	Roles and functions clarified. Improved resource flows and programme management.
Tested tools and methods to facilitate action available and being used, particularly at decentralized level	Planning manuals and training developed	UNV programme is new, so possible limits in current support, capacity building and sustainability. Use and availability of tools not systematically promoted.
Enhanced strategic information and data	Zambia HDR, DHS, Evaluation of MDGs, PRSP	Use not certain for some (HDR) but MDGs/PRSP used in policy formulation and decision making

was an important and successful contribution to creating capacity to implement HIV/AIDS initiatives. However, UNDP contributions of training, planning support and basic operational resources such as transport were also seen as important. Community-based structures receive UNV advice and assistance in proposal development and resource mobilization. In addition, DATFs and PATFs have been enabled to articulate formal planning and budgeting processes that are being operationalized into documents and implemented with the assistance of UNVS.

Success is reflected in increases in existence of plans and levels of action at decentralized levels, and increased funding flows to HIV/AIDS projects at community levels—particularly from the World Bank/ZANARA (Zambia National Response to AIDS) CRAIDS initiative. The government has requested roll-out to all districts. UNDP's role is seen to be 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 CRAIDS and Development Co-operation Ireland (DCI) support at provincial level.

Nevertheless, challenges remain to ensure sustainability and optimal effectiveness of UNV-related capacity development. Training, human resource and systems development for DATFs are still at a relatively early stage. Questions were also 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 reliably effective. However, most commentators felt that the immediate benefits were substantial and that, while these concerns were real, they should not hold up deployment of UNVs.

Somewhat less widely reported, but critical, outcomes occurred at the level of NAC. As mentioned above, UNDP supported NAC capacity development at a stage when 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 now increased support to NAC. Without UNDP support in the interim, NAC might have collapsed completely.

UNDP has been able to develop planning tools and instruments both locally and regionally that have been used in the capacity development process. Examples include tools and manuals in HBC, mainstreaming and nutrition. Tools and methods should now be available for use at decentralized levels during the scale-up process. However, there has not been a noticeable effort in promoting the use of these tools. This was evident during group discussions with DATF members in the North-Western Province who made particular requests for enhancement of capacities and skills in this area to increase DATF and line ministries' understanding and responses to HIV/AIDS.

UNDP also added to capacity building in civil society. Support to organizations and particular activities such as training have strengthened organizations such as NZP+. Support to Churches Health Association of Zambia, the coordinating body of the faith-based organizations, has helped to strengthen the faith-based organizational response in HIV/AIDS and provided a basis for faith-based organizations to assume a stronger role in the response. This has helped to increase resource mobilization: The Global Fund to Fight AIDS, TB and Malaria and President's Emergency Plan for AIDS Relief (PEPFAR) resources are now being channelled through Churches Health Association of Zambia.

There were perceptions that UNDP can be an unreliable and inefficient funder of civil society organizations, with negative implications for effectiveness and sustainability. However, this might be due to unrealistic expectations of some NGOs. Those that had been given catalytic Programme Acceleration funding seem, in general, to have continued growing and mobilizing resources from elsewhere. In the case of NZP+, UNDP has consistently supported and funded it since its inception in 1996.

UNDP has also contributed to strategic information related to the MDG evaluation and PRSP that has been used in policy and has produced country Human Development Reports that consider HIV/AIDS and were highly regarded sources of information. UNDP's support for KKCAF has indirectly enhanced the fund's capacity to develop a collaborative programme in nutrition with the University of Zambia. However, it has been difficult to ascertain whether the Human Development Report and KKCAF research have led to any substantive changes in the national response so far.

4.5 MAINSTREAMING AND POVERTY AND IMPACT MITIGATION

UNDP is widely thought to have helped facilitate a shift towards HIV/AIDS being seen as development and multisectoral issue at national and district levels in Zambia. This has, to varying extents, been translated into plans and actions. UNDP support in the area of the PRSP, TNDP 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 seems evident in PRSP HIV/AIDS sections. Some informants reported that UNDP had also facilitated decisions to allocate national budgets to HIV/AIDS and promote responses within ministries.

The first-ever HIV/AIDS mainstreaming workshops for line ministries' planners were supported and conducted by UNDP in collaboration with the NAC and the Churches Health Association of Zambia. UNDP placed UNVs in the line ministries after training the planners and the focal points in mainstreaming HIV/AIDS. Each ministry was provided with mainstreaming tool kits, which are still in use.

UNDP has not yet implemented some of its initiatives to train key stakeholders in all sectors to promote mainstreaming. Other development partners have begun supporting mainstreaming programmes in various line ministries and a number of sectors have begun workplace initiatives. The impact of these changes and what progress could be attributed to UNDP is uncertain. However, mainstreaming is at an early stage and further support will be required to operationalize it.

UNDP was widely considered to have enhanced mainstreaming and multisectoral involvement in HIV/AIDS at the district and local level through UNDP training, tools and other support. However, there is a need to consolidate this. For example, it was noted that UNVs often end up focusing on HIV/AIDS Programme issues rather than true mainstreaming across all relevant sectors.

Support for NZP+ and the ZBCA helped raise awareness of workplace HIV/AIDS issues, including infected workers' rights. However, ZBCA's effectiveness was limited, and it could not be ascertained that UNDP support had led to actual implementation of workplace programmes thus far.

Within the UN itself, the Workplace Programme has been chaired by the Assistant Resident Representative/ HIV/AIDS Advisor. The UN system is engaged in the HIV/AIDS response on an increasing level over the last few years. The World Health Organization (WHO) provides a central role to technical support of the health sector response, both for the public and private sector. ILO, United Nations Children Emergency Fund (UNICEF), UNAIDS, and the United Nations Fund for Population Activities (UNFPA), among others, have provided support that is leading to specific outcomes in their areas of specialization, such as reproductive and adolescent health and child health and school health programmes through the Education and Health sectors. Although more needs to be done, recognition of the limitations on the UN agencies' budgets has been taken into account.

Limited mainstreaming of HIV/AIDS into other UNDP programmes in governance, the environment and the economy was noted. However, district-level outcomes seem to be attributable, in part, to leveraging experience and decentralized structures that have developed through efforts of UNDP's Decentralization Support Programme. UNDP programme officers were also trained in mainstreaming HIV/AIDS. As a result, in the environment, the Zambia Wild Life Authority developed an HIV/AIDS workplace policy. Under governance, the National Assembly has a draft workplace policy, and the Human Rights Commission is assisting NZP+ to ensure rights-based approaches are used in programming and responding to HIV/AIDS.

UNDP has not fully used opportunities to build on regional UNDP initiatives (related to mainstreaming, development and poverty planning) in order to promote more solid mainstreaming within Zambia at the sectoral level. The involvement of other donors and current limitations of UNDP capacity and budgets mean that sectoral mainstreaming may not be a key area of comparative advantage for UNDP in Zambia. However, given the early stage of mainstreaming, opportunities for UNDP to use its comparative advantages in this area may well arise.

4.6 PARTNERSHIP AND COORDINATION

Developing partnerships and strengthening the coordination of support to HIV/AIDS programmes was a key determinant of the overall effectiveness and efficiency of a multisectoral approach in Zambia. The

most prominent outcome of UNDP activity in this area has been enhanced coordination, mobilization and leveraging of other donor resources for responses at the district and provincial levels (see Table 12). In particular, UNDP has successfully used its pilot programmes to leverage further support for decentralized structures and community initiatives through coordination with CRAIDS and DCI, as well as the Policy Project in Southern Province.

However, a number of important potential partners knew little about UNDP initiatives, and opportunities for stronger coordination have been missed. For example, several informants felt that UNDP's positive contribution to the multisectoral response and coordination at institutional and community level (and specific initiatives such as UNVs) were not accompanied by adequate communication to other partners to mobilize complementary support for the UNDP Programme. UNDP did have extensive consultations at the highest levels in the civil service, including workshops with Permanent Secretaries. However, in terms of implementation and funding, the partners had little information and thus could not participate in developing or clarifying the responsibilities and functions of the UNVs.

The UNDP Resident Coordinator has coordinated the UN system. The Resident Representative has also provided leadership for the UN Theme Group. The role of the UN Theme Group (as well as individual agencies such as UNAIDS, UNICEF, ILO, WHO and UNFPA) in the evolution of the national response to HIV/AIDS has had some dependence on the leadership provided by the Resident Representative. This role may become even more significant in order to ensure that the gains of a coordinated, unified and resource optimizing approach are fully realized. Lessons and experiences from the North-Western Province are also felt to provide a basis for continued UNDP leadership by the Resident Representative.

The Assistant Resident Representative/HIV/AIDS Advisor has played technical and other leadership and coordination roles within the UN family. The Assistant Resident Representative has also participated and played coordination roles within the Expanded Theme Group and its technical committees. Smaller UN agencies, in particular, seem to appreciate UNDP's coordination, facilitation and support roles and highlighted the benefits of a technically strong UNDP programme advisor. The Chair of the Theme Group on HIV/AIDS has, however, been rotated among UN agencies. UNAIDS also appears to be assuming an increasing role in coordination.

In this context, it was difficult to form an opinion of how strong UNDP coordination and leadership roles at national level have been and what the outcomes have been. Some informants felt that UNDP had missed opportunities to assist the government and donors in defining HIV/AIDS strategic priorities more clearly.

A final area in which UNDP facilitated greater coordination has been through support to civil society initiatives. Particularly in relation to NZP+, this has enhanced coordination of support, advocacy and involvement at central and decentralized levels. Support to AMICAALL also has potential for coordination across stakeholders at the local level, though outcomes could not be identified at this stage.

TABLE 12. OUTCOMES RELATING TO PARTNERSHIPS AND COORDINATION

Outcomes	UNDP Programmes/ Activities/Outputs	Comments
Resources being leveraged from multiple sources to support community-based initiatives and contributing to improved effectiveness of other partner programmes, e.g. CRAIDS	UNV and DATF planning and institutional support in North-Western Province; UNV input into proposals and project support	Increased funding flows to communities. UNV role critical.
Coordination mechanisms at national level promoting strategic and operational coherence	UNDP provided coordination and participation in Expanded Theme Group; technical committees	Provided coordination and leadership within the UN system and donor community
Effectiveness of smaller UN agencies enhanced	Support to ILO and other agencies with limited capacity and resources	Benefits of technical and financial support reported by some key informants
Coordination of civil society capacity enhanced	Support to NZP+, AMICAALL	

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

UNDP has contributed to several important outcomes in the national response to HIV/AIDS in Zambia. These outcomes have been achieved in a challenging environment and with relatively limited resources.

The main thrust of UNDP's work has been to strengthen awareness and institutional capacity to support a multisectoral, multi-level and rights-based response. Although the final outcomes of interventions have not yet manifested in many cases, UNDP has clearly influenced the environment and institutional context of the HIV/AIDS response—generally in positive ways that facilitate better programme implementation. Several achievements are particularly prominent:

- NAC was supported at a time when support from other sources was extremely limited. This maintained a basic level of function at a time when NAC may otherwise have collapsed. UNDP support also allowed key lessons to be learned by various stakeholders that create potential for a much stronger HIV/AIDS response in future.

- The importance of a decentralized approach to achieve national programme objectives at implementation level has been established in Zambia. At the same time, UNDP has contributed key knowledge on how decentralized structures and processes can be established at provincial, district and lower levels to allow for roll-out of the decentralized response.

- An environment and mechanisms for a strengthening community-based response has been created.

- UNDP has shown innovative ways to strengthen human resource capacity for the HIV/AIDS response through use of national UNVs, and has also enhanced capacity through other capacity development activities.

- UNDP has provided catalytic support to key civil society organizations that have influenced governance of the HIV/AIDS response at each level. This has, in particular, led to more involvement and recognition of the rights of infected and affected people. In turn, this creates conditions that make it much more likely that the HIV/AIDS response will be effective in prevention, care and support.

- Important steps have been made towards effective multisectoral mainstreaming of HIV/AIDS by increasing acceptance of it by political leadership, line ministries and at decentralized levels. However, actual implementation remains at an early stage.

UNDP has generally been successful in ensuring that its interventions have been relevant to national strategies on HIV/AIDS and can contribute to achieving national objectives. Coordination with the government and focus on capacity development have been strong features of UNDPs initiatives.

UNDP's experience in Zambia suggests several strategic issues:

- **Effectiveness of strategic selection of priority institutions and programme areas, and risks of fragmentation.** UNDP has targeted support to several coordinating institutions and organizations. Choice of priority gaps for support seems to have been strategic in the context of the national response and has achieved important outcomes. However, particularly in earlier use of Programme Acceleration Funds, this seems to have resulted in risks of fragmentation and support being spread too thinly across areas to ensure optimal effectiveness. Greater availability of resources from other sources for various programmes and organizations should make it more feasible for UNDP to avoid fragmented approaches in future.

- **UNDP roles in decentralized responses.** Support for decentralized responses by other donors has been limited and UNDP's work with the DATFs and PATFs has demonstrated a functional and practical approach for inclusion of households, communities, traditional rulers, civil society, NGOs, and the public sector in addressing the HIV/AIDS pandemic.

- **UNDP as an innovator.** Particularly in its role in developing processes for decentralized responses to HIV/AIDS and use of national UNVs,

UNDP has shown the ability to develop innovative ways to address problems and 'how business can be done differently'. This innovation can create important precedents and tools that can then be taken to scale by other partners in national responses.

- **Effectiveness of national UNVs.** UNVs are a key instrument available to UNDP to support national responses, particularly at decentralized levels. National UNVs have had a substantial effect and have the advantage of being well orientated to local context. At the same time, they cost substantially less than external UNVs or consultants and have greater potential for scaling up and sustainability. Their impact has been a catalyst to greater government consideration of human resource issues. Nevertheless, ultimate effectiveness and sustainability of UNV-dependent capacity-development initiatives remains uncertain and needs further consideration.

- **Need for consolidation and effective exit strategies to ensure effect and sustainability.** The immediate benefits and significance of UNDP support to DATFs, PATFs and civil society organizations are understood. However, the effectiveness, sustainability and final outcomes of this support will depend on systematic and continuous support and more focused development of exit strategies, which will allow for withdrawal of or changes to UNDP roles, including facilitation of large-scale roll-out. In the case of civil society organizations, lack of continuous support or clear exit strategies can threaten their effectiveness and sustainability, and lead to some scepticism about UNDPs role.[8]

- **Potential to develop synergy with other development partners.** UNDP has limited financial and human resources. Therefore, its ability to forge partnerships to leverage its capacity and institutional development initiatives (in order to achieve scale and depth) requires strategic alliances to mobilize other partners' support. UNDP Zambia has developed strategic partnerships and synergy with key partners such as DCI and CRAIDS that illustrate the potential for this. The partnerships have enabled roll-out of UNDP's district-level successes and have provided resources to enhance outcomes at the district and community level. However, improved communication and strategic coordination with other donors is required.

- **Comparative advantages in partnering with the government and ability to support mainstreaming across sectors, but under-utilized opportunities.** Government informants from the political to the technical level noted that UNDP has a relatively strong relationship with the government. UNDP has been a key partner on issues of development and economic management with the various ministries, especially the Ministry of Finance and National Planning. UNDP has established relationships with the government in areas such as PRSPs and sectors such as Environment and Tourism. These relationships and familiarity with policy and planning issues in particular sectors provide opportunities to be successful in supporting the national response to HIV/AIDS. However, opportunities to enhance HIV/AIDS responses, or mainstream HIV/AIDS in and through other UNDP programmes, have been under-utilized.

- **Programme ownership by key stakeholders.** UNDP has tried to ensure that the programme and support, such as UNV allocation, has been demand driven. Beneficiaries have played important roles in the formulation and implementation of the programme at each level. This has enhanced effectiveness and sustainability.

- **Flexibility to make funds available for urgent and strategic use.** UNDP has had a comparative advantage in its ability to rapidly and flexibly mobilize support to address key gaps in the national response, such as NAC capacity, at times when other partners have either not recognized needs or not been able to provide support. However, rapid responses can spread resources thinly and risk loss of strategic focus and continuity.

- **Availability of internal capacity and resources, but over-stretched capacity.** Since 2000, increased allocation of human and financial resources to HIV/AIDS by UNDP has given it the ability to provide substantive support to

8 In some cases, lack of sustainability seems to have been beyond UNDP's control. For instance, support to the commercial sex workers through the TASINTHA Programme dissipated after the organization collapsed due to internal conflicts rather than programme design issues.

initiatives and to other partners. The expertise provided by the UNDP Programme Advisor was seen as an important asset, particularly by smaller agencies that could access technical support from UNDP. However, UNDP CO capacity has been spread thinly to perform the many tasks required for more effective support to the national response, including partnership development and leveraging of other resources.

5.2 RECOMMENDATIONS

1. **Consolidate and expand key interventions and ensure effective exit strategies.** Risks of losing strategic focus due to a wide and rapidly changing spread of activities should be avoided. In particular, extension of the decentralized model of the North-Western Province to other parts of the country should be actively supported. In general, UNDP should consider more systematically how to build on Zambian experience in consolidating, scaling up and ensuring sustainability of its initiatives to manage the risk of disappointing final outcomes.

2. **Continue to promote use of UNVs, but develop a more holistic approach to use of this resource and to capacity building.** Particular attention should be given to ensuring sustainability, that the capacity building approach is sound, and identifying appropriate support to increase UNV effectiveness. This may require support in areas such as monitoring and evaluation.

3. **Strengthen partnerships to increase effectiveness and scale of UNDP interventions.** Greater attention should be given to developing partnerships to leverage the resources of other partners, and particularly to building on positive synergy established with the World Bank for promoting decentralized action. UNDP should also assist implementing partners in accessing resources from other sources.

4. **Improve communication and dissemination of information about UNDP programmes.** An enhanced advocacy and communication strategy is important to ensure optimal use of partnerships for support and scaling up of UNDP initiatives, and to increase UNDP's role in knowledge sharing.

5. **Explore ways to develop a process for equitable resource allocation at the district level.** Community and district-level stakeholders need more equitable access to support for implementing their HIV/AIDS related plans. Current practice does not ensure equitable access across communities and districts, leading to some despair and frustration. UNDP may be able to use its influence and expertise to address this.

6. **Support efforts within UNDP to improve resource commitment and efficiency.** Specific attention should be given to ensuring adequate CO capacity to meet the challenges of an expanded HIV/AIDS Programme and roles. Efficiency of funding processes should also be strengthened, particularly if civil society organizations are to be supported.

7. **Increase use of UNDP's strong relationships with the government and potential for mainstreaming.** UNDP can use comparative advantages in these areas to improve effectiveness of the national response and consolidate mainstreaming into development and sectoral programmes. A particular opportunity exists for mainstreaming HIV/AIDS into other UNDP programmes. However, it will need to coordinate its mainstreaming approaches with other donors active in various sectors.

8. **Strengthen planning, monitoring and evaluation of UNDP HIV/AIDS programmes for an outcomes-based approach.** Programme formulation, as well as monitoring and evaluation of use of funds and other aspects of UNDP interventions, need to be strengthened to enhance accountability and ensure that staff understand and implement the UNDP's outcomes orientated approach.

9. **Clarify UNDP coordination and leadership objectives and roles on HIV/AIDS within the UN and broader donor community.** UNDP can play a useful role, especially for smaller agencies. However, roles will need to be clarified in relation to UNAIDS as well as other partners that may have particular capacity and skills available.

ANNEX 1. ACRONYMS AND ABBREVIATIONS

AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
CO	Country Office
CRAIDS	Community Response on HIV/AIDS
DATF	District AIDS Task Force
DCI	Development Co-operation Ireland
DDCC	District Development Coordinating Committee
HBC	Home Based Care
KKCAF	Kenneth Kaunda's Children's Foundation of Africa
MDG	Millennium Development Goal
NAC	National HIV/AIDS/STIs/TB Council
NGO	Non Governmental Organization
NZP+	Network of Zambian People Living With HIV/AIDS
OVC	Orphans and Vulnerable Children
PATF	Provincial AIDS Task Force
PDCC	Provincial Development Coordinating Committee
PLWHA	People Living With HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
TB	Tuberculosis
TNDP	Transitional National Development Plan
UNAIDS	Joint United Nations Programme for HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Emergency Fund
UNV	United Nations Volunteer
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZANARA	Zambia National Response to AIDS
ZBCA	Zambia Business Coalition on HIV/AIDS

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ANNEX 3. PEOPLE INTERVIEWED

GOVERNMENT

Kunyima Banda, Local Government Association of Zambia
Dr. B. Chibende, Deputy Chairperson (Siavonga DATF), District Director of Health for the District Health Management Team, DATF, Siavonga
John Chidata, Chairperson Mwinilunga District Development Committee, Mwinilunga District Commissioner
Dr. Brian Chituwo, Chairperson Cabinet Committee on HIV/AIDS and Minister of Health
M. Choogo, Counsellor (Siavonga District Hospital), Member, DATF, Siavonga
B. Chundu, Director, Economic and Technical Cooperation, Ministry of Finance and National Planning
C. Chunda, Manager, Planning and Development, Mwinilunga District Health Board
Mary Hachitapika, Member, DATF, Siavonga
P. Kabengele, District Forestry Officer, Ministry of Lands
M. K. Kafuwala, C.O.C, Judiciary
Mrs. Kafwimbe, North-Western Province Deputy Permanent Secretary
Mr. Kapumo, Acting District Commissioner
H. Kasampa, Senior Agricultural Officer, Ministry of Agriculture and Co-operatives
Faith Kayoba, Member, DATF, Siavonga
F.M. Kayombo, Treasurer, DATF, Solwezi
J. Kgumba, Member, DATF, Solwezi
R. M. Liteta, Officer in Charge, Prisons Commission
Mr. Lumbama, Permanent Secretary, North-Western Provincial Development Coordinating Committee
I. Matanda, Head, Human Resource Administration, Cabinet Office
F.M. Mpenzhi, Representative, DATF, Solwezi
Mr. Mufuzi, Coordinator, Local Government Association of Zambia
Seth Muleya, North-Western HIV/AIDS Focal Point Person Assistant Secretary, North-Western Province
Senior Chief Mumena, Chairperson, North-Western Province PATF
A. Musanda, Member, DATF, Solwezi
H. Musanda, District Agricultural Information Officer, Ministry of Agriculture and Co-operatives
Dr. Rosemary Musonda, Acting Director-General, National HIV/AIDS/STIS/TB Council
Mr. Mwansa, National Coordinator, Alliance of Mayors and Municipal Leaders Initiative on AIDS at Local Level
Reverend P. Mwenya, Treasurer, DATF, Siavonga
Kambinga Nondo, District Commissioner's Office
K. Nondo, Chairperson, DATF, Solwezi
Gladys Nyirenda, District Administrative Officer, District Commissioner's Office
Dr. Alex Simwanza, Director of Programmes, National HIV/AIDS/STIS/TB Council
E Stridiel, District Commissioner and Chairperson, DDCC, Siavonga

UNDP

S. Bobe
B. Chansa
G. Chilufya
B. Chirwa
E. Chirwa
A. Chuma, Resident Representative
F. Daka
B.P. Kumari
Dr. Rosemary Kumwenda, Assistant Resident Representative and HIV/AIDS Advisor
Lebogang Motlana, Deputy Resident Representative
M. Mukhia
L. Mulenga
Winnie Musonda, Environment Specialist
V. Mwansa
A. Nyimba
D. Sibandi
M.Y. Sichanga
L. Sinyama
M. Soko
Delia Yerokun, HIV/AIDS Programme Specialist
L. Ziwa

UN SYSTEM

Kenneth Bwembya, UNV
E. Sakala, UNV, Siavonga, UNV
Dr. C. Sozi, Country Coordinator, UNAIDS

BILATERAL DONORS

A. Daly, Health Advisor, Department for International Development (DFID)
Nina Schuler, Observer, World Bank
D. Zulu, ILO

NON-GOVERNMENTAL ORGANIZATIONS, CIVIL SOCIETY, AND OTHER

M. Banda, Zambian Network of People Living With HIV/AIDS
B.M. Chama, Technician in Charge, Zambia Telecommunications Company
Mrs. Chikamba, Kenneth Kaunda Children of Africa Foundation
H. Chingambu, Youth Representative
W. Kamwana, faith based organization
M. Kanyanda
M. M. Maswabi
Mr. Mfula, Kenneth Kaunda Children of Africa Foundation
Dr. Simon Mpuka, Director of Programmes, Churches Health Association of Zambia
Crispin Mulele, Programme Officer, Community Response Initiative on HIV/AIDS
Anthony Mulenga, District Coordinator, Zambia Association for Persons With Disabilities
R. Mwanza, Zambian Network of People Living With HIV/AIDS
G. Mwanza
A.S. Mweene
Kelvin Simwanza, Principal, Mwinilunga Trades Training College

ANNEX 4. FINANCIAL RESOURCES FOR THE HIV/AIDS RESPONSE

TABLE A1. PROJECTED RESOURCE NEEDS FOR THE NATIONAL RESPONSE TO HIV/AIDS

Objective	Cost Estimate (USD)	Share of Total Resource Requirements (%)	Sources of Funding by Category
Reduction of infection	245,345,000	43.9	1. Government and public sector
Mitigation of socio-economic effects	280,725,000	50.2	2. Donors (Co-operating Partners — bilateral and multi-lateral agencies)
Monitoring, evaluation and technical support	13,300,000	2.4	3. Private sector
Coordinating	19,332,000	3.5	4. Households
Total	**558,702,000**	**100**	

Source: NAC, National Data Base. Note: The costing of the HIV/AIDS Strategic Framework depicted the total resource needs over the five-year implementation programme of the Framework. Approximately USD 560 million is required, inclusive of HAART, for the strategic framework.

TABLE A2. EXTERNAL INFLOWS FOR HIV/AIDS BY PRIORITY SUB-POPULATION

Sub-Population	Period	Commitment (USD)	Share of Funds (%)
CSW	1998 – 2001	937,486	0.81
Men	1994 – 2002	7,695,166	6.69
Miners	1999 – 2002	15,000	0.01
Other	1996 – 2003	25,535,825	22.20
OVC	1993 – 2002	13,629,564	11.85
PLWHA	1993 – 2002	12,848,350	11.17
Private	1999 – 2000	1,937,000	1.68
Untargeted	1996 – 2004	46,599,366	40.51
Untargeted	1994 – 2002	2,500,000	2.17
Youth	1997 – 2003	3,333,634	2.90
Total	**1993 – 2003**	**115,031,390**	**100.00**

Source: NAC records/Database 2004.

TABLE A3. NAC EXPENDITURES OF GOVERNMENT FUNDING BY ACTIVITY

Activity/ Programme Area	Time Period	Expenditure (USD)	Share of Funds (%)
Awareness	2001–2002	49,208	14.68
Capacity building	2001	13,333	3.98
Committee expenditure	2001–2002	3,380	1.01
Conferences	2001–2002	7,937	2.37
Operations (administration)	2001–2002	216,764	64.65
Prevention	2001	31,222	9.31
Vaccines (research)	2002	1,153	0.34
VCT	2002	2,316	0.69
Verification of traditional remedies (research)	2001	8,888	2.65
Working groups	2002	1,097	0.33
Total		**335,302**	**100.00**

Source: NAC 2004.

TABLE A4. INTERNAL (DOMESTIC) AND EXTERNAL (INTERNATIONAL) FINANCIAL FLOWS FOR HIV/AIDS BY SOURCE

Source	Time Period	Amount (USD)	Share of Funds (%)
GRZ	2001-2004	100,000,000	28.200
ADB	2002-2004	1,200,000	0.340
DANIDA	1993-2000	2,810,842	0.790
DCI	2003-2007	460,000	0.001
EC/EU	1996-2003	6,403,030	0.020
CIDA	1997-2001	814,000	0.002
French Government	1999	35,000	0.000
DFID	1994-2009	35,479,233	10.030
GTZ/Germany	2000-2004	2,994,924	0.840
IBRD/IDA	1996-2002	245,000	0.000
ILO	2000	12,000	0.000
Ireland	1994-2002	2,627,215	0.740
Italy	2000-2003	560,027	0.160
JICA	1999-2001	350,000	0.100
The Netherlands	1996-2002	20,328,500	5.750
NORAD	1999-2004	3,062,810	0.860
Sida	1999-2001	13,479,189	3.810
GFATM	2002-2006	152,693,000	43.170
UNAIDS	1999-2004	615,000	0.170
FAO	2003	505,000	0.140
UNDP	1999-2006	9,087,091	2.570
UNESCO	1998-2000	74,000	0.005
UNFPA	1997-2006	3,456,272	0.990
UNHCR	2000-2004	3,172,417	0.900
UNICEF	1997-2004	3,263,570	0.920
USAID	1999-2002	34,050,000	9.630
UNV	1999-2000	329,000	0.100
WFP	1998-2001	15,802,428	4.470
WHO	1999-2007	1,944,000	0.550
World Bank (ZANARA/ CRAIDS)	2003-2008	42,000,000	11.870
Total	**1993-2004**	**353,674,818**	**100.000**

Source: NAC 2004.

TABLE A5. HIV/AIDS RELATED FUNDING INFLOWS BY PRIORITY INTERVENTION

Programme Area	Period	Commitment (USD)	Share (%)
Behaviour change communication	1993-2004	32,892,747	28.59
BHS	1994-2002	40,260,603	35.00
VCT	1998-2001	80,000	0.07
Drugs	1996-2000	10,077,955	8.76
HBC	1998-2002	1,830,190	1.59
High risk	1999	102,439	0.09
Clinical care	1999-2000	162,644	0.14
Mother to child transmission	1999-2002	4,489,693	3.90
Multisectoral	1998-2002	7,626,277	6.63
Other	1996-2001	1,186,129	1.03
OVC	1998-2003	6,460,750	5.62
STIs	1999-2002	1,665,000	1.45
Stigma and discrimination	2000-2002	0	0.00
UN Programme	1999-2002	1,497,020	1.30
VCT	1999-2002	6,699,943	5.82
Total	**1993-2004**	**115,031,390**	**100.00**

Source: NAC Database 2004.

ZIMBABWE COUNTRY STUDY

HIV/AIDS

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

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The authors thank the UNDP Country Office Zimbabwe for the invaluable help it provided.

ZIMBABWE

CONTENTS ZIMBABWE COUNTRY STUDY

Boxes, tables and figures

1. INTRODUCTION

1.1 INTRODUCTION

The purpose of the Zimbabwe outcome evaluation is to assess, within the context of the Millennium Development Goals (MDGs) and the Declaration of Commitment, UNDP's role and contribution to the HIV/AIDS response in the country. This assessment was conducted within the context of the following outcome theme areas: governance, leadership for development, capacity development, partnership coordination for country level development results and the mitigation of HIV/AIDS impact and poverty eradication.

This evaluation covers the period beginning in 1999, with the introduction of the National Strategic Results Framework (SRF), and includes current and already implemented activities. It also assesses UNDP's efforts in galvanizing development partners to address the globally identified and accepted multi-sectoral nature of the epidemic, within the context of Zimbabwe's current multiple socio-economic and governance challenges.

This report summarizes how the evaluation was carried out and describes the situation in Zimbabwe, including human development conditions, factors influencing the achievements and challenges in each outcome theme area, and an analysis of the progress report on the MDGs.

A brief analysis of the HIV/AIDS situation is provided, including prevalence rates trends, and some key areas of note. The Zimbabwe national multi-sectoral response is described including national government, UNDP and development partners' responses. It is followed by an analysis of the outcome of UNDP's role, contributions and support. Conclusions and recommendations are provided to lend insight into how programmes and future support should be channeled.

1.2 METHODOLOGY

The evaluation was based on the UNDP Evaluation Office Guidelines for Outcome Evaluators. The methodology involved document review to gain familiarity with UNDP's programmes and documented evidence of programme strategies, including the results of other evaluation reports. Stakeholders were interviewed at various levels, using interview guides and focus group discussions. Specific instruments tailored to the interview requirements of different stakeholders were used to interview stakeholders at national, provincial, district and community levels. Where appropriate, focus group discussions were conducted, particularly interviews with community groups.

While approximately 7 to 10 participants were expected to be in each focus group, sometimes the number was larger due to financial and time constraints. Respondents were divided into homogeneous groups, based on sex, age and interests. Respondents at national provincial, district, ward, village and household levels were included in the interviews. To complete the triangulation of information gathered, a stakeholder workshop was held to validate the perceptions and views of the participants, against documentary evidence and information obtained from field visits at national, and sub-national levels.

2. COUNTRY BACKGROUND

2.1 CURRENT DEVELOPMENT ENVIRONMENT

In order to fully understand UNDP's role and contributions to HIV/AIDS in Zimbabwe, it is important to describe the factors that influence the outcomes of its programmes and support to the country. One must also take into account some of the factors that are beyond UNDP's control, such as the deteriorating economic conditions, culture and issues related to governance.

2.1.1 Economy

During the last four years, the hostile macro-economic environment has caused a drastic decline in Zimbabwe's economy. Despite efforts to turn around the economy, there are still shortages of foreign currency, and unemployment is currently estimated at 80 percent.[1] Approximately 72 percent of Zimbabweans were classified as poor (living at or below the poverty line) by end of 2002.[2] Meanwhile, a worsening budget deficit has re-triggered rapidly climbing inflation. As of December 2005, inflation rates were recorded at 502.4 percent.[3] As a result, the ability to

1 Consumer Council of Zimbabwe 2005 year-end report.
2 "ZHDR 2003: Redirecting our Responses to HIV/AIDS," Mupawaenda and Murimba, Education sectoral report.
3 Reserve Bank of Zimbabwe, December 2005.

provide social services has declined significantly at the national, community and household levels during the past four years. There is a continuing steep decline in the value of the Zimbabwe dollar against major international currencies. In addition, there is dwindling donor support in the light of the country's political situation and reduced direct foreign investment and balance of payments support, plunging Zimbabwe into deeper economic abyss.

2.1.2 Culture

While Zimbabwe's society is multiracial and multi-ethnic, the majority of the population is African. The traditional African society, particularly among populations that live in rural areas, live in coherent community groups made up of extended families. Development of urban society has led to smaller, nuclear families and a more individualistic way of life, but in rural areas, social structures and their attendant values have largely remained intact.

Although poverty and change in socio-cultural values have led to the disruption of traditional community structures and ties, it is the HIV/AIDS epidemic that has put Zimbabwe's community support systems and networks under enormous strain. Morbidity, loss of family members, and weakened community ties have seriously eroded community capacity to protect its citizens and maintain the socio-economic gains achieved since the country's independence. There are an estimated 1.3 million orphans,[4] which also hampers the ability of community structures to provide support.

2.1.3 Patriarchy and gerontocracy

Zimbabwe society is predominately patriarchal. This undermines women's authority for decision making at all levels and diminishes their control over decisions related to their reproductive health rights and sexuality. Women also tend to have more restrictive access to services and are therefore at greater risk of HIV infection. In addition, gerontocracy, another important aspect of Zimbabwe society, leaves young people disempowered because it discourages their participation in most of the decisions that affect their well being, particularly on issues of sexuality. In Zimbabwe, marriage is a strong institution that shapes sexual behaviour in ways that increase the risks of infection. These socio-cultural factors have contributed significantly to the vulnerability and susceptibility of women and youth to the epidemic. Young women are therefore at greatest risks of infection, since they are hampered both by their gender and age.

2.1.4 Governance and legal instruments

The Zimbabwe government has shown some commitment to a national HIV/AIDS response through the enactment of the National AIDS Policy, National AIDS Levy, selecting Goal 6 of the MDG (HIV/AIDS) as one of its three areas of focus, and endorsing the African Consensus and Plan of Action: Leadership to Overcome HIV/AIDS. It has also accepted the outcome of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) of June 2001 and embraced the Maseru/Southern Africa Development Community Declaration on HIV/AIDS of July 2003.[5] In addition, a number of legal instruments and policies such as the Sexual Offences Act, the National AIDS Policy, the National Gender Policy, and the Legal Age of Majority Act have been established and now operate as part of the country's response to HIV/AIDS, as they guarantee the rights and welfare of individuals and social groups. Efforts have been made to harmonize these policies with international conventions and treaties, including such acts as the Convention on the Rights of the Child and the Elimination of all Forms of Discrimination Against Women, of which Zimbabwe is a signatory.

The government also supports projects that target people living with HIV/AIDS (PLWHA) and women, such as the Prevention of Mother to Child Transmission (PMTCT) and supports access to antiretroviral drugs. HIV/AIDS is now on the agenda of many leaders, including government officials, senior managers of the civil service, and faith-based and political party leaders.

While the government has declared the epidemic a national disaster, evidence from consultations and documents indicate that the Government of Zimbabwe response has not matched its declarations of commitment. Awareness of HIV/AIDS in Zimbabwe is high, but knowledge about how HIV is transmitted, the physical and economic implications of the disease, and the support and treatment that are available for the infected and affected are scarce. Advocacy on AIDS is minimal. There is a lack of

4 Accessed online at www.unicef.org, 2005.

5 The Maseru/ Southern Africa Development Community Declaration on HIV/AIDS endorsed and adopted the implementation of the Southern Africa Development Community Strategic Framework on HIV/AIDS.

campaigns that talk openly about the epidemic to stakeholders and address issues of sexual networks that fuel transmission, stigma and discrimination. Despite the public pronouncements about the will to fight HIV/AIDS, there is also a lack of openness about the cause of death of leaders who die of AIDS, indicating that there is still denial, stigma and discrimination associated with AIDS.

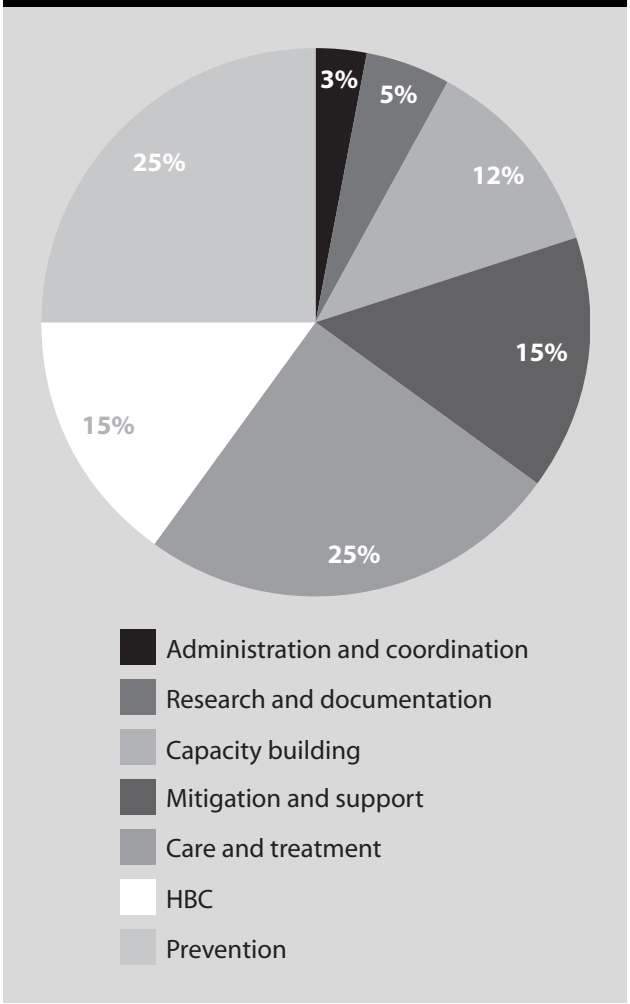
2.1.5 National response

The National Aids Council (NAC) coordinates the National HIV/AIDS response and operates as a statutory entity, consisting of a Secretariat and Management Board. At the district and ward levels, all Ward AIDS Action Committees (WAACs) are chaired by councilors who are politicians. District and ward consultations indicate that this structure may not be ideal, as politically appointed officers are very powerful and are inclined to lean towards party interests in administering their functions.

NAC is perceived to be ineffective in its coordination of the national HIV/AIDS response. In Figure 1, the Mashonaland East Province indicated their work-mix in terms of the implementation of their provincial programs. These programmes are decentralized to their districts, wards and village structures.

It is evident from the breakdown of the percentages that the coordination of work done in the provinces is limited. Most reports do not mention anything about coordination. If NAC's coordination of the national response were effective, the impact of the epidemic would be less severe, and the use of resources would have yielded more positive results to contain the spread of AIDS.

FIGURE 1. THEMATIC AREAS AND PROPORTION OF PROGRAMME EFFORTS[6]



2.2 MILLENNIUM DEVELOPMENT GOALS

Document review and fieldwork corroborate the UN Declaration findings that poverty, underdevelopment and illiteracy are major contributing factors to the spread of HIV/AIDS. HIV/AIDS in Zimbabwe and elsewhere is compounding poverty and reversing or impeding development gains in an integrated manner.[7]

The Government of Zimbabwe has acknowledged the links between HIV, gender, poverty and human development by selecting and monitoring the progress of the following MDGs as the priority goals among the eight MDGs: Goal 1 – Poverty and hunger, Goal 3 – Gender, Goal 6 – HIV/AIDS. The Government acknowledges that in order to achieve all the MDG targets set for 2015, the country must successfully launch and sustain its fight against the HIV/AIDS pandemic by reducing poverty and empowering both women and men to reduce their vulnerability to AIDS. If the spread of HIV/AIDS is reversed and equality between men and women becomes a reality, the productive sectors, such as agriculture and industry, will contribute to economic growth and poverty and unemployment will be reduced. More resources will be made available to spend on education and the health sectors, and environmental initiatives will expand to facilitate forging global partnerships.

6 Mashonaland East Province Office Circular.

7 UN, "Declaration of Commitment on HIV/AIDS, Global Crises — Global Action," 2001, para II page 9.

The first Zimbabwean MDG Report was produced under the leadership of the Ministry of Public Service, Labour and Social Welfare, which also chairs the Cabinet Social Service Action Committee, the ministry responsible for the poverty reduction agenda. The process was coordinated by UNDP Zimbabwe. To assist in the preparation of the report, a National MDG Taskforce that consisted of government and civil society was established. Seven multi-sector MDG thematic groups were formed that comprised of agriculture, education, environment, gender, health, HIV/AIDS, and social development welfare, and global partnerships. The report has emerged as one of the most important instruments for tracking and monitoring progress at the national level, and for establishing effective public campaign strategies for the attainment of sustainable development. However, there are capacity constraints to MDG reporting and monitoring.

In Zimbabwe, setting up a consistent and reliable database for MDG tracking and reporting poverty levels, and mobilizing the nation around the MDG banner during the current conditions of economic hardships present major challenges. Against the background of economic hardships, the HIV/AIDS pandemic continues to present substantive challenges, threatening to undermine and even reverse the current achievements of MDG targets and development efforts. However, with increasing poverty and several other development challenges emerging, the positive impact of the MDG process cannot be minimized. As socio-economic conditions continue to deteriorate, social tension increases, creating conducive conditions for social unrest. Close association with MDGs is indicative of a return to a long-term national development agenda by the Government of Zimbabwe. Hopefully, this will act as a positive image building measure to galvanize local and international commitment, and will assist in diffusing social tension by motivating the nation to work hard to meet the country development targets set by stakeholders.

3. HIV/AIDS SITUATION

The UNAIDS/WHO AIDS Epidemic Update of 2005 indicates a decrease in the adult HIV sero-prevalence in Zimbabwe from 26 percent in 2002 to 21 percent in 2005. The Ministry of Health and Child Welfare (MoHCW) also indicates a decline from 24.6 percent in 2002 to 20.1 percent in 2005, attributing the differences in rates to methodological differences in establishing the estimates.[8] While it is commendable that there is a decrease, the rate is still very high and it is important to ensure sustained decline.

The 2005 MoHCW Genscreen approximations indicate that approximately 1.6 million people are presently living with HIV in the country. There are an estimated 186,140 annual AIDS deaths, and 21.4 percent of them are children. By the end of 2005, an estimated 180,600 new infections will have occurred; 2.4 percent of them will be in children.[9] A major issue of concern is that Zimbabwe is developing a legacy of HIV/AIDS orphans. An estimated 75 percent of the 1.3 million orphans reported by UNICEF in the country for 2005 were orphans due to HIV/AIDS.[10]

According to the MoHCW report[11] the following factors have contributed significantly to the high HIV/AIDS prevalence levels in Zimbabwe:

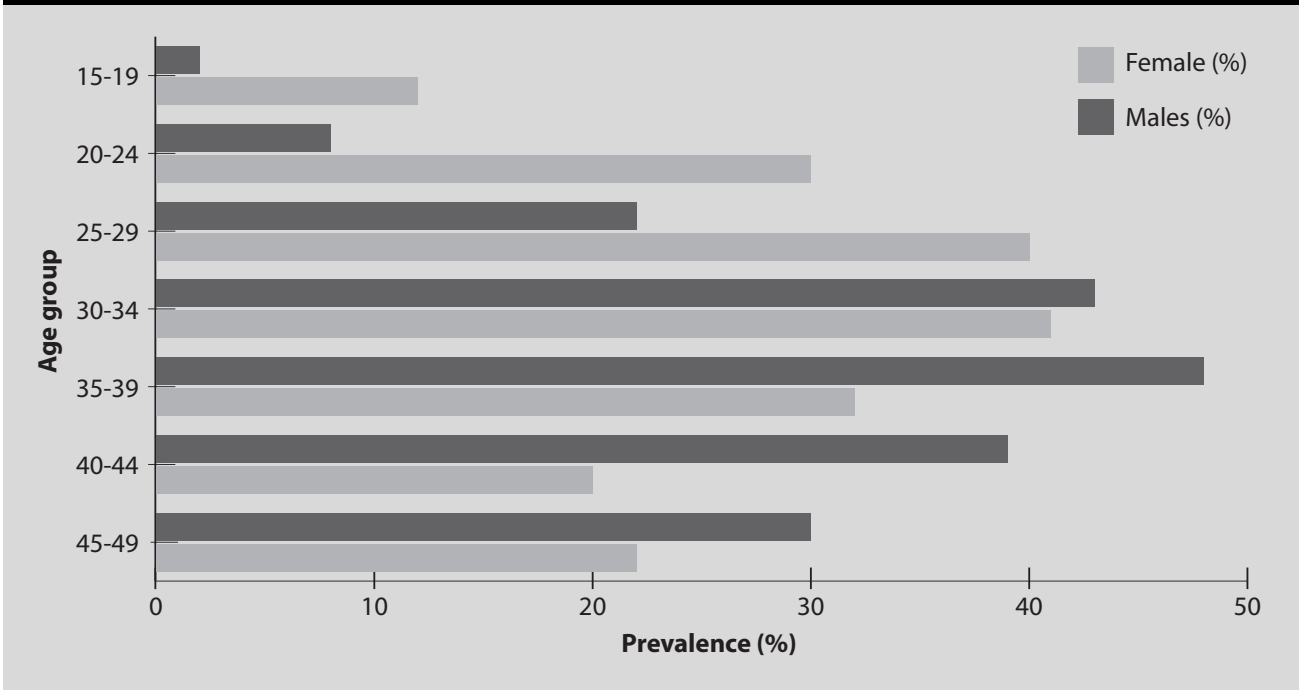
- High prevalence of other sexually transmitted infections
- Low levels of male circumcision
- Relationships with multiple sexual partners
- Traditionally low, incorrect and inconsistent use of condoms
- Mobility of partners
- Poverty and low socio-economic status of women

Figure 2 points out disparities based on gender and age groups.[12] Prevalence among women is 1.35 times higher than among men. It is higher in the younger age groups for women than it is for men. HIV infection rates among young women is 12 percent in the 15 to19 year age group. The rate is 2 percent for men in the same age group.

The HIV/AIDS pandemic affects the most reproductive and economically viable age group (15 to 49 years old), resulting in serious development consequences to the country. The Zimbabwe Human Development Report (ZHDR) notes loss of skilled labour both in the public and private sectors, and therefore a decline in valuable human capital that could make substantive contributions to socio-economic

8 See Annex 5 with technical note on HIV prevalence estimation methodology.
9 MoHCW, "Zimbabwe HIV/AIDS Estimates 2005," 2005.
10 Accessed online at www.unicef.org, 2005.
11 MoHCW, "The HIV/AIDS Epidemic in Zimbabwe," 2004.
12 MoHCW, "Zimbabwe National HIV/AIDS Estimates," 2003.

FIGURE 2. PREVALENCE RATES BY AGE AND GENDER



Source: MoHCW, "Zimbabwe National HIV/AIDS Estimates," 2003.

development in the country. Loss of household income diminishes social safety nets and inevitably overwhelms government social protection and security programmes. The same report also confirms the linkage between the pandemic and poverty, a relationship that has become increasingly bi-directional as the impact of HIV/AIDS is inducing poverty, while poverty exacerbates further risks and vulnerability to HIV infections.

4. COUNTRY RESPONSE

4.1 NATIONAL RESPONSE

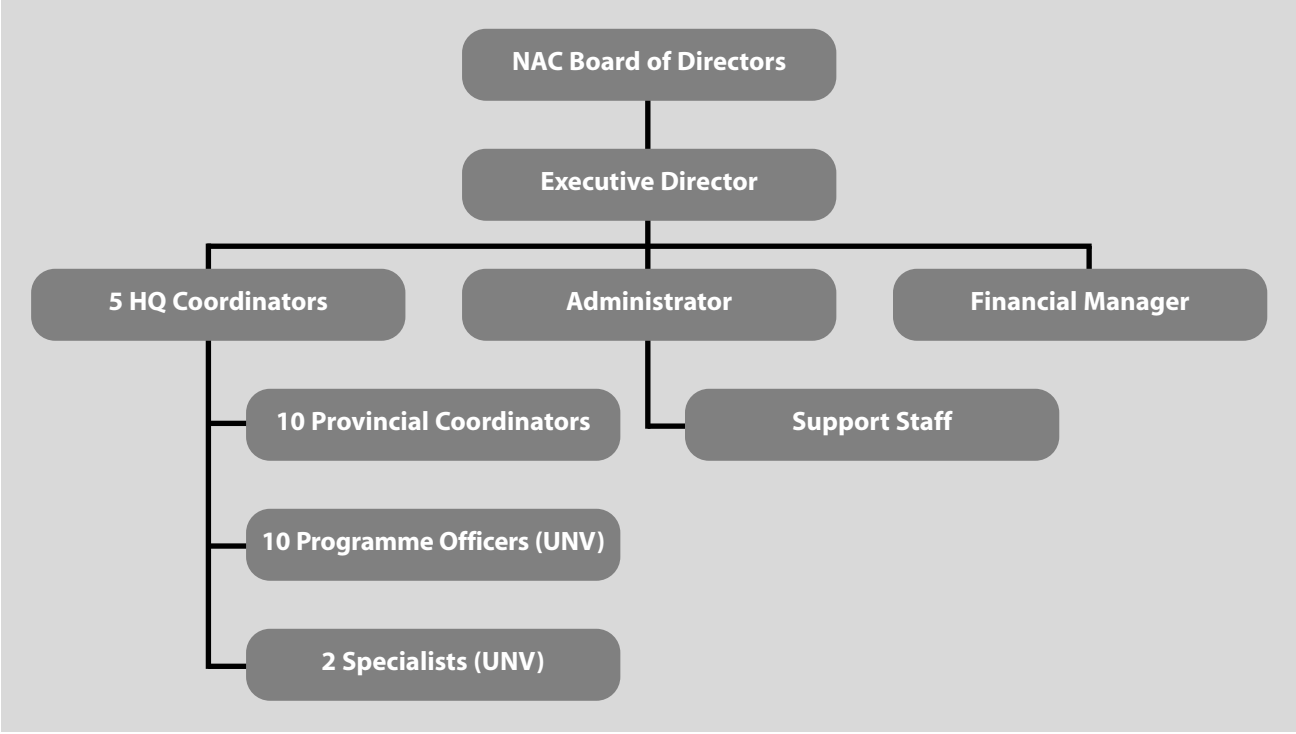
In Zimbabwe, the first HIV case was diagnosed in 1985. The following year, the Zimbabwe AIDS Health Experts Committee was established as an initial strategic response. The Government of Zimbabwe, with the support of the UNCT, including UNDP, then created the National AIDS Coordination Programme (NACP) in 1987, located within the MoHCW to mobilize human, technical and financial resources for mitigation of AIDS impact and prevention of infections. In 1988, the Five-year Medium Term Plan (MTP I) was launched, followed by MTP II for 1994-1998. The government instituted a policy on blood screening that resulted in very few infections from blood transfusions.[13]

The NACP made significant progress in increasing HIV/AIDS awareness, and has developed both the National HIV/AIDS Policy and Strategic Framework for 2000-2004. The main focus of the Framework was the employment of broad-based, participatory and consultative processes, which drew attention to the epidemiological and socio-cultural drivers of the epidemic. The primary policies and strategies of the Framework include the following:

- Promote delay in onset of sexual activity among the youth
- Promote safe sex as normal behaviour in all sexual relationships that deters risks to transmission of HIV infection
- Promote availability of male and female condoms that should be accessible and affordable to all sexually active individuals who wish to use them
- Promote the development of innovative behavioural change communication strategies to reach key groups with factual and effective messages about HIV/AIDS

13 Evaluation of UNDP's Effectiveness in Addressing HIV/AIDS in Southern Africa: Zimbabwe Country Office Briefing Note ," 2004.

FIGURE 3. STRUCTURE OF THE NATIONAL AIDS COUNCIL[14]



Notes: United Nations Volunteer (UNV) Specialists are for research and documentation and for Information Technology. Headquarters Coordinators are in the following areas: policy and strategic planning; monitoring, evaluation and research; social support and community mobilization; behavioral change, youth, gender and workplace; information, communication and advocacy.

- Promote availability and accessibility of information on PMTCT interventions to reduce transmission of HIV

Operational guidelines have also been developed for voluntary counseling and testing (VCT), PMTCT, treatment and home-based care and are being implemented through decentralized provincial and district structures.

NAC replaced the NACP when it became increasingly obvious that HIV/AIDS was not only a health issue but also a development problem. It was established through an Act of Parliament through the NAC Act of 1999, and NAC became operational in 2000, after a national secretariat provincial coordination offices, decentralized District AIDS Action Committees (DAACs), WAACs and Village AIDS Action Committees (VAACs) were established.

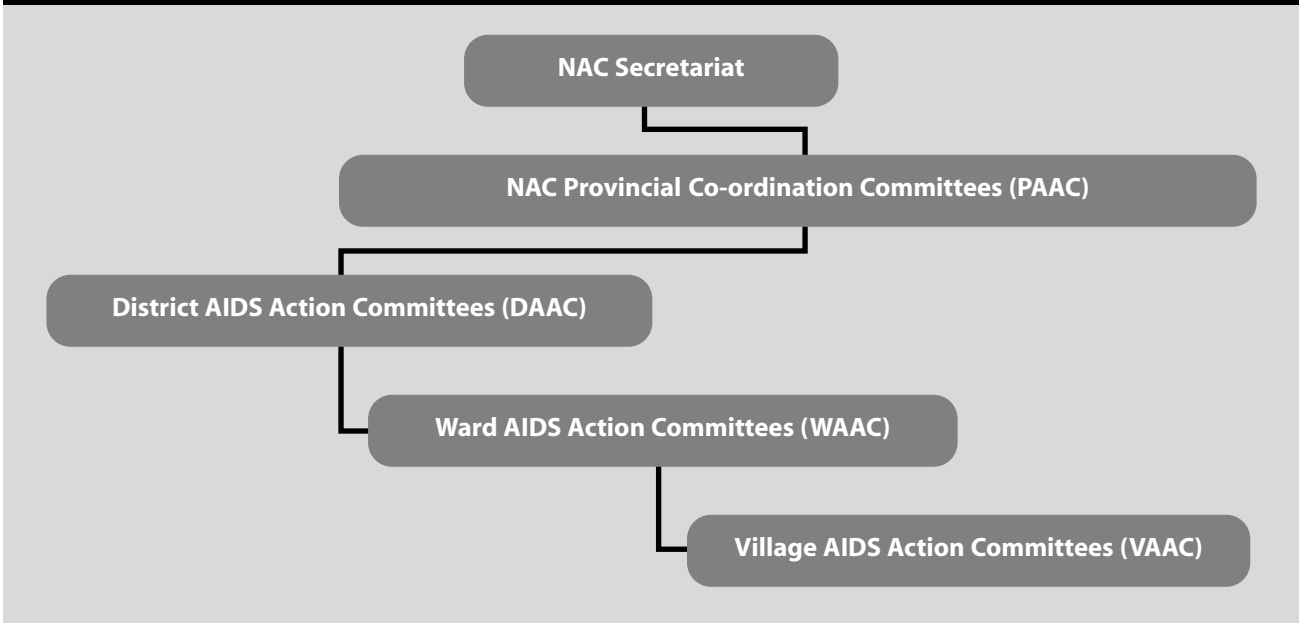
NAC coordinates the national HIV/AIDS response, setting legislative, policy and strategic plans and systems as directed by the Government of Zimbabwe. It was mandated to raise funds through the National AIDS Levy by prescribing a contribution of 3 percent payroll income tax into a Trust Fund for AIDS activities. NAC manages and disburses these funds for implementing various activities in the fight against HIV/AIDS. It has been working with partners to support various activities to create awareness, prevent and manage care and support activities. The overall operational framework of the NAC is depicted in Figure 3.[15]

The establishment of the NAC and the government's willingness to engage other stakeholders, including civil society and the private sector in the fight against HIV/AIDS was the beginning of the multisectoral response to the pandemic in the country. The MoHCW's AIDS and Tuberculosis Programme was responsible for monitoring HIV prevalence rates, using sentinel surveillance and data analysis to formulate HIV/AIDS related policies, developing strategic plans, and monitoring the implementation of interventions activities.

In May 2002, HIV/AIDS was declared a national disaster by the government. This laid the foundation

14 "Support for the NAC HIV/AIDS Programme Coordination (ZIM/00/010)."
15 UNDP, "Outcome Evaluation on HIV/AIDS in Zimbabwe," 2004.

FIGURE 4. DECENTRALIZED NATIONAL AIDS COUNCIL STRUCTURES



for resource mobilization for the fight against the pandemic. Various fora were established for the national strategic response. A Care and Treatment Forum under the coordination of the MoHCW was specifically set up for scaling up antiretroviral therapy (ART), while another one was responsible for orphans and other vulnerable children (OVC) at the Ministry of Public Service, Labour and Social Welfare. A partnership forum for HIV/AIDS was also established in 2003 under NAC with the main purpose of bringing together various actors for strategic planning, formulation and coordination.[16]

NAC has led the decentralized national response of HIV/AIDS activities and established structures down to the village level as shown in the organization chart in Figure 4.

Other areas of the response include the following:

- Blood screening
- VCT
- PMTCT
- Treatment of opportunistic infections
- ART
- Home based care
- Monitoring prevalence trends and analysis using sentinel surveillance
- Establishing policies relating to HIV/AIDS
- Planning and monitoring interventions against the spread of the epidemic

The various stakeholders under the umbrella of NAC have developed annual expenditure budgets from 2001 to 2005 and provided costs estimates to 2015, as indicated in Table 1.

TABLE 1. HIV/AIDS COSTING 2001-2005 AND PROJECTION FOR 2015 (IN 1999 USD)

	Conservative option	Pragmatic option
Prevention strategies and activities	6,483,636	7,209,090
Care strategies and activities	2,881,818	4,409,090
Mitigation strategies and activities	872,727	872,727
Enhanced sector response strategies	1,490,909	1,563,636
Monitoring and evaluation	72,727	272,727
Development of District AIDS Action Plans	181,818	281,818
Total	**11,983,635**	**14,609,088**
Cost per yYear	2,396,727	2,921,817
Projected cost to 2015	**31,157,451**	**37,983,628**

Source: MoHCW, NAC, and UNAIDS/Harare 1999.

16 "Evaluation of UNDP's Effectiveness in Addressing HIV/AIDS in Southern Africa: Zimbabwe Country Office Briefing Note," 2004.

Zimbabwe made progress in building national capacity to plan and implement a multisectoral HIV/AIDS response, particularly at district and provincial levels (see Annex 4).[17] The structures are made up of representatives from various sectors that implement HIV/AIDS programmes at different levels. Umbrella organizations formed by sectors include: Zimbabwe AIDS Network (ZAN) in the non-governmental organization (NGO) sector; Zimbabwe Business Council on HIV/AIDS (ZBCA) in the private sector; Zimbabwe Interfaith Network Against AIDS in the faith-based sector; and government ministry focal persons in the public sector.

4.2 UNCT'S SUPPORT TO THE NATIONAL RESPONSE

The support rendered by the UNCT in Zimbabwe to the HIV/AIDS response complements UNGASS, where a declaration was made to halt and reverse the impacts of the pandemic by 2015. In 2000, a separate HIV/AIDS Theme Group, supported by UNAIDS as its Secretariat, was set up by the UNCT.[18] The Theme Group focused on promoting awareness and prevention of transmission of HIV and sexually transmitted infections, and advocated for increased commitment to the multisectoral response. It also acted as the main vehicle for joint policy formulation, coordination and integrated action.

As a means of ensuring follow-up to the Declaration of Commitment, the UNDP Resident Representative assumed chairmanship of the Theme Group in 2002. Subsequently, a lot of effort was made to establish an Expanded UN Theme Group by extending participation to other donor agencies. The activities carried out by the Theme Group include guidance on the assessment of the HIV/AIDS component in the inter-agency Common Country Assessment undertaken jointly by the UN, Government of Zimbabwe and other development partners. The Theme Group on the HIV/AIDS component in the Zimbabwe United Nations Development Assistance Framework also provided guidance. The Framework for 2005-2009 indicates the close cooperation between the United Nations System and the Government of Zimbabwe.

4.3 UNDP RESPONSE

Before 2000, UNDP's activities in the area of HIV/AIDS were mainly through the Theme Group and primarily focused on resource mobilization for the joint UNCT Programme and the development of a strategy for a UN response to the pandemic in Zimbabwe. However by 2000, UNDP Zimbabwe CO began to implement its own HIV/AIDS strategy and interventions. The Country Cooperation Framework[19] for 2000-2003 adopted a strategy to combat HIV/AIDS through a comprehensive programme by coordinating local level efforts, using rural district councils, and working with UNVs and NAC.[20] UNDP's support focused on capacity development, using strategic, upstream policy and advocacy to mobilize national social actors, while simultaneously supporting and strengthening district level multisectoral responses.

In the context of the SRF, UNDP assistance acknowledged the need for the implementation of comprehensive strategies to limit the spread of HIV/AIDS and mitigate its social and economic impact. Institutional capacity development was perceived as a key element that would facilitate the planning and implementation of the multisectoral strategies. The NAC was expected to be fully operational, and capable of developing and coordinating operational strategies and plans.

The 2004 Multi-Year Funding Framework Strategic Framework Goal 5 delineates the following strategic response:

- Leadership and capacity development to address HIV/AIDS
- Development planning, implementing and HIV/AIDS response
- Advocacy and communication to address HIV/AIDS

Targets for HIV/AIDS were also established, and seven outcomes were set up in the SRF, to address the crosscutting elements of the pandemic. UNDP supported the following initiatives.

4.3.1 Advocacy and the National ZHDR

UNDP with partners, Poverty Reduction Forum (PRF) and the Ministry of Public Service, Labour and Social Welfare produced the ZHDR 2003,

17 UNDP, "Outcome Evaluation on HIV/AIDS in Zimbabwe," draft report, 3 December 2004.

18 "Evaluation of UNDP's Effectiveness in Addressing HIV/AIDS in Southern Africa: Zimbabwe Country Office Briefing Note," 2004.

19 The Country Cooperation Framework was extended for a further two-year period.

20 "Evaluation of UNDP's Effectiveness in Addressing HIV/AIDS in Southern Africa: Zimbabwe Country Office Briefing Note," 2004.

'Redirecting our Responses to HIV/AIDS Towards Reducing Vulnerability—The Ultimate War for Survival'. The report is based on the impact and dynamics of HIV/AIDS on several sectors. It demonstrates the linkage between HIV and development. The report has been used as an advocacy tool to highlight the HIV/AIDS situation in the country and the responses used to develop future responses in addressing the multiple challenges posed by the epidemic.

Another critical advocacy tool supported by UNDP has been the Zimbabwe 5-year Progress Report on the MDGs. It was used to sensitize the country on the MDGs, their role in development and the attainment of its objectives.

Similarly, UNDP funded the development of the 2004 Macro-Economic Policy Framework Report, which developed strategies, good practices and set priorities for macro-economic reform in Zimbabwe. It highlighted AIDS as a critical developmental concern and the need to mainstream the MDGs into country development processes. The Poverty Assessment Study Survey II, also sponsored by UNDP, is also perceived to be a potential tool for effective advocacy for sustainable reduction of poverty. This is especially important given the linkages between the spread of AIDS and poverty.

4.3.2 Support to NAC

UNDP assisted in strengthening district-level multisectoral responses through capacity development at the local levels by deploying national UNVs to NAC and provincial offices. UNDP has seconded 12 professional national UNVs to support implementation of the district response.

4.3.3 Southern Africa Capacity Initiative

UNDP Zimbabwe CO is spearheading the regional initiative for Southern Africa. It is dealing with the triple threat of food insecurity, weakened capacity for governance and HIV/AIDS, which are undermining Southern African countries' capacity to meet the MDGs. Southern Africa Capacity Initiative (SACI) supported the assessment for the rapid roll-out of ART to district and community levels, partnering with the MoHCW, as an entry point for its introduction into the country. It also supported impact assessments for the MoHCW, Agriculture, Education, Sports and Culture and the Public Service, Labour and Social Welfare for the review of sector policy and human resource planning. Support has also been provided through workshops for strategic planning and systems thinking for senior personnel of the MoHCW.

4.3.4 Mainstreaming HIV/AIDS into development projects

UNDP supports mainstreaming of HIV/AIDS into projects and its Workplace Programme. It also promotes the mainstreaming of HIV/AIDS into development planning and strengthening the capacity of sector ministries and NAC for management, coordination and impact mitigation. This initiative also supports the participation of the private sector, civil society and the acceleration of the district response initiatives, including service delivery systems, within the context of the rapidly deteriorating humanitarian situation. The support includes the integration of HIV/AIDS into national, macroeconomic policies and sectoral plans, and the formulation of national poverty reduction processes.

4.3.5 Training and mainstreaming HIV/AIDS

Training workshops were held to develop HIV/AIDS action plans for all the ministries and to design workplace programmes for HIV/AIDS for each ministry and their departments.

4.3.6 HIV/AIDS Policy for the public service

This included production of the draft HIV/AIDS policy for the public service. UNDP was also involved in the establishment of the HIV/AIDS Coordination Unit to oversee the implementation of the policy within the Public Service Commission.

4.3.7 Modeling HIV/AIDS into macro-economic models

The HIV/AIDS epidemic has adverse effects on all aspects of economic development, but its precise impact has not been fully demonstrated, particularly at the macro-economic level. The current macro-economic models in the country do not take into account HIV/AIDS, and this has resulted in the allocation of inadequate resources to address the problem in a comprehensive and holistic manner.

4.3.8 Business impact assessment

UNDP was also involved in lending support to the ZBCA to develop competencies in assessing the HIV/AIDS impact on business performance.

4.3.9 Mainstreaming HIV/AIDS into UNDP supported projects

UNDP supported the Parliamentary Support Project to sensitize Members of Parliament on their role and

contribution to the HIV/AIDS response, particularly at the constituency and legislative levels. It also supported the creation of HIV/AIDS information resource centers with the Parliamentary Information Resource Centre established and located within Parliamentary Constituency Centres and supported as part of programme activities.

4.3.10 Global Fund Against AIDS, Tuberculosis and Malaria (GFATM)

Zimbabwe was awarded USD 14.1 million under the first round of the GFATM to fight AIDS, tuberculosis and malaria. NAC will manage and implement the Fund with technical assistance from UNAIDS. UNDP will provide oversight for disbursement of funds, procurement of goods and services and reporting. The overall goal of the programme is to achieve reduced transmission among young people, improve access to VCT for expansion of PMTCT services, and strengthen the provision of community and home based care services.

4.4 DEVELOPMENT PARTNERS' RESPONSE

The United Nations created a separate HIV/AIDS Thematic Group in 2000 with UNAIDS as the Secretariat. This was initiated to mobilize partners and donors around the Partnership Forum, under the auspices of the NAC.

The UN Theme Group on HIV/AIDS include UNAIDS' nine core sponsors, Food and Agriculture Organization, UNIFEM, UN Information Centre, UNICEF, UNESCO, The Oak Foundation, World Bank, Centers for Disease Control (CDC), USAID, Department for International Development, Canadian International Development Agency, European Union, and NAC, by invitation. It is a mechanism for joint policy formulation, coordination and action around HIV/AIDS issues in Zimbabwe.

Multilateral and bilateral donors are involved in the following activities:[21]

- In 1998, UNICEF sponsored the travel of government officials to Uganda to observe current programmes on AIDS.
- UNESCO is involved in improving communication through electronic discussions.
- USAID has supported the establishment of VCT centers.
- Oak Foundation held workshops on health and HIV/AIDS for NGOs at community level.
- The World Bank started a multisectoral response to HIV/AIDS in 2000.
- The CDC is carrying out interventions on sexually transmitted infection surveillance.

Zimbabwe AIDS Network (ZAN) was formed in 1990 as an umbrella organization to coordinate the NGO sector response in order to avoid duplication of efforts, since some NGOs did not cooperate by submitting work plans as requested. ZAN coordinates 140 NGOs and represents them in the decentralized AIDS Action Committees, which constitute the multisectoral and multi-level structures of NAC. The other major challenge for NGOs is the provision of services without adequate capacity for delivery. Capacity building programmes to acquire 'AIDS competence' are required.

Private-sector organizations have responded differently to the threat of HIV/AIDS. The response was based on an information, education and communication strategy and on condom use. According to the ZHDR 2003, the informal business sector, which is the fastest growing segment of industry, has no organized response to HIV/AIDS. The ZBCA Initiative was launched in 2002 and was designed to formulate an HIV/AIDS response for this sector and contribute to the national response.

Media institutions have been used as vehicles for communicating HIV/AIDS prevention and awareness messages and are a vital venue in the fight against HIV/AIDS. However, according to the 2003 ZHDR Report, the media has not been responsive in the fight against the pandemic. The media is perceived to have contributed to irresponsible reporting that further promotes stigma and discrimination.

Civil society response has been varied. It is mainly focused on addressing issues related to the social impact of AIDS. Some civil society organizations have played a crucial role in fighting the epidemic. However, according to a 2003 report by NANGO, most civil society organizations are plagued with weak leadership and, consequently, are unable to respond effectively to the challenges posed by AIDS. Other challenges are lack of capacity to mainstream HIV/AIDS into their current programmes and the inability to select appropriate interventions to achieve measurable impact. Most of the organizations are carrying out similar interventions, such as creating awareness and distributing condoms, without assessing why these interventions have not led to substantial reduction in infection rates.

21 Project ZIM/00/010 Support to NAC programme coordination.

Faith based organizations are also responding to the HIV/AIDS pandemic. Most older churches, which operate mission hospitals in rural areas, have been instrumental in providing healthcare services in the country, particularly at a time when the public health systems are facing a crisis. Many of them provide home based care, peer education and orphan care programmes. However, some churches use Christianity and traditional African values to deter the use of effective HIV/AIDS programme interventions and strategies, which are in conflict with the ideologies of the church. This may increase risks of infections.

Community based responses have generally relied on voluntary work and the assistance provided by community members. Community based organizations' responses include provision of support to PLWHA and people who are affected, using impact mitigation strategies.

The following is a summary of complementary development partners' activities and interventions that were implemented in collaboration with UNDP:[22]

- **The Ministry of Finance and Economic Development and other ministries—**UNDP has worked with these ministries to integrate HIV/AIDS and gender dimensions into all development policies, plans and strategies through capacity development.
- **NAC—**UNDP has supported NAC to enhance its capacity to coordinate the national multisectoral and multilevel response to HIV/AIDS.
- **NAC and the UNDP regional programmes and Bureau of Development Policy—**UNDP has developed tools for mainstreaming HIV/AIDS into national policies, strategies and plans.
- **The Cabinet Action Committee on Health and Social Services, Inter-Ministerial Committees, HIV/AIDS Focal Points and Development Planners—**UNDP has advocated for mainstreaming and integrating HIV into all development policies, plans, strategies and implementing workplace programs.
- **UNIFEM—**UNDP is working with UNIFEM to ensure that the gender and human rights dimensions of HIV/AIDS are recognized, understood, taken into consideration and addressed as integral parts of the national response.
- **EMCOZ, ZNCC, CZI, International Labour Organization, ZAPSO and the Trade Unions—**UNDP provided guidance on the development of workplace policies and programs.
- **World Bank—**UNDP's project to mainstream and integrate HIV/AIDS into development in Zimbabwe complements the World Bank's support for capacity enhancement for the Ministry of Finance and Economic Development on public sector expenditure review, public expenditure review (PER) for social sectors, with a focus on health, education, and pensions.
- **UNCT Theme Group on HIV/AIDS—**UNDP provided technical support and assistance for the development of generic methods and tools for community capacity assessments, impact analysis, monitoring and evaluation.
- **PRF—**UNDP provided an important advocacy tool for reducing the spread of HIV/AIDS in Zimbabwe using the ZHDR 2003.
- **Biomedical Research and Training Institute, Blair Research Institute and the Health Education and Research Division of the University of Natal—**UNDP helped carry out collaborative research on the impact of HIV/AIDS.
- **National UNVs—**UNDP has deployed national UNVs to provide technical support to initiatives at the central government level.
- **Bureau of Development Policy Special Initiative on HIV/AIDS Community Capacity Enhancement Project—**UNDP will promote collaboration among agencies to encourage the use of indigenous foods and medicinal plants.
- **UNAIDS—**UNDP works with UNAIDS to ensure that globally recognized best practices and technical expertise are scaled up.
- **ZAN—**UNDP and ZAN are strengthening their relationship in order to mobilize the NGO sector for mainstreaming HIV/AIDS activities.
- **CDC—**UNDP provided support for development of the ZIM-AIDS Information Portal, to be established at NAC.

22 UNDP, "Project Document Zim/03/002, Mainstreaming and Integration of HIV/AIDS into Development in Zimbabwe," 2003.

5. OUTCOME OF UNDP CONTRIBUTIONS AND SUPPORT

5.1 GOVERNANCE

The main outcomes in governance are: strengthening national and sub-national governance institutions to facilitate a more efficient coordination of the multi-sectoral and multilevel response, and strengthening economic governance through mainstreaming HIV/AIDS into sector activities. UNDP's support to the Ministry of Finance and Economic Development has resulted in strengthening economic governance, complementing the World Bank's capacity enhancement on public sector expenditure for social sectors. Consequently, mainstreaming HIV/AIDS has been addressed during general economic processes and deliberations, which have led to government budget allocation for AIDS activities. UNDP assisted the Cabinet Action Committee on Health and Social Services to advocate for mainstreaming and integrating HIV/AIDS into all development policies, plans and strategies, including policies for developing and implementing workplace programmes for both public and private sectors. Similarly, the International Labour Organization in partnership with EMCOZ and others have provided guidance in developing workplace policies and programmes for the private sector.

Advocacy tools like the ZHDR, the MDG Progress Report, and the 2004 Macro-Economic Policy Framework Report have enhanced the Government of Zimbabwe's response efforts, resulting in mainstreaming HIV/AIDS into the national development agenda. The MDGs have been useful as an overarching development vision for addressing national policy issues on HIV/AIDS. HIV/AIDS policies have been established for the public sector, and task forces and focal points have been appointed in ministries and departments. UNDP's support to NAC through the District Response Initiative has also led to the institution of a more participatory approach for annual planning for HIV/AIDS that includes the input of stakeholders from the district and community levels.

5.2 LEADERSHIP FOR DEVELOPMENT

The major outcome under leadership for development is increased commitment by leaders at all levels to contribute to the fight against HIV/AIDS and to mitigate its impact on PLWHAs, families and communities. UNDP support in this area has led to the development of key national documents, which have laid the foundation for the policies that steer NAC's coordination of the National Response, such as the National AIDS Policy and Strategic Framework. UNDP's support and advocacy have strengthened national leadership political commitment, resulting in the establishment of the NAC Act and, subsequently, the provision to collect 3 percent payroll tax to set up the National AIDS Levy. Advocacy and continuous dialogue with the government about the development dimension of HIV/AIDS have also contributed to increasing government leaders' understanding of the development implications of the pandemic and, therefore, the need to create and implement policies to reduce the adverse effects of the disease. Similarly, leaders now appreciate the importance and the need to adopt the MDGs as a tool for measuring the country's progress towards the attainment of sustainable human development.

UNDP's support to form partnership forums, such as the UNCT Theme Group, and its expansion to include non-UN members to deliberate on AIDS issues has strengthened the capacity of national leadership and development partners to work towards establishing and achieving common goals in support of the national response. Similarly, support to ZAN has led to strengthened organizational capacity and emerging leadership in civil society.

UNDP also provided assistance through the Parliamentary Reform Programme to strengthen national leadership. A joint UNDP and Futures Group training programme improved the capacity of parliamentarians to advocate on issues of HIV/AIDS, gender and human rights. Policy analysis skills were provided to legislators to ensure integration of HIV/AIDS into all bills and budget allocations that are currently being reviewed and passed by parliament. This has ensured that budgetary allocations are earmarked for HIV/AIDS to accelerate the fight against the epidemic. Members of Parliament can now review HIV/AIDS policies and the progress of the implementation of those policies, with a view to providing support and adding value to all HIV/AIDS activities in Zimbabwe. They are also now able to review the performance of government ministries and parastatals in HIV/AIDS and can support mainstreaming HIV/AIDS across their constituency relations programmes. Members of Parliament now

support and implement an HIV/AIDS workplace programme in Parliament.

5.3 CAPACITY BUILDING

Two major outcomes can be attributed to UNDP contributions in capacity building: building capacity of 10 provincial offices, and increased recognition of the need to train Zimbabweans in knowledge generation on HIV/AIDS. UNDP's deployment of UNVs in Zimbabwe has taken into consideration the current humanitarian crisis in the country and the need to respond to human resources needs and gaps in technical skills areas. UNDP recruited 12 UNVs: 10 were deployed to serve as Programme Officers in 10 provinces, and 2 were assigned to NAC headquarters as Information Technology and Research Documentation Specialists. The UNV Programme Officer in Mashonaland East Province has made significant contributions by helping the province strengthen its capacity in programme planning, implementation and research. He has produced Uzumba Maramba Pfungwe district evidence-based best practices, including the challenges to programme implementation. This reference document can be used to scale up successful practices in this district and other districts in the future.

The participatory approach used to develop the ZHDR 2003 also built the capacity of various ministries and sectors in HIV/AIDS information and knowledge generation. Participation in the process has resulted in establishment of an information database and documentation of unique HIV/AIDS situations that are specifically relevant to their constituencies. UNDP support in developing tools for mainstreaming HIV/AIDS into development policy and programmes has also resulted in increased national and sub national capacity to mount a multi-sectoral and multi-level response to the pandemic. The programme to equip Parliamentary Information Centres with information on HIV/AIDS has built the capacity of legislators to respond more effectively to the pandemic at the grassroots level.

UNDP's role as temporary Principal Recipient for the GFATM is pending its provision of capacity building for NAC to eventually assume this responsibility. It was difficult to discern the extent of its progress during the evaluation. However, the current location of NAC within the MoHCW, the country's economic crisis, and the shortage of appropriate human resources are likely to limit its capacity building objectives in the near future.

UNDP's support to the Zimbabwe Business Council on HIV/AIDS has strengthened members' competencies in HIV/AIDS impact assessment and mainstreaming in the private sector and their workplaces. Similarly, support to ZAN has strengthened the capacity of the organization to mobilize civil society involvement in the national response.

5.4 PARTNERSHIP COORDINATION

UNDP's support for mainstreaming and integrating HIV/AIDS into development has increased the Government of Zimbabwe's acceptance of the need to strengthen partnerships between UNDP, government and other stakeholders through collaboration and networking. Stakeholder consultations, facilitated by UNDP as Chair of the Theme Group, have led to consensus building and a trend toward maintaining a common multisectoral development response to HIV/AIDS. Despite this positive trend, key informants from both UNDP and UNAIDS indicate fundamental differences between the two institutions in HIV/AIDS programming. Criticisms emerged during the evaluation, which indicate that if these differences are not resolved, it will be difficult to attain the UN Theme Group objectives of a sustainable, integrated response. It is especially difficult since UNDP is expected to be the lead development agency, working with the government as a trusted and neutral ally in development. It is therefore important to review issues related to the differences and clarify areas of responsibilities and collaboration to facilitate a more collaborative partnership in the future.

UNDP's partnerships with civil society through ZAN, the private sector through the ZBCA, and PRF have facilitated increased participation, enhanced capacities and competencies in HIV/AIDS assessment and programme development. However, it was difficult to discern the impact of the programmes during the period of evaluation.

UNDP's strengthened partnership and collaborative approach in dealing with the Government of Zimbabwe provided a solid foundation for its temporary assumption of custodial responsibility as Principal Recipient and Manager of the GFATM, pending strengthening NAC's capacity to assume its role. UNDP has provided critical support

at a time of dwindling resources for development, due to donor abandonment, and in the face of a continuing humanitarian crisis in Zimbabwe. UNDP has 'stayed the course'—setting up a conducive environment for funds operation, while simultaneously building the capacity of NAC to eventually assume management responsibility.

5.5 MITIGATION OF HIV/AIDS IMPACT AND POVERTY ERADICATION

UNDP led by example by initiating the 'We Care' Programme, its internal workplace HIV/AIDS programme, to mitigate the impact of the pandemic on its employees. This initiative strengthened employees' ability to respond to HIV/AIDS in the workplace, household and UN community. However, the Programme should be strengthened and scaled up, because the issue of stigma and discrimination is still perceived to be a major concern, as very few individuals are willing to disclose their HIV status.

UNDP also provided support through budget allocation to HIV/AIDS for the public service, private sector and various civil society institutions. It was widely acknowledged that without UNDP support it would have been difficult to achieve the results attained so far in the fight against HIV/AIDS. As one key informant pointed out, UNDP has played a major role and contributed to the declining prevalence rates in the country. It can also be credited for enhancing stakeholders' understanding of the linkages between HIV/AIDS and poverty and advocating for the need for a sustainable poverty reduction strategy.

UNDP's advocacy led to the Government of Zimbabwe's prioritization of MDGs 1, 3 and 6 on the national development agenda, arguing that if gender-equitable poverty reduction efforts are realized, then it would become easier to respond to the HIV/AIDS pandemic.

Civil society has also emerged with holistic approaches for mitigating the impact of HIV/AIDS, combining programmes for gender and PLWHA empowerment, poverty alleviation efforts and impact mitigation at grassroots levels. UNDP supported the District Response Initiative that enhanced PLWHA rights. Provisions were made to incorporate policies and strategies into the multisectoral response frameworks at the DAAC, WAAC and VAAC levels. The platform created by the District Response Initiative offered an opportunity for integration of PLWHA activities into development activities, alongside other people who are not living with AIDS. This should assist in reducing stigma and discrimination for PLWHA. However, it was noted that these programmes were not supporting micro-financing for PLWHA projects at the grassroots level, a component that is critical for sustaining impact reduction.

Various media workshops, supported by UNDP through the PRF, resulted in building the capacity of media practitioners in reporting and creating HIV/AIDS awareness. This has subsequently led to an increase in print and electronic media messages on HIV/AIDS awareness.

5.6 ANALYSIS OF UNDP'S CONTRIBUTION TO THE OUTCOMES

This evaluation found that, despite the many challenges faced by Zimbabwe since 2000, some progress has been made in building national capacity to plan and implement a multisectoral and multi-level response to the HIV/AIDS epidemic. UNDP has contributed significantly to this outcome. In addition to building NAC's capacity for planning, implementation and coordination of the expanded multisectoral response, UNDP has assisted in resource mobilization through the GFATM to augment the Government of Zimbabwe resources provided through the National AIDS Levy. The NAC's information communication technology, administrative and financial systems have been established and are functioning. Vehicles have also been procured and are being used for programme activities. However, the installation of the ZIM-AIDS Information Portal is pending its development by the National Research Laboratory. Dissemination of information still remains a challenge.

NAC has also been supported to establish provincial, district, ward and village action AIDS committees. UNDP provided technical support to NAC's provincial staff to implement capacity building workshops for DAAC, WAAC and VAAC members on programme planning, implementation, management and evaluation. Fieldwork consultations carried out in the Province of Mashonaland East indicated that the provincial, district, ward and some village structures have been established. The PAAC, DAAC, WAAC and VAAC are multisectoral entities with PLWHA representatives.

The 2005 NAC Annual Plan and Budget for Mashonaland East Province have made provisions for the multisectoral entity. However, the report also indicates that most DAACs, WAACs and VAACs do not have adequate capacity to effectively coordinate NGOs and community-based organizations operating in their various communities. In addition, stakeholders have been critical of the fact that the number of decentralized structures is too large, and many do not have clear procedures for coordination, even among themselves. It is difficult to demarcate responsibilities because these structures all deal with the same beneficiary organizations and local politics further complicate the situation (as exemplified in the case study in Box 1).

BOX 1. CASE STUDY: CHAOS ROCKS CHITUNGWIZA'S HIV/ AIDS PROGRAMMES IN MASHONALAND EAST PROVINCE

Confusion is reigning in Chitungwiza with District AIDS Action Committee (DAAC), councilors and Ward AIDS Action Committees (WAAC) duplicating roles in HIV/AIDS programmes. Lack of clearly defined roles of the two committees and ward councilors has caused confusion. The local authority leadership is accused of imposing their authority on the process for selecting and compiling a list of candidates, with some people getting assistance because of their relationship to councilors and other officials. The situation has resulted in some families getting assistance at the expense of others in dire need. A councilor conversant with the operations of the two committees noted that, in some instances, the number of people on the lists compiled at ward level exceeded that required by DAAC. The committee has turned away some people, and in some wards, officials have failed to reach a consensus on the people who should be supported through the programme. In some instances, two separate lists were forwarded to the committee for consideration.

The NAC introduced the concept of DAACs and WAACs as implementing agents for HIV/AIDS programmes at community levels by identifying and rendering assistance to people in need. The role of councilors as ex-officio members is to supervise the implementation of WAAC and DAAC programmes. However one problem in Chitungwiza is that instead of 14 WAACs, there are only 5. In addition, some councilors felt that peer educators, who volunteer to implement HIV/AIDS programmes, should be paid to show appreciation for the work they do in the community. At the moment, volunteers are paid approximately 2,000 Zimbabwe dollars per month, which is paltry considering the economic situation in the country.

Comments: This case study illustrates the inefficiency and ineffectiveness in the provinces regarding the implementation of HIV/AIDS programmes at district and ward levels, and the confusing roles and functions of the decentralized structures. These structures are supposed to coordinate, not implement programs.

Source: *Zimbabwe Herald*, 10 March 2005.

There is also general agreement among UNDP staff, NAC Management, UNAIDS and others that NAC still has glaring capacity gaps and has not been effective in its capacity as coordinating agency for the national response. NAC is perceived to have focused on functions such as implementation, which should be left to the other organizations designated to undertake such responsibilities. One of NAC's challenges is clearly defining its coordination role and synchronizing that definition with its legislatively mandated responsibilities.[23] Another issue of concern is NAC's location within the MoHCW and the responsibilities of that ministry in the coordination efforts. It is difficult to envisage the MoHCW managing the coordination of other ministries and sectors, since it is at the same statutory level. Besides, coordinating a multisectoral approach means that the coordinator should be located in a neutral zone, so that interventions are not skewed toward any sector and reflect the needs and programmes of all sectors clearly impacted by the disease.

In addition, it is important for Zimbabwe's HIV/AIDS response strategy to be synchronized with regional and international frameworks, such as the MDGs, the Declaration of Commitment and the Maseru Declaration. The NAC, as the coordinating agency for the national response, is therefore expected to play a critical role in tracking national capacity and monitoring progress towards goals. Stakeholders should be informed regularly about the progress made against set targets and the resources required to meet them. While some organizations, such as CDC and other stakeholders, have assisted in supporting the development of a national system for monitoring and evaluating progress, NAC's capacity to adequately use this system and report to stakeholders remains weak. This is particularly evident regarding monitoring national capacity for achievements of the MDG and UNGASS goals and targets.[24]

23 Co-ordination here being defined as the ability to integrate, correlate and harmonize all levels of the national HIV/AIDS response strategies among stakeholders including government, private sector and civil society.

24 UNDP, "Outcome Evaluation on HIV/AIDS in Zimbabwe," 2004.

UNDP has contributed substantively in mainstreaming HIV/AIDS into various development activities and programmes in Zimbabwe. UNDP achieved these outcomes in collaboration with other UN agencies, civil society and government sectors. However, UNDP has also missed opportunities to scale up mainstreaming HIV/AIDS into development activities in the country.

The current relationship between government, civil society and the private sector, which is characterized by suspicion and implementation of individual approaches, is not conducive for a multisectoral and integrated response to the HIV/AIDS pandemic. The roles and relationship between UNDP and UNAIDS need to be clarified and strengthened. A collaborative approach among all stakeholders will facilitate consensus building around a common approach to winning the fight against HIV/AIDS.

The prevailing unstable socio-economic environment in Zimbabwe poses further challenges to the response efforts. Brain drain and high staff turnover in the government, private sector and civil society means that some of the efforts devoted to capacity building may be lost as people move elsewhere to look for better opportunities, taking with them their technical expertise. It is therefore important to simultaneously focus on the HIV/AIDS response and to establish systems for stabilizing the macro-economic environment to reduce the migration of critical and experienced human resources.

While UNDP's contribution towards the mainstreaming of HIV/AIDS into the development agenda is becoming increasingly evident in national policies, the impact of the multisectoral response is not effective due to inadequate political will to enforce policy adherence and implementation. It is therefore important for the Government of Zimbabwe to strengthen and maintain its advocacy and social mobilization campaign, while working closely with UNDP and other development partners to maintain a common perspective for implementing the national response.

6. CONCLUSION

In general, UNDP has made important contributions to the national HIV/AIDS response in Zimbabwe. UNDP has 'stayed the course' and remained committed to being a principal ally and partner to the Government of Zimbabwe, mobilizing resources through the GFATM, strengthening partnerships with development partners, and building institutional capacities in support of the national response. UNDP continued to work with Zimbabwe at a time of dwindling resources and donor support. It acted as a temporary custodian for GFATM, while attempting to build NAC's responsibility to assume the Principal Recipient role—deploying UNVs to NAC's central and decentralized offices to build capacity in information technology, research, and documentation and programming.

UNDP has supported civil society and private sector organizations in strengthening capacity for social mobilization of sector participation and developing policies and tools for mainstreaming in support of the national response.

UNDP contributions to building partnership through the Expanded Theme Group to include more stakeholder representation has led to the development of important documents such as the ZHDR 2003, SRF and poverty reduction initiatives highlighting the critical linkages between poverty and HIV/AIDS, the multidimensional nature of the epidemic, and the need to mainstream HIV/AIDS into all sector programs.

While UNDP's achievements in the face of Zimbabwe's crisis are commendable, UNDP has also missed some opportunities for scaling up programs, such as its own 'We Care' Workplace Programme. The challenges ahead for UNDP are to maintain the current momentum, while working closely with the Government of Zimbabwe to manage the macro-economic dilemma of the country and simultaneously sustain its advocacy campaign on HIV/AIDS to maintain stakeholder commitment.

6.1 RECOMMENDATIONS

1. The current political and economic conditions in Zimbabwe demand continuous efforts to build social capital and consensus for sustained multi-stakeholder buy-in and commitment to the national response. The UNDP supported PRF provides a platform for multi-stakeholder deliberations and should continue to be supported by UNDP. UNDP should expand participation in the PRF so that more stakeholders

can deliberate on how partners from government, civil society and the private sector could best work together to respond to the pandemic using their strengths and comparative advantages.

2. The UN Expanded Theme Group has been an effective forum for development partners' dialogue. UNDP should continue to use it to mobilize other donor support and resources, and establish and strengthen new partnership networks so a more integrated and participatory approach is implemented for donor coordination, with each partner bringing its strength and comparative advantage to the table.

3. The MDGs provide an important roadmap for reducing poverty and addressing additional risks and vulnerability to the spread of HIV/AIDS. UNDP should keep discussions about MDGs in the forefront of the country's dialogue on development, as it will enhance the multisectoral efforts required to fight the HIV/AIDS epidemic. Advocacy tools used to promote MDGs should be simplified to meet the needs of civil society organizations that work at the grassroots levels so the information can be adequately disseminated.

4. UNDP has made significant contributions to promote and achieve acceptance of the multi-sectoral development nature of HIV/AIDS. It has used that advocacy to make a case for establishing NAC and decentralized offices. UNDP's capacity building efforts for NAC is constrained by NAC's location within the MoHCW, because it will be difficult for MoHCW to effectively support NAC's coordination role as a statutory equal to other ministries and sectors. UNDP should therefore use its position as lead UN agency and chair of the UN Theme Group to influence the Government of Zimbabwe to move NAC to a higher level cabinet office. This will facilitate participation by other ministries and limit MoHCW's influence to planning and developing programmes for the health sector.

5. UNDP should support NAC in reviewing its current policy of appointing councilors who are politicians to chair WAACs, as their political affiliations have caused conflict of interests in carrying out their responsibilities. More neutral figures should be elected to chair WAACs, to ensure that the needs of people from all political parties are addressed.

6. UNDP currently acts as Principal Recipient for the GFATM, pending strengthening NAC's capacity to assume its responsibilities. UNDP should review its current role for conflict of interests and develop a plan for accelerating the capacity-strengthening programme, focusing on financial and resource management, so it can promptly relinquish its position as Principal Recipient. In addition, UNDP should strengthen NAC's capacity in outcome-based monitoring and evaluation to enhance its capacity for coordination of the national response. This will also enhance NAC's role in resource mobilization, building partnerships, minimizing duplication, and providing a 'level and transparent' system so that all partners could feel comfortable participating in activities to support the national response.

7. Access to treatment is increasingly becoming an important issue. UNDP should use its comparative advantage in capacity building to enhance the MoHCW, NAC and other organizations' abilities to handle treatment issues and facilitate the management of ART schemes and programmes. This would encourage funding partners, such as the GFATM, to start supporting such programmes.

8. The culture of gerontocracy, inherent in Zimbabwean society, is clearly not conducive for a sustainable response strategy to the pandemic. Since Zimbabwean youth are at higher risk and vulnerable to HIV/AIDS, UNDP should make concrete efforts to include youth programmes in its HIV/AIDS supported programmes by entering into joint programmes with HIV/AIDS service organizations currently working with youths.

9. Support to civil society organizations is essential for decentralized structures, established through UNDP support to NAC, to thrive. UNDP should review its current initiatives and help strengthen capacity of these organizations in institutional governance and operational systems. This will ensure that the organizations become more responsive to the needs of the beneficiaries at the community level.

10. Support to umbrella organizations, such as ZAN for civil society and ZBCA for the private sector, is essential for coordinating these sectors. UNDP should consider continuing to build their

capacity or working closely with other donors who may wish to channel their resources to enhance their capacities.

11. Media institutions and practitioners play vital roles in raising HIV/AIDS awareness and reporting. According to ZHDR 2003, the media are perceived to have contributed to irresponsible reporting that may have led to stigma and discrimination. UNDP should include media practitioners in its advocacy plan and provide training to raise capacity in media ethics reporting on AIDS.

12. The current decline in resources and donor support in Zimbabwe presents a daunting challenge for resource mobilization, particularly in the face of the HIV/AIDS pandemic. UNDP should work closely with the Government of Zimbabwe to review its budgetary allocations for HIV/AIDS, determine the level of resource gaps and assist in mounting a resource mobilization campaign to increase donor support and resources for HIV/AIDS awareness, prevention, care and support, including treatment.

13. Research reports and stakeholder consultation confirm that, despite the public pronouncement about the will and commitment to fight HIV/AIDS, stigma and discrimination is still rampant in the country. Leaders who are living with AIDS are reluctant to declare their status and even when they die, the cause of death is withheld. UNDP should assist leadership by mounting public campaigns to reduce stigma and discrimination and subsequently reduce the glaring gap between the Government of Zimbabwe rhetoric and actual commitment.

14. UNDP should review its current support towards the national response, assess its impact, determine programming and resource gaps, define areas of future priority support in line with its institutional strengths, and develop comparative advantages.

ANNEX 1. ACRONYMS AND ABBREVIATIONS

ART	Antiretroviral Therapy
CDC	Centers for Disease Control
CO	Country Office
DAAC	District AIDS Action Committee
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
MDG	Millennium Development Goal
MoHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NGO	Non Governmental Organization
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PRF	Poverty Reduction Forum
SACI	Southern Africa Capacity Initiative
SRF	Strategic Results Framework
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Education and Scientific Organization
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Women's Development Fund
UNV	United Nations Volunteers
VAAC	Village AIDS Action Committee
VCT	Voluntary Counseling and Testing
WAAC	Ward AIDS Action Committee
ZAN	Zimbabwe AIDS Network
ZBCA	Zimbabwe Business Council on HIV/AIDS
ZHDR	Zimbabwe Human Development Report

ANNEX 2. REFERENCES

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ANNEX 3. PEOPLE INTERVIEWED

GOVERNMENT OF ZIMBABWE

M. Beni, Mininstry of Education, REM Tutor, NAC/UNDP DAAC Murehwa Meeting
S. Chipunza, MoHCW, HPO
Ms. Chiyanja, Local Government, Director
Emily Gondo, Controller and Auditor General, Deputy Director
Maria Gorett, Mines and Mining Development, Chief Metallurgist
A. M. Gurajena, Murehwa District Council, Acting CEO, NAC/UNDP DAAC Murehwa Meeting
T. S. Hlatywayo, Small and Medium Enterprises, Under Secretary
E. Juru, Child MP
E. C. Kadzondera, Industry and International Trade, Under Secretary
D. Kandira, Home Affairs, Human Resources Assistant
Judith Kaulem, PRF Coordinator
Dr. M. Madhombiro, Justice-Prison Service, Director, Health Services
George Madzimure, Local Government, Acting Under Secretary
Panganai Magambe, Water Resources, Acting Chief Accountant
Idine Magonya, DAC, DAC
C. Makoro, DAC, PLWHA
C. R. Makwena, Registrar General's Department, Registrar
I. Mandaza,Youth Development, Acting Deputy Director
C. Mhike, Ministry of Health (Sister In Charge), NAC/UNDP DAAC Murehwa Meeting
Takura Mhonde, Water Resources, Under Secretary
S. Muchiurawa, Gutu RDC, Ward 13 Councilor
K. Mudhefi, AREX, Ward 13 Gutu
G. Musa, Herbalist, DAC
T. S. Musoko,Youth Development, Gender and Employment Creation, Director
Mr. Naboth, Transport and Communications, Senior Executive Officer
Nathan Nkomo, Pensions Department, Deputy Director
Ruth Nyachowe, Public Service Commission, Departmental Secretary
H. Nyamayaro, Mines and Mining Development, Deputy Secretary
Thomas Pasipamire, Transport and Communications, Deputy Director
B. T. Rusike, MoHCW, Acting DMO
Godfrey H. Sigododhla, Justice -Legal and Parliamentary Affairs, Director
George Sixpence, Small-Medium Enterprises, Senior Executive Officer
Learnson Tagara, Public Service Commission, Deputy Manager
Shushine Tarupiwa, Public Service Commission, Manager
J. Taruvinga, NAC, PAAC — Mashonaland East
S. Tokoda, Industry and International Trade, Human Resources Assistant
R. Toropilo, DAC, CSW
S. S. Zembe, Public Service Labour and Social Welfare, Director
R Zharira, Patron for Child MP
H. Zimudzi, NAC

UNDP

Emmanuel Bwera, Organizer
Dr. Jesiman Chipika, Programme Coordinator — POEM
Bernard Mokam, Acting Resident Representative
Nomasomi N. Mpofu, Programme Coordinator — GSIP
May Nakazibwe, Programme Officer — GSIP
James Nkangabwa, Programme Officer — HIV/AIDS
D. Nyamwera, UNDP/NAC, PLC

UN SYSTEM

Dr. Karl-Lorenz Dehne, UNAIDS, Country Coordinator
Steven O`Brien, UNAIDS, Information Management Officer

CIVIL SOCIETY ORGANIZATIONS, NON-PROFIT ORGANIZATIONS, OTHER

J. Bukuta, NAC/UNDP DAAC Murehwa Meeting
C. S. Chapungu, Care International, Driver — Chirumanzu
M. Chidima, Chairlady, NAC/UNDP Meeting, Macheke
C. Chikwasha, Rock Haven, NAC/UNDP Meeting, Macheke
M. Coster, C. G Moison Village, NAC/UNDP DAAC Murehwa Meeting
C. Goba, VCW Welcome B, NAC/UNDP DAAC Murehwa Meeting
E. Gweshe, SAHRIT, NGO Representative, NAC/UNDP DAAC Murehwa Meeting
N. Jakopo, Chairlady, NAC/UNDP Meeting, Macheke

Lovemore Kadenge, ZBCA, Acting Director
F. Kanotangudza,VHW Islaham Village, NAC/UNDP DAAC Murehwa Meeting
T. Kashesan, DAAC, Youth Representative, NAC/UNDP DAAC Murehwa Meeting
S. Kashiri, C. G Moison Village, NAC/UNDP DAAC Murehwa Meeting
B. Kutseza, Changwe A, NAC/UNDP DAAC Murehwa Meeting
M. Mabhuro, Local Government, District Administrator, NAC/UNDP DAAC Murehwa Meeting
D. Machakaire, Head Woman, NAC/UNDP Meeting, Macheke
E. Madhairo, VHW Horsely Village, NAC/UNDP DAAC Murehwa Meeting
Dr. Phineas Makurira, PRF, ZHDR Ambassador
E. Manake, Care International, Field Officer - Gutu
T. Mangwende, VCW Linden Village, NAC/UNDP DAAC Murehwa Meeting
C. Mapfumo, Benavistor Plot 3, NAC/UNDP Meeting, Macheke
D. Mashonganyika, DAAC, PLWHA Representative, NAC/UNDP DAAC Murehwa Meeting
J. Matsatsa, VHW Welcome A, NAC/UNDP DAAC Murehwa Meeting
F. W. Mavedzenge, Health, District Nursing Officer
T. Mavhangira, Benavistor Plot 3, NAC/UNDP Meeting, Macheke
M. Mawuta, Health Worker, NAC/UNDP Meeting, Macheke
T. Mbundire, Traditional Healer, NAC/UNDP DAAC Murehwa Meeting
C. Mukombe, Chairlady, NAC/UNDP Meeting, Macheke
A. Mutasa, VCW Howgate, NAC/UNDP DAAC Murehwa Meeting
A. Mutero, DAAC, Coordinator, NAC/UNDP DAAC Murehwa Meeting
T. Muzamhindo, Local Government, District Administrator, NAC/UNDP DAAC Murehwa Meeting
R. Muzanenhamo, Muza Estate, NAC/UNDP Meeting, Macheke
L. Ndemera, Vidico, NAC/UNDP Meeting, Macheke
E. Ndlovu, Kraal Head, NAC/UNDP Meeting, Macheke
P. Njenje, DAAC, Chairperson, NAC/UNDP DAAC Murehwa Meeting
V. Nyagwizo, MYDGEC, RDO, NAC/UNDP DAAC Murehwa Meeting
M. Nyakuedzw, Secretary, NAC/UNDP Meeting, Macheke
Dr. Nancy O'Rourke, Consultant
T. Sikatewingwi, Iddesliegh Estate, NAC/UNDP Meeting, Macheke
D. Simon, VHM Nyamakaira Village, NAC/UNDP DAAC Murehwa Meeting
M. S. R. Tokwani, Care International, Coordinator for HIV/AIDS, HQ
Whande, Care International, APM for HIV/AIDS-Mvuma
E. Zaranyika, Hornsely, NAC/UNDP DAAC Murehwa Meeting
P. K. Zindi, GRDC, Acting SSO

ANNEX 4. BUDGET FOR MASHONALAND EAST PROVINCE

National AIDS Council – Mashonaland East Province
Detailed Summary of Provincial and District Level Workplans and Budgets
Total Budget: 9,930,054,200

	Budget Item and Level of Plan	2005 Budget	Allocation (%)
District Level Work Plans and Budgets	Prevention of HIV transmission	1,654,000,000	25.0
	Care and treatment	1,654,000,000	25.0
	Home based care	992,400,000	15.0
	Mitigation and support	992,400,000	15.0
	Capacity building and coordination	793,920,000	12.0
	Research and documentation	330,800,000	5.0
	Administration	198,480,000	3.0
	Subtotal	***6,616,000,000***	***100.0***
	Percentage of district level activities		***66.6***
Provincial Level Work Plans and Budgets	Provincial coordination and networking	1,461,000,000	14.7
	Monitoring and evaluation	1,016,400,000	10.2
	Provincial office administration	836,654,200	8.5
	Subtotal	***3,314,050,200***	
	Percentage of provincial level activities		***33.4***
Grand Total		**9,930,054,200**	**100.0**

Source: 2005 Work plans and Budgets

ANNEX 5. TECHNICAL NOTE ON HIV PREVALENCE ESTIMATION METHODOLOGY IN ZIMBABWE

Estimates are based on data from Zimbabwe's sentinel surveillance for Ante-Natal Care (ANC). Epidemic Projection Package (EPP) software was used to produce estimates for the national adult, 15-49 years HIV prevalence for Zimbabwe. Before the ANC data is entered into EPP, population sectors were first classified as urban, rural and 'other', including large-scale commercial farms, administrative centres, and state lands, based on the residence of the women attending the clinics. The data would then be adjusted accordingly, to avoid over- or under-estimation. The EPP would then be used to fit separate HIV epidemic curves to the ANC data and the three curves from the three different population strata would be combined to provide one national HIV epidemic by applying the population distribution to urban, rural and 'other' categories from census data. The HIV prevalence curve generated by EPP would then be used as an input to the software package spectrum, so as to generate the estimates of HIV prevalence for adults and children, the number of new infections, new AIDS cases and AIDS mortality.

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