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Second Independent Evaluation 2002-2008
Country Visit to Ethiopia - Summary Report

UNAIDS

Second Independent Evaluation 2002-2008

Country Visit to Ethiopia

Summary Report

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BPR	Business Process Re-engineering
BSS	Behavioural Surveillance Survey
CBO	Community-based Organisation
CCM	Country Coordinating Mechanism (GF)
CDC	Centers for Disease Control (US)
CRDA	Christian Relief and Development Association
CSO	Civil Society Organisation
DaO	Delivering as One
DHS	Demographic and Health Survey
DOL	Division of Labour
EBCA	Ethiopian Business Coalition Against AIDS
EIFDDA	Ethiopian Inter-Faith Forum for Development Dialogue and Action
EMSAP	Ethiopia Multi-Sectoral AIDS Programme (World Bank)
ERP	Enterprise Resource Planning
ExCom	Executive Committee
FBO	Faith-based Organisation
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
GF	Global Fund (abbreviation of GFATM)
GFATM	Global Fund to fight AIDS, TB and Malaria
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Organisation
GTT	Global Task Team
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HoA	Head of Agency (UN)
HSDP	Health Sector Development Plan
HSS	Health systems strengthening
IDU	Injection drug user
IEC	Information, education and communication
IGA	Income generating activity
IHP	International Health Partnership
ISTF	Implementation Support Task Force
JT	Joint Team
M&E	Monitoring and evaluation
MARP	Most at risk population
MOH	Ministry of Health
MSM	Men who have sex with men
NACS	National HIV/AIDS Council Secretariat
NASA	National AIDS Spending Assessment
NEP+	Ethiopian Network of PLHIV
NFE	Non-formal education
NHA	National Health Account
NPF	National Partnership Forum
PAF	Programme Acceleration Fund
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty 2005/6-2009/10
PBS	Protection of Basic Services
PEPFAR	President's Emergency Programme for AIDS Relief (USG)
PLHIV	People living with HIV
RC	Resident Coordinator
RCC	Rolling Continuation Channel (GF)

RHB	Regional Health Bureau
RNE	Royal Netherlands Embassy
SPM	Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response
TSF	Technical Support Facility
TWG	Technical Working Group
UA	Universal Access
UCC	UNAIDS Country Coordinator
UN	United Nations
UNCT	UN Country Team
UNDAF	UN Development Assistance Framework
UNGASS	UN General Assembly Special Session on AIDS
UNTG	UN Theme Group
USG	United States Government

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Disclaimer

Full responsibility for the text of this report rests with the authors. The views in this report do not necessarily represent those of UNAIDS nor of the people consulted.

1 Introduction

1.1 This report is a summary of findings from a short evaluation visit to Ethiopia as part of the Second Independent Evaluation of UNAIDS. The country visit took place 8 to 23 October 2008. The team consisted of Derek Poate, Kathy Attawell, Paul Balogun and Dr Woldemedhin Teklesadik Haile who conducted interviews with civil society organisations. The team were based in Addis Ababa and made a visit of two days to Bahir Dar, capital of Amhara Region.

1.2 The summary report draws on material in a set of evaluation framework tables (described in the inception report for the evaluation[1]), which are based on information gathered from meetings with a range of stakeholders (Annex 5) and from review of key documents (Annex 4).

1.3 Ethiopia is one of 12 countries sampled for visiting during the evaluation[2]. It is not a comprehensive evaluation of the programme in Ethiopia. Instead, it examines the effectiveness and efficiency of UNAIDS, so the main focus of interest is in the value added by the joint programme. The material in the framework tables from these country visits, visits to regional offices of UNAIDS Secretariat and Cosponsors, global visits and interviews, and surveys of other stakeholders will be synthesised together in an overall evaluation report due to be submitted in August 2009.

1.4 Following a brief overview of the country context in Section 2, the report presents the main findings from the visit in Section 3, which is structured in line with the conceptual framework of the evaluation (see Box 1). Section 4 highlights key issues and discussion points arising from the findings.

Box 1 Evaluation scope and objectives

The purpose of the second independent evaluation of UNAIDS is to assess the efficacy, effectiveness and outcomes of UNAIDS (including UNAIDS Secretariat, the PCB and Cosponsors) at the global, regional and country levels and, specifically, to what extent UNAIDS has met is ECOSOC mandate for an internationally coordinated response to the HIV/AIDS pandemic and the continuing relevance of its mandate and objectives in the current global environment. At country level, the evaluation focuses on the following questions:

- The evolving role of UNAIDS within a changing environment
- The Division of Labour between the Secretariat, Cosponsors, Agencies and Countries
- Strengthening health systems
- The administration of the Joint Programme
- Delivering as One
- Involving and working with civil society
- Gender dimensions of the epidemic
- Technical support to national AIDS responses
- Human rights
- The greater and meaningful involvement of people living with HIV

The conceptual framework for the evaluation organises these questions under three broad themes: how UNAIDS is responding to the changing context; how UNAIDS is fulfilling its mandate; and how UNAIDS works. In addition, it addresses how UNAIDS has responded to the recommendations of the first independent evaluation.

[1] The Second Independent Evaluation of UNAIDS 2002-2008 Inception Report. 20th October 2008
[2] The other countries are Cote d'Ivoire, DRC, Haiti, India, Indonesia, Iran, Kazakhstan, Peru, Swaziland, Ukraine and Vietnam

2 Country context

2.1 HIV was first detected in Ethiopia in stored sera collected in 1984 and the first two AIDS cases were reported in 1986. Since then HIV and AIDS has become a major public health and development problem and was declared an emergency in 2002 by the Ethiopian government.

2.2 Ethiopia has a generalised HIV epidemic, with some concentration among population groups that engage in high-risk behaviour and in specific regions. Although the epidemic stabilised in urban areas in the mid 1990s and started to decline from 2000, HIV and AIDS still pose a threat to achievement of the MDGs and to national security. An estimated 1.04 million people in the country are living with HIV. Overall HIV prevalence is estimated at 2.1% but ranges from 7.7% in urban areas to 0.9% in rural areas. HIV prevalence is significantly higher among women (2.6%) than among men (1.7%). HIV incidence in 2006 was estimated at 0.26%, with most new infections occurring in urban areas. Women – many in the age group 15-24 – accounted for 53.2% of new infections. Life expectancy in Ethiopia is falling as a result of the epidemic and is expected to drop from 59 to 50 years by 2010. The country also has one of the largest populations of children orphaned by AIDS in sub-Saharan Africa, currently estimated at 886,820. AIDS has become the leading cause of mortality in 15-49 year olds, accounting for an estimated 43% of all adult deaths.[3] Awareness of HIV is high but only 30% of men and 16% of women have comprehensive knowledge of how HIV transmission can be prevented.

2.3 The National HIV/AIDS taskforce was established in 1985 under the Federal Ministry of Health (MOH). In 1987 the National AIDS Control Programme (NACP) was set up as a Department in the MOH. HIV/AIDS surveillance activities began in 1989. Two medium-term HIV/AIDS prevention and control plans were designed and implemented in 1989 and 1996, with emphasis on information, education and communication, condom promotion, surveillance, patient care and the expansion of HIV screening laboratories.

2.4 The National HIV/AIDS Policy was formulated by MOH and adopted by the Council of Ministers in 1998 with a subsequent update in 2007. The HIV/AIDS Prevention and Control Office (HAPCO) was established in 2002 after two years as the National HIV/AIDS Council Secretariat (NACS). It developed and implemented a 5-year national strategic framework (2000-2004), which focused on reducing HIV transmission, associated morbidity and mortality and impact on individuals, families and society. The strategy was built on four issues: multi-sectoralism; participation; leadership; and efficient management including adequate monitoring and evaluation (M&E).

2.5 The Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response (SPM) (2004-2008) identified six strategic issues: capacity building; community mobilisation and empowerment; integration of HIV and AIDS activities with health programmes; leadership and mainstreaming; coordination and networking; focus on special target groups; and creating one M&E system.

2.6 At the time of the evaluation visit Ethiopia was receiving approximately $350 million per year from PEPFAR, $250 million per year from the Global Fund, $20 million from the Clinton Foundation, $10 million from the World Bank, and smaller amounts from UN agencies and other sources.

[3] 2005/06 Annual HIV/AIDS Monitoring & Evaluation Report Ethiopia.

3 Findings

How UNAIDS has responded to the five year evaluation

3.1 The 2002 Five-Year Evaluation put forward 29 recommendations. Of these, 18 have a direct application or influence at country level, though many are also linked to wider global and regional initiatives. Annex 3 lists these 18 country-oriented recommendations in note form with a comment on the situation in Ethiopia. Of the 18 recommendations for which an assessment could be made, six were assessed as having achieved a high level of progress; three medium; and nine low progress.

How UNAIDS is responding to the changing context

3.2 This section deals with the way in which UNAIDS (Secretariat and Cosponsors) have responded to the changing aid architecture. Three topics are explored: the evolving role of UNAIDS in a changing environment; reform within the UN and Delivering as One; and support to strengthen health systems.

The evolving role of UNAIDS

3.3 During the period covered by the evaluation, UNAIDS in Ethiopia has developed institutionally from a support role to the UN Theme Group (UNTG) into a Joint Programme of Support. The UNAIDS Country Coordinator (UCC) reports that the Secretariat country office currently has three main areas of focus: support for HAPCO; the Joint Team; and engagement with key national civil society networks (NEP+, EBCA and CRDA). As reported in the following sections, the Joint Team has brought a wider range of UN agencies together to fight the epidemic and created opportunities for a more coherent approach within the UNDAF. The expansion of financial support through the Global Fund (GF) and PEPFAR has brought new challenges to the role and contribution of UNAIDS to the national response.

Strengthening health systems

3.4 Health systems issues are included in the national HIV strategy, reflecting the strong lead by the health sector in the HIV response in Ethiopia. There are cross-linkages between the Plan for Accelerated and Sustainable Development to End Poverty (PASDEP – Ethiopia's PRSP) 2005/6-2009/10, Health Sector Development Plan (HSDP) III 2005/6-2009/10 and the Strategic Plan for Intensifying MultiSectoral HIV/AIDS Response (SPM) 2004-2008. The UNAIDS Secretariat and Cosponsors played an important role in the development of the health sector HIV response Road Map, including through a UNAIDS-funded consultant. UNAIDS Secretariat and UNDP also contributed to the development of the national multisectoral Plan of Action to reach universal access, which incorporated the Road Map. WHO is supporting MOH efforts to address human resources for health including through the Treat, Train and Retrain programme.

3.5 Both the major HIV donors in Ethiopia – Global Fund (GF) and PEPFAR – are funding health systems strengthening (HSS) programmes and activities. This has been driven by the MOH, which views HIV funding as an opportunity to strengthen the sector. The UN has had little influence on MOH direct engagement and MOU with the GF or PEPFAR or on the HSS agenda. However, UNAIDS has used its membership of the CCM to influence the development of the GF Round 7 proposal and contracted consultants to support proposal development; the social mobilisation technical working group for the proposal was chaired by the UNAIDS Secretariat and a UNAIDS-funded consultant led the HSS technical working group. The extent to which donor funding for the health sector takes account of HIV issues is difficult to determine.

3.6 The MOH tracks the use of HIV funding for HSS. Limited progress has been achieved with regard to taking forward the National AIDS Spending Assessment (NASA), owing to lack of commitment from HAPCO and potential overlap with the planned MOH National Health Account (NHA) exercise.

3.7 There is no stated UNAIDS position on HIV and HSS in Ethiopia and this issue has not been discussed by the Joint Team. The UNAIDS Secretariat in Geneva is in the process of defining its position. While there are no specific agreements between the UNAIDS Secretariat country office and WHO or other relevant Cosponsors in Ethiopia with regard to HSS, both the Secretariat and WHO support HSS within and outside the International Health Partnership (IHP) process. Cosponsors' roles depend more on their specific mandate. There is no clearly articulated UNAIDS role or plan of action in Ethiopia vis-à-vis international health initiatives such as the IHP (although UNAIDS Secretariat and some Cosponsors participated in the IHP process and are signatories to the IHP Compact). The degree of engagement with key actors varies depending on which Cosponsor, which initiatives and actors are considered.

Delivering as one

3.8 Evidence suggests that there has been a strong focus on aid effectiveness in Ethiopia, but with rather different orientation inside and outside the UN agencies. The Minister of Health is clear that the Government of Ethiopia (GOE) wants to maximise the benefits of synergy, with one plan for the UN based on the comparative advantage of UN partners and avoidance of duplication. GOE is also focused on ensuring that partners implement the 2005 GOE Harmonisation Manual. This is, at present, something that ExCom agencies, but not the non-Ex-Com agencies, are attempting to do.

3.9 The Paris Declaration has not directly contributed towards the UNAIDS approach, which primarily focuses on enhancing coordination of a multisectoral response to the epidemic, because the aid effectiveness agenda focuses on coordination within sectors. This tension was clearly seen as a challenge during design of the UNDAF (2005) which, at GOE insistence, took a sectoral approach.

3.10 In terms of UN reform, Ethiopia is classified as neither a Delivering as One (DaO) pilot country nor a 'self-starter'. As such Ethiopia is not in the mainstream of current reform processes and reform has not provided greater opportunity for experimentation by the Ethiopia UN Country Team (UNCT). The Resident Coordinator (RC) expressed the opinion that little substantive progress has been made by the UN in Ethiopia on the reform agenda and that the last two years have been spent working to build consensus across heads of agencies (HoA) on the need for change.

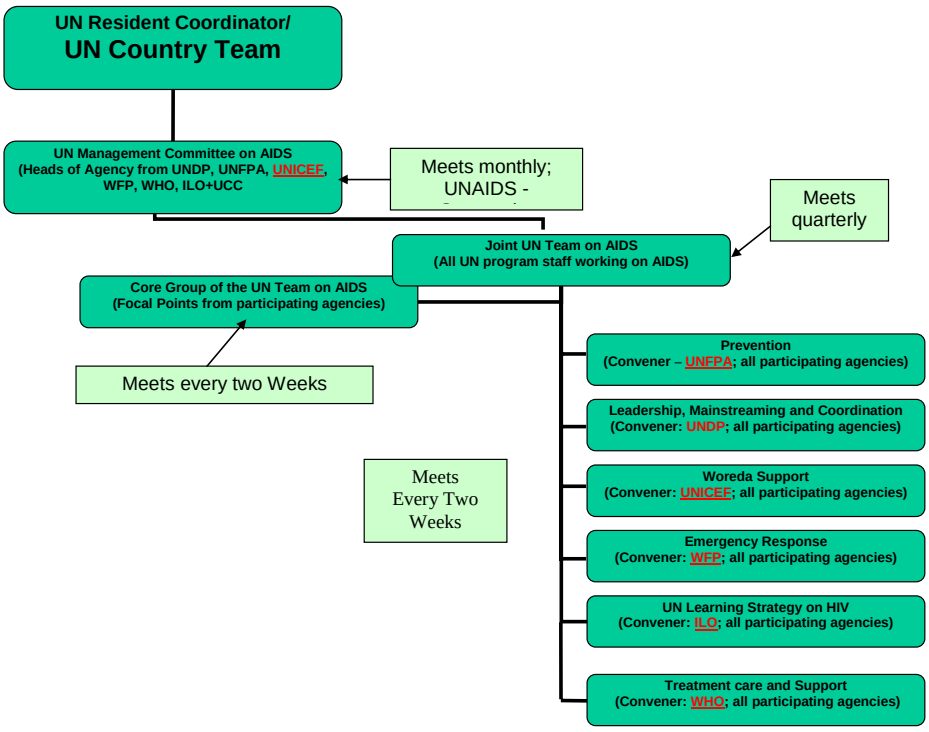
How UNAIDS works

3.11 Many of the changes in UNAIDS during the period covered by the evaluation have occurred as a result of reforms in organisation and management. This section addresses these by looking at the Division of Labour (DOL) among the Secretariat and Cosponsors and arrangements for administration of the Joint Programme.

The Division of Labour between the Secretariat and Cosponsors

3.12 In Ethiopia a Joint UN Management Committee on AIDS was created in late 2005, in response to the UN Secretary General's letter establishing Joint Teams on AIDS. Not all agencies within the Joint Programme of Support are represented on the Joint UN Management Committee on AIDS. UNESCO, UNHCR, World Bank (and IOM) are not included, partly reflecting their lack of staff in-country and grade of staff in post. The chair of the Management Committee is appointed by the RC, after consultation with Heads of Agencies (HoAs). The Joint Team comprises a Core Group and, initially, five Implementation Support Task Forces (ISTFs), which were established in late 2006. Following a dispute over scope of work, the Management Committee established an additional task force by separating out Treatment, Care and Support into a new ISTF in late 2007. Figure 1 illustrates the structure and indicates frequency of meetings. Roles are based on those suggested in the UNDG Guidance Note on Joint Programming4 and suggestions on roles and responsibilities for HoAs in the 2006 Guidance on Joint Teams.

Figure 1



[4] UNDG (2003) Guidance Note on Joint Programming. United Nations Development Group, December 2003.

3.13 In the 22 months that the Joint Team has been operating, significant progress has been reported in a number of areas as a result of cooperative working (even if not explicitly reflecting division of labour. Examples reported to the evaluation team include:

- Advocacy and support for the setting of national targets for Universal Access to Prevention, Treatment Care and Support; developing and costing the National Multisectoral Plan of Action for the AIDS response and Health Sector Road Map for Universal Access.
- Advocacy for intensifying HIV prevention. The UN Prevention Taskforce has been instrumental in establishing National Prevention Advisory Board and Technical Working Group under HAPCO and in other key activities which have the potential to support a national focus on HIV prevention.
- Advocacy and support for the establishment of the HAPCO pooled fund (HIV/AIDS Governance Fund), to enable multilateral and bilateral donors to support HAPCO Secretariat capacity building. The capacity building component of the pooled fund is managed by UNFPA.
- Advocacy and support for development of a Joint Programme supported by NORAD (but see Box 1).
- Advocacy for civil society representation on the CCM. Having a Management Committee structure was important since it allowed negotiation of a common UN position on support to civil society and advocacy with HAPCO for civil society engagement and inclusion in the successful proposal for funding under GF Round 7 (US$25 million).
- Assistance with the preparation of Ethiopia's proposal for the Rolling Continuation Channel (RCC) to the GF (approved $106 million) and support for grant negotiation for World Bank EMSAP 2.

3.14 Despite these achievements there is a strong sense that the present approach involves high transaction costs. Review of Management Committee attendance shows limited attendance by representatives of agencies such as FAO and no attendance by the World Bank. Attendance records also show a decrease in attendance by HoAs and substitution by policy or programme staff of a lower grade. Minutes suggest that the Management Committee has increasingly become a forum for policy discussion rather than decision making, thus co-opting the role of the Core Team.

3.15 Interviews with Joint Team members indicate a wide range of views on the value of the team and a lack of consensus about the benefits. Views expressed included:

- Membership is the price of gaining access to UBW funds at global level.
- Most UN agencies now engage with HAPCO whereas, before 2005, only the UNAIDS Secretariat, WHO and UNDP engaged with HAPCO.
- Provides access to a wider range of expertise, sharing information within the Core Group, and improved opportunities for dialogue across agencies and some cooperation.
- Membership allowed (the agency) to professionalise work on HIV and AIDS, build visibility with other UN agencies such as UNFPA, and gain access to PEPFAR funding.
- Allows us to understand what others are doing, but is not really delivering what we want, such as acting as a mechanism for the UN to collectively commission research on real drivers of the epidemic and then develop common advocacy positions based on evidence. When we tried developing advocacy positions without evidence, the advocacy positions were anodyne and reflected our mandates.
- Being seen as a willing member supporting the reform agenda is important. Being a member of the Joint Team has allowed us to attend meetings with HAPCO, but this hasn't actually affected what we have done in the area of HIV and AIDS. The Joint Team is frustrating, since it almost entirely focuses on process, with little focus on results.

- Useful for monitoring what smaller agencies are advocating and doing and for minimising chances of contradictory advice to the agency's partners.
- No benefit yet. The UN, with its large number of small projects, is part of the reason that implementation is slow in the HIV sector. These projects impose unacceptable transaction costs on government in contrast with the situation in other sectors such as education (SWAp) and transport and health more generally. A greater concern is that the IHP be made to work.

3.16 As regards the contribution of the Joint Team to the national response, a major issue is that the team does not participate in the six monthly review of the tripartite MOU between PEPFAR, GF and GOE in which key decisions are taken. In view of the relative scale of resources this undermines meaningful UN engagement at a strategic level.

3.17 Potential benefits from working as a team have been identified in the areas of UN staffing and staff capacity; joint initiation of activities; fund raising; and accountability. The actual findings in these areas are mixed.

3.18 There is no evidence that the Management Committee has taken a strategic approach to consider what staffing and capacity is required by the Joint Team and therefore implications for staff recruitment or training within individual agencies. Staffing decisions appear to be driven by agency needs and there is no discussion about how to compensate for any adverse implications for the Joint Team and responding to the DOL. Examples are UNDP, which has reduced staffing in line with its global strategic plan priorities; FAO which has not delivered against the 18 month work plan and where the member of the Core Team recently retired; and World Bank, where the Task Manager is Washington DC-based. WHO, UNESCO, UNHCR and ILO have increased staff dedicated to HIV work in response to commitments at country level. UNICEF has also shifted and increased capacity, but in response to what they think is needed to meet their mandate rather than within the context of the Joint Team. A similar situation exists in UNFPA and WFP.

3.19 Some examples have been found of joint initiation and funding of specific interventions. UNESCO, recognising that HIV prevention was not included in national educational policy, reached an agreement with the World Bank (regional funding and managed by the World Bank Regional HIV Adviser based in Nairobi) to fund an international consultant and for Italian Cooperation to fund national consultants to develop a national strategy. WHO cites instances of other agencies funding attendance of Ethiopians at international meetings when WHO has not had the funds. WHO was approached to work on mother-to-child transmission by GOE, but then invited UNICEF to work in cooperation with WHO to provide support to GOE. Norway's experience of trying to fund a joint programme is described in Box 2.

Box 2 Norway's experience of trying to support a joint programme

Norway has supported HIV programmes in Ethiopia through both UNICEF and UNFPA for some years. With the changing development policy in Oslo under which HIV and AIDS is now a cross-cutting issue, the Norwegian Embassy saw an opportunity to support both the UNDAF and One UN reforms and to tackle HIV through a joint programme with UNICEF and UNFPA for a rights-based approach to adolescent and youth development.

Norway wanted to avoid agency-specific orientation in the project document and achieve genuine joint working and equal ownership with a tripartite contractual arrangement and single source of funds. The tripartite approach was, however, found to be too complicated by NORAD HQ and both UN agencies. A second approach, to appoint one of the agencies as an Administrative Agent (AA), failed after signing, when the Comptroller of the AA said the agency could not transfer funds to another UN agency. Ultimately, separate agreements were signed with UNFPA and UNICEF in March 2008 thus reinforcing the *status quo ante*.

Source: Evaluation interviews

3.20 No evidence has been found of a joint approach to fund raising or that membership of the Joint Team has led to increased access to funds for Cosponsors. The UNAIDS Secretariat country office Senior Programme Advisor developed a proposal for a pooled fund for the Joint Programme of Support at the request of the RC. The proposal was not implemented for three reasons. First, because GOE did not support it, because they feared that it would be used to fund civil society. Second, the proposal was not supported by HoAs, mainly because, according to the RC, they couldn't agree on an allocation mechanism between agencies. Third, potential donors thought that the fund would replicate the HAPCO pooled fund that had been established, and to which the World Bank, one of the Cosponsors, was already contributing under EMSAP.

3.21 Some progress has been made toward increasing individual accountability. Joint Team members receive official and formal notification on their roles and responsibilities from their HoA. This was agreed at the November 2007 Management Committee meeting. But since individuals' performance has not yet been assessed in 2008, it is too early for there to be any evidence on what effects this will have.

3.22 It is not clear from the current allocation of roles within the Joint Team, to what extent it was influenced by the global DOL that arose from the recommendations of the Global Task Team.[5] The UNICEF Representative states that the DOL in Ethiopia was based on agency capacity, presence and potential added value. However, the process was not documented and it is unclear to what extent it was initiated in response to the global DOL. Some other Cosponsors take the view that presence in the Joint Programme of Support reflected the need for agencies to be visible in the UNDAF and the existing work programmes of agencies.

3.23 A self assessment by the Joint Team (November 2007)[6] found that: The application of the UNAIDS DOL based on a country level SWOT was extensively discussed by Management Committee in 2005 before establishing the Joint Team. But most Joint Team members and partners are not familiar with the DOL and how it is applied in Ethiopia. There has been some confusion between the DOL application and the ISTFs which are functional areas for UNDAF implementation. Other technical areas (and lead agencies) need to be identified and mandated to support the National Response. The Core Group has made recommendations to the Management Committee on how to resolve the issue but, in the main, the Management Committee has not approved implementation of the recommendations. The only action was producing a brochure (March 2008) that describes roles and responsibilities.

The administration of the joint programme

3.24 Administration of the UNAIDS Secretariat at country level is based on an arrangement with UNDP updated most recently in 2008. That new agreement does not significantly increase administrative efficiency in the Ethiopia office. The main impact is to formalise the relationship between the two agencies and guard against instances in which UNDP may seek to move beyond providing administration into management of UNAIDS. This has not been reported as a problem in Ethiopia. The annexes to the new agreement (not yet issued) may bring improvements, but it is not clear what will be included within these. For instance, a move to a situation where UNAIDS Secretariat staff can directly raise vouchers within ATLAS (the enterprise resource programme used by UNDP to administer finances), rather than just having read-only privileges, would speed up administration. This is apparently already the case in similar circumstances with UNODC. Secretariat staff would also like access to UNDP e-learning facilities.

[5] Global Task Team on Improving AIDS Coordination by Multilateral Institutions and International Donors, Final Report June 2005

[6] UN Joint Team (November 2007). Results of Internal Assessment of Performance of the Joint Team. Internal Document, 28th November 2007.

3.25 An interview with the staff association representative based in Ethiopia suggests that there are no significant personnel issues arising in the UNAIDS Secretariat country office, but there are concerns about the current multiplicity of contractual arrangements. Problems arise because the various contracts confer different status even though many staff are doing the same or very similar work. There are no firm guidelines from UNAIDS Geneva about office staffing. The number of international staff on fixed term WHO contracts is determined in Geneva. Otherwise, most other positions are dependent on the UCC being able to mobilise funds, mainly through projects. The challenge is that the Addis Ababa office has grown from 5 to 23 and now has a number of staff who have been on Special Service Agreements (SSA) for several years. These contracts are handled under procurement rather than personnel and do not accrue any benefits such as leave, sickness or pension.

3.26 The only source of dedicated funding within the joint programme is the Programme Acceleration Fund (PAF). Secretariat and Cosponsor staff report that the PAF mechanism does not work well. The size of PAF funding is too small to be of much interest to Cosponsors. Administrative issues, such as having to get approval for allocations from both the Regional Support Team (RST) and UNAIDS Geneva, and slow disbursement (funds allocated in the 1st quarter may not be available until the 3rd or 4th quarters) undermine its use. Comments from Cosponsors included:

- Not interested in PAF funding, since it doesn't cover salaries.
- Have not applied, since too complex and slow.
- Received around US$500,000, over several proposals. Was difficult and slow, also (the agency) has problems receiving funds channelled through UNDP.
- Used PAF funds in 2006 to hire consultant (US$20,000) to draft (agency) programme on HIV/AIDS.
- (Agency) has a rule making it difficult to receive sums below US$100,000 and so therefore hasn't spent US$67,000 allocated in 2007
- Applied in 2007 for first time. Was allocated US$216,000, but have not yet received the funds. Finds the system slow, bureaucratic and not transparent. Also, funds are wasted on small projects, when would be better used for something strategic.
- Have not applied. System is too bureaucratic for relatively small amounts of money.
- Do not use.

How UNAIDS is fulfilling its mandate

3.27 This section examines the substantive areas where UNAIDS is mandated to provide leadership and support for the national response. Achievements are examined for work with civil society, dealing with gender, provision of technical support, human rights and the greater and meaningful involvement of people living with HIV.

Involving and working with civil society[7]

3.28 UNAIDS Secretariat country office staff report no specific written guidance from Geneva on engaging with civil society. While there is no separate plan for the Partnerships and Social Mobilisation Team in Ethiopia relating to working with civil society, the country office work plan 2008-2009 includes a key result and related activities for civil society. It appears that there has been more active engagement with civil society since UNAIDS established the Partnership Adviser post and team (the team has four staff in total, in addition to the Adviser three staff are

[7] Civil society and civil society organisations (CSOs) refers to the range of organisations outside government involved in the HIV and AIDS response including non-government organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs), the private sector and the media.

reported to be working respectively on gender and human rights; private sector partnerships, civil society and prisoners; and with NEP+). There is no Joint Programme or Team plan for working with civil society that involves all Cosponsors. Working with civil society is not included in the UNDAF. There is no budget or allocation of resources for working with civil society or, more specifically, to support implementation of activities in the UNAIDS Secretariat country office work plan although some resources have been secured through the PAF.

3.29 There has been no formal progress reporting against the UNAIDS Secretariat country office work plan. The main focus of civil society-related activities is reported to be: advocacy for its involvement (including PLHIV) in the national response; resource mobilisation for civil society, for example, from the GF; capacity building for civil society networks, focusing on those receiving GF Round 7 funding, in particular NEP+ and EIFDDA, on management, leadership, M&E, strengthening regional associations and members; and support to strengthen the National Partnership Forum (NPF).

3.30 A comprehensive overview of funding allocated for civil society organisations (CSOs) by government and donors is not available; this information is not tracked by UNAIDS. Examples provided, however, indicate that donors and government are allocating funds to civil society networks, umbrella groups and organisations to strengthen institutional capacity and to implement programmes and services.

3.31 Civil society umbrella organisations are represented on national policy-making bodies. Funding for NEP+ and EIFDDA through GF Round 7 is attributed to civil society representation on the CCM. Dialogue between civil society networks, in particular CRDA, and HAPCO has resulted in plans to develop a government-civil society framework for engagement and is believed to have contributed to increased allocation of funding for CSOs by Federal and Regional HAPCOs. However, key informants interviewed, including civil society networks, were unable to provide examples of specific policy or programming outcomes resulting from civil society representation and participation and noted that civil society influence remains limited.

Gender dimensions of the epidemic

3.32 Interviews revealed a widely held view among donors and UNAIDS that there has been improvement in GOE policy frameworks and approach to gender, for example, development of a National Action Plan for Gender Equality, the relatively recent establishment of the Ministry of Women's Affairs, and political support for women's issues. However, gender is considered to be still insufficiently reflected in national HIV/AIDS policies and plans and implementation of policy remains a challenge; this is an area where UNAIDS could provide more support. Indicators disaggregated by sex are included in M&E frameworks. Equality indicators are, however, less prominent. Gender focuses on women with little analysis, for example, of the role or vulnerability of men.

3.33 Efforts have been made to ensure that the UNDAF, which includes HIV and AIDS as one of five priority areas, includes gender-specific indicators. However, the evaluation team was unable to find any evidence of a strategic UNAIDS approach by the Joint Team to address gender and HIV in analysis or support for national policy development. No country-specific specific overall UNAIDS policy guidance on gender and HIV is available.

3.34 Efforts have been made to assess gender capacity (human and financial resources) across the UN and to strengthen staff knowledge and understanding. It is less clear that attention has been paid to developing internal knowledge and understanding specifically on gender and HIV. Limited human resources dedicated to gender within UNAIDS is a constraint.

3.35 There are no Secretariat or Cosponsor polices and programmes on gender norms and sexual minorities. This reflects the lack of policies and guidance at global level. It also reflects the perception that addressing these issues is sensitive in Ethiopia. Lack of data also limits engagement in policy dialogue. UNAIDS Secretariat and Cosponsors are only just beginning to address this (see section on Human Rights below). As yet there is no UNAIDS support to GOE to address the needs of sexual minorities.

Technical support to national AIDS responses

3.36 It is not possible to assess the need for technical support or the volume and nature of technical support requested in Ethiopia. There are no specific technical support plans or technical support requirements identified within the overall HAPCO work plan. HAPCO is currently undergoing a Business Process Reengineering (BPR), which donors anticipate will identify technical support needs. UNAIDS has attempted to use the SPM and the HAPCO work plan to plan technical support but HAPCO makes requests in an ad hoc manner; UNAIDS does not track requests made to all Cosponsors and the Secretariat.

3.37 The Joint Team Programme of Support reflects the HIV/AIDS priority areas and results matrix in the UNDAF. There is no consolidated Joint Team technical support plan, in part due to the lack of a HAPCO plan and in part as it is considered that this would duplicate the work plans of the Implementation Support Task Forces (ISTFs). There has been no consolidated reporting against the ISTF work plans, which makes it difficult to comment on the overall nature and volume of technical support planned or provided by UNAIDS. Financing of technical support is a challenge, with agencies seeking resources from their HQ or through the PAF, or using the TSF, which has its own resources.

3.38 Technical support is judged to be less well coordinated than it might be. There appears to be some duplication of effort, for example, in technical support to HAPCO for M&E. The need for the ISTFs is debatable, since these do not appear to be functioning effectively as entry points and 'coordinators' of technical support. In addition, there is no systematic approach to monitoring or evaluation of the quality or outcomes of technical support provided across UNAIDS, with the exception of support provided through the TSF (UNAIDS Secretariat has a system to seek feedback and evaluate technical support sourced from the TSF) and no internal or independent evaluations were made available to the team.

3.39 Recipients of technical support report satisfaction with the support provided by the UN, for example by the UNAIDS Secretariat to HAPCO and to CSOs such as NEP+ and EIFDDA, and by UNFPA and UNICEF to the Ministry of Youth, and UNESCO to the Ministry of Education.

3.40 Both HAPCO and the Ministry of Youth indicated that technical support provided is somewhat piecemeal and that they would appreciate a more strategic approach. HAPCO must share some of the responsibility for this, as noted above. Areas where HAPCO indicated that the UN could provide more strategic support included: coordinated advocacy and clear technical guidance for a multisectoral response, for a coherent, appropriate and more targeted approach to prevention and behaviour change to counter the current emphasis of the MOH on large-scale, untargeted approaches such as community conversations and HIV counselling and testing (HCT), and to address gaps in information about the epidemic.

3.41 As regards strengthening the Three Ones, technical support has made a clear contribution. HAPCO, Ethiopia's one coordinating body, reports that UNAIDS technical support has strengthened its capacity. However, UNAIDS has been unable to address HAPCO limitations that are related to its institutional location under the MOH.

3.42 Ethiopia has one strategic plan. The extent to which UNAIDS was able to influence the current SPM is debatable. The GOE was criticised by donors and civil society for lack of consultation during the development of the plan. However, UNAIDS played an important role in the development of the Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support 2007-2011, which includes specific targets and costings. UNAIDS' involvement in the evaluation of the current SPM will be important in influencing the subsequent plan. It remains to be seen how much UNAIDS will be able to help ensure that the next plan is truly multisectoral and responsive to the specifics of the HIV epidemic in Ethiopia unless it works in collaboration with donors and civil society partners to advocate for this.

3.43 Ethiopia has an M&E framework, developed in 2003. However, there is some way to go before there is 'one M&E framework'. Major partners such as the GF and PEPFAR are using separate frameworks and indicators, the 2003 framework is really just a set of indicators, and the M&E system does not adequately capture the contribution of civil society or of non-health sectors. The UNAIDS Secretariat M&E Adviser to HAPCO is working to address these challenges including through the M&E Technical Working Group. HAPCO is keen to revise the framework and TOR have been developed, but further progress has not been possible as HAPCO has been engaged in the BPR.[8] The UNAIDS Secretariat country office has made a strong contribution to developing approaches for structured and joint reviews and has been instrumental in bringing civil society organisations into the M&E system. The internal capacity of Cosponsors is uneven and technical support and capacity building have not, in general, been well coordinated. There is some evidence of recent studies contributing to debate about sector policy, noted under Section 4.

Human rights

3.44 Human rights are highlighted in the current UNDAF, in relation to HIV and AIDS and good governance. However, it is difficult to identify a specific rights-based orientation in UNAIDS policy and programmes in Ethiopia or a coherent strategy for addressing HIV and human rights across the joint programme. Within the joint programme, UNDP leads on human rights and HIV, but lacks staff capacity.

3.45 Human rights are a sensitive issue in Ethiopia and data are lacking on outcomes for vulnerable groups and on stigma and discrimination. The focus of the GOE is on universal access and a population-wide rather than a targeted approach.[9] Allocation of funds for programmes and services for vulnerable and marginalised groups is limited to the specific groups highlighted in the PASDEP and SPM (in and out of school youth, sex workers, truckers, migrant labourers and uniformed services). Donor funding tends to prioritise programmes and services for the same groups.

3.46 UNAIDS as a Joint Programme has not been proactive in providing leadership on HIV and human rights or, more specifically, in supporting the rights of vulnerable or marginalised groups and ensuring that their needs and priorities are addressed in national plans and strategies. UNAIDS Secretariat has, however, recently provided support to improve the evidence base concerning MSM, for example, funding the completion of a study on HIV and MSM by an Addis Ababa University researcher, and has planned the first workshop on HIV and human rights to be held in Ethiopia.

[8] Since the evaluation team visit, HAPCO has committed to a participatory assessment of the national HIV/AIDS M&E framework and the development of a new M&E plan and has agreed to provide funding for this to complement funding and technical support provided by the UNAIDS Secretariat and WHO. The process is expected to commence in December and to be completed by February 2009.

[9] The SPM 2004-2008 for intensifying a multisectoral HIV response puts targeted response as one of the thematic areas. HAPCO considers that the HIV response among MARPs is being scaled up.

3.47 Responsibility for addressing the needs of different most at risk populations is spread across several Cosponsors e.g. sex workers (UNFPA), IDU and prisoners (UNODC), MSM (UNDP/UNAIDS Secretariat). UNODC does not have a presence in Ethiopia. There does not appear to have been any Joint Team discussion of how the UN can work together on human rights and HIV issues or how issues relating to prisoners and IDU should be addressed.

3.48 Government policy commitment to legal and human rights for PLHIV in Ethiopia has not yet been translated into action. MSM behaviour is criminalised and there is no evidence of UNAIDS action to address the legal context.

3.49 Networks and organisations of vulnerable and marginalised populations are not involved in policy-making, programme implementation and M&E, and there is no evidence of a UNAIDS strategy to build the capacity of these groups.

Greater and meaningful involvement of people living with HIV

3.50 UNAIDS provided support for NEP+ to access funding from GF Round 7 and the Secretariat country office work plan includes provision for technical and capacity building support to NEP+. The Secretariat has seconded a staff person to NEP+ since April 2008 to support capacity assessments of member networks and capacity building activities. Examples of the latter include supporting the development of work plans and implementation plans for member networks and facilitating training from the TSF on GF-related programme and financial management and M&E. The small-scale project fund has been used to support PLHIV associations. The National Network of Positive Women Ethiopians reported to the team that they had no relationship with UNAIDS; UNAIDS Secretariat reports that support has been provided for resource mobilisation, development of an advocacy strategy and a workshop for women living with HIV.

3.51 UNAIDS is using the PAF to support development of regional networks of PLHIV, communications training and support to the Gambella Association of PLHIV for improved governance, income generating activities and home-based care, and review of NEP+ organisational structure and human resources issues. The PAF fund is managed by UNFPA. UNAIDS efforts to ensure that governance and representation of PLHIV networks and associations are transparent and democratic could be strengthened.

3.52 UNICEF and WFP will work with NEP+ on procurement, home-based care and nutritional support, but there is little evidence that Cosponsors view PLHIV engagement as an issue they should address across their work. Awareness within the Secretariat of the importance of PLHIV involvement is high but this is less apparent within Cosponsors.

3.53 NEP+ is represented on national policy making bodies including the CCM and NPF, and national and regional NEP+ are involved in HAPCO and Regional HAPCO project review processes. PLHIV associations receive funding for programmes and service delivery from Regional HAPCOs and are involved in M&E through the HAPCO quarterly review process.

3.54 The perception of PLHIV organisations is, however, that PLHIV involvement is largely tokenistic and that their influence on policy and programming is limited. The main reported outcome of PLHIV involvement is HAPCO support for GF funding for NEP+ and Regional HAPCO funding for regional and local PLHIV networks and associations.

4 Discussion points

4.1 Towards the end of the country visit the evaluation team held a workshop with participants from UN agencies and civil society.[10] The presentation used by the team is at Annex 4 together with notes from the concluding exercise which looked at challenges facing UNAIDS globally over the next five years. In the presentation the evaluation team highlighted many of the areas of success they had seen:

- Technical support provided is appreciated by recipients.
- Advocacy with HAPCO and GOE regarding CSO representation.
- Advocacy with the CCM and technical support for GF Round 7 proposal development (including funding for EIFDDA and NEP+).
- Reconciling the HIV prevalence rate.
- Better coordination of UN system and dealings with HAPCO.
- Costing the universal access plan.
- Good cosponsor inputs to HAPCO Technical Working Groups.
- Catalysing innovative projects.

4.2 As explained in the introduction, this country study is one of twelve which will be synthesised into the overall evaluation of UNAIDS. It is not a comprehensive evaluation of the programme in Ethiopia. Instead, it examines the effectiveness and efficiency of UNAIDS, so the main focus of interest is in the value added by the joint programme. As regards how the programme works, the team noted several positive achievements:

- Mechanisms and structures are in place for the Joint Team, following guidelines.
- The Joint Team is operational but with appreciation of problems by the member agencies.
- Resources are available for joint programming.
- Participation in the Joint Team is recognised in most agencies as part of individual accountability.
- There is some evidence for DOL but lack of clarity about how it functions.

4.3 Overall, some clear points emerge from the interviews and review of documentation. In summary these are:

- There is a lack of guidance from UNAIDS Geneva on a number of issues, for example, prevention, sex work, gender, sexual minorities, that holds back development of common positions and programmes among the Cosponsors.
- Despite a well staffed office, UNAIDS Secretariat in Ethiopia lacks resources to implement activities in its work plan and is reliant on the PAF and funds from Geneva.
- The UNAIDS approach to a range of issues is not strategic; there is a continuing emphasis on *ad hoc*, small-scale one-off projects.
- There is an urgent need to identify gaps in the national response and address these across the UN through a strengthened technical leadership role, including support for research and synthesis of available information in order to strengthen the evidence base.
- The Joint Team is too internally focused; there is a need to share information on what UN agencies are doing more widely with government, civil society and the donor community and to play a stronger role in sharing evidence.
- UNAIDS does not speak with one voice. Cosponsors feel they have to attend meetings rather than work through one agency putting forward a common UNAIDS position.

[10] Representatives from HAPCO and GOE were invited but were unable to attend

4.4 With regards to the national response, three key issues emerge with implications for UNAIDS. The first is that the current policy of the MOH, which is the most influential player in the national response, is to promote universal access through expansion of facilities and services, leading with HCT. Secondly, there is a related emphasis on treatment, care and support without adequate attention to prevention, resulting in limited emphasis on a multisectoral response. Thirdly, despite the fact that NGOs and civil society play an important role and are starting to engage in policy development, civil society influence remains limited; new proposals by government to restrict the activities of CSOs that receive funding from external donors could potentially undermine their involvement in the national response. These factors have important implications for the UN.

4.5 Although data are incomplete, the best available analysis of epidemiological data suggests that the epidemic is less generalised and more complex than had been thought. The national response, which has elements more associated with hyper-endemic countries in southern Africa, needs to be configured to respond to the particular circumstances of Ethiopia. The recent World Bank Epidemiological Synthesis presents the policy implications in clear language:

> *'The study uncovered a number of major findings which have implications for policy and practice in the country, including: the epidemic may be less severe, less generalized and more heterogeneous than previously believed, with marked regional variations; the diversity of the HIV epidemic seems to be related to sexual behaviour patterns; small towns may be HIV hot-spots that have had marginal attention in HIV prevention efforts to date; traditional high-risk groups such as sex workers seem to be reducing some of their risky behaviours. Young populations, especially never-married sexually active females have the greatest risk of HIV infection in the country; discordant couples are also a concern, pointing to a clear need for couple counselling services which are presently non-existent or rudimentary. The lack of recent data and research, especially on high risk groups, makes further conclusions difficult, and highlights the clear need for more research.'*

4.6 This points the way towards a UN strategy of support to the GOE that places a high priority on research to improve the evidence base, and emphasises prevention in the national response, including the important role of civil society. The need for the UN to demonstrate leadership, advocacy, technical support and evidence about the epidemic is obvious. The issue for UNAIDS is how well the Joint Team can rise to this challenge.

4.7 A key question for the evaluation of UNAIDS is the counterfactual: what would have been achieved without the joint programme at country level. Whilst there are many clear examples of the achievements of the UNAIDS Secretariat and Cosponsors in Ethiopia, there is little to demonstrate the added value to these parties, or external stakeholders, of working together.

4.8 Considerable effort has gone into developing the organisational structure and processes for the Joint Team and good progress has been made in implementing the relevant UN guidelines. But much less consideration has been given to identifying the benefits of a joint approach, in particular in support of a more effective national response, ensuring buy-in to the approach based on these benefits, and designing the Joint Team structure and processes to deliver such benefits. Thus function is following form, rather than vice versa.

4.9 Key elements of team working, such as a coherent approach to staffing and staff capacity, performance measures for the team as a whole and accountability at agency level for ensuring that they deliver on commitments to the team, are absent. Interviews with members of the Joint Team and review of minutes indicate that meetings tend to focus on process rather than results. Most importantly, there are no financial incentives for collaborative team working. While there is some evidence of team work between members at Core Team level, the lack of effective team

work at Management Committee level suggests that agencies do not see significant benefits to working as a team.

4.10 The policy challenges facing GOE present an opportunity for UNAIDS Ethiopia to develop robust evidence and analysis of the drivers of the epidemic and a coherent strategy for advocacy concerning effective prevention approaches. This would both strengthen the case for GOE adopting a multisectoral approach and provide a strong rationale for the UN agencies to support development of an effective Joint Team.

4.11 Experience to date suggests that the UNCT should also reflect on what form of organisation of the Joint Team would enhance its effectiveness, given capacity constraints. The UNCT should also consider how to create mechanisms to manage the members as a team and the development of team capacity, as well as reconsidering the need for one fund for the Joint Programme of Support. Implementing such suggestions will present considerable challenges, since agencies' internal systems and procedures are not supportive of such approaches.

Annex 1: List of people consulted

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UNAIDS Programme Acceleration Funds Proposal 2008-2009

UNAIDS Secretariat Ethiopia Work Plan 2008-2009

UNCT (2008) UNDAF Review and Planning Regional Workshops May 27 – July 2, 2008

UNDP (2006) Evaluation of UNDP's Role and Contributions in the HIV/AIDS Response in Southern Africa and Ethiopia

UNDP (2006) Country Evaluation: Assessment Of Development Results Ethiopia
UNHCR (2008) HIV and AIDS in Refugee Settings in Ethiopia PEPFAR Project Assessment and Programming Mission – July 2008
Vaillancourt, D, Chakraborty, S. and Taha, T. (2005) Evaluation of the World Bank's Assistance in Responding to the AIDS Epidemic: Ethiopia Case Study. World Bank Operations Evaluation Department
WHO (2006) WHO's Contribution to Universal Access to HIV/AIDS Prevention, Care and Treatment. HIV/AIDS Department WHO Geneva
World Bank (2005) Evaluation of the World Bank's Assistance in Responding to the AIDS Epidemic: Ethiopia Case Study
World Bank (2008) HIV/AIDS in Ethiopia - An Epidemiological Synthesis. HAPCO & GAMET
World Food Programme 2003-2006 Ethiopia Country Programme Mid-Term Evaluation
World Health Organization Regional Office For Africa Monitoring Health Sector Progress towards Universal Access for HIV Prevention, Care, and Treatment Reporting Form For 2007

Annex 3: Progress towards five-year evaluation recommendations

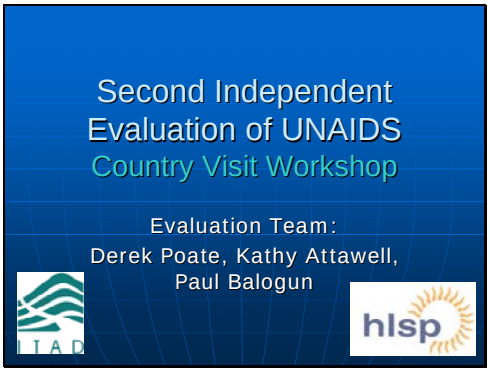
Rec. No.	Abbreviated description of topic	Notes on actions taken	Progress[11]
3	Support to the GFATM	Advocacy with the CCM and technical support for GFATM R7 proposal development (including funding for EIFDDA and NEP+).	H
10	UNAIDS …maintains global advocacy, with particular emphasis on political and resource commitments. Opportunities need to be taken to advocate for a gendered response and to promote the successful techniques of partnerships and horizontal learning	Global advocacy has contributed to increased financial resources from which Ethiopia benefits; securing domestic political commitment to HIV/AIDS funding is a challenge given significant external funding. Limited evidence of efforts to advocate for gendered response. Participation by civil society in HAPCO, CCM and NPF	M
11	Secretariat expands current work on information into a substantial functional area to support the roles of coordination, advocacy and capacity building.	No directly relevant evidence.	L
12	Develop a strategy and workplan to promote evaluations and research into impact at national and regional levels, with the aim of generating data to inform national responses. Priority should be given to studies of behavioural change and contextual factors, including gender, stigma and poverty.	Limited evidence of efforts, with exception of UNFPA drivers of the epidemic study and World Bank synthesis study, to generate data to inform national response or to evaluate impact.	L
13	Develop CRIS with objectively measurable indicators of an expanded response at country level	No progress with implementation of CRIS in Ethiopia; UNAIDS proposing to introduce CRIS 3.	L
14	UBW to bring together all planned expenditure on HIV/AIDS by the Cosponsors at global and regional levels should be continued and expanded to reflect all country level expenditure as well	Most country level expenditure is outside the UBW and is not yet planned or reported in a consolidated way for the joint programme.	L
16	Humanitarian response	WFP is working on HIV and humanitarian issues	M
17	Cosponsors should promote high standards of transparency and reporting by publishing and making publicly available all Cosponsor country and regional budgets and the annual outturn	Limited evidence seen through the development of CPAPs under the UNDAF. Unclear about transparency of outturn to the wider public.	M
18	In those countries where a medium-term expenditure framework and public expenditure review process is	Proposal to undertake a National AIDS Spending Assessment not yet implemented.	L

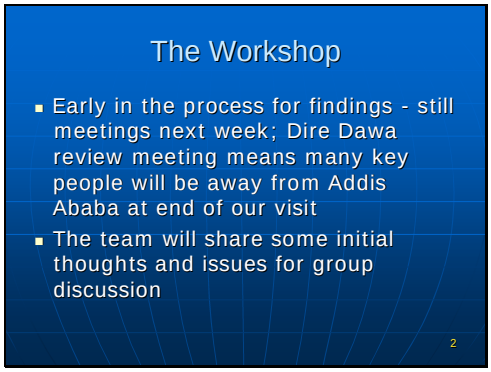
[11] H-High; M-Medium; L-Low. Assessment by the evaluation team

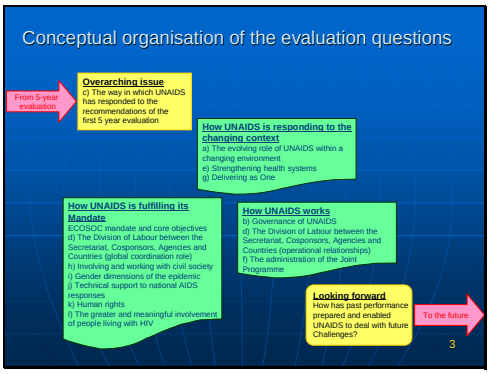
Rec. No.	Abbreviated description of topic	Notes on actions taken	Progress[11]
	underway, that HIV/AIDS be treated as a specific crosscutting topic for monitoring and reporting		
19	OECD donors should link their own bilateral country programmes to national HIV/AIDS strategies and make financial contributions to HIV/AIDS work by the Cosponsors conditional on demonstrated integration and joint programming, reflecting the comparative advantage of the Cosponsors at country level	OECD donors are aligned behind the national strategy in compliance with Three Ones and Paris Declaration commitments.	H
20	Continue with and expand the PAF facility, especially to support monitoring and evaluation, if current initiatives by the Secretariat can be shown to improve the allocation process, utilisation and speed of processing.	PAF in use but no evidence of improvements in the allocation process, utilisation and speed of processing.	L
21	Numbers and disposition of CPA (*now UCC*)	*Not applicable – evidence to be developed at global level*	
22	Theme groups should have clear objectives with monitorable indicators of both substantive change and process contributions to the national strategy	Development of the Joint Team and Management Committee; UNDAF.	H
23	Expanded theme groups should evolve into partnership forums, led by government	Change of structure with NPF linked to HAPCO and UNTG now Joint Team Management Committee.	H
24	Expand and strengthen national systems to monitor and evaluate interventions, and analyse surveillance data	Extensive technical support given to HAPCO (also by PEPFAR); support to reconcile prevalence estimates; analytical work by World Bank to synthesise epidemiological data.	H
25	Programme of joint reviews led by national governments should be launched	Quarterly Joint Programme Reviews of HAPCO now institutionalised.	H
26	UN system at country level must take a strategic view of implementation of national policies and strategies and exploit opportunities for synergy between the sectors	No evidence seen.	L
27	UNAIDS to act as a broker of good practice for local-level efforts that are designed for horizontal learning and replication	Some evidence of innovative projects; but little of analysis or dissemination of good practice.	L
28	Increase support for scaling up by developing strategies as a service both to national governments and to partner donors	No evidence seen.	L

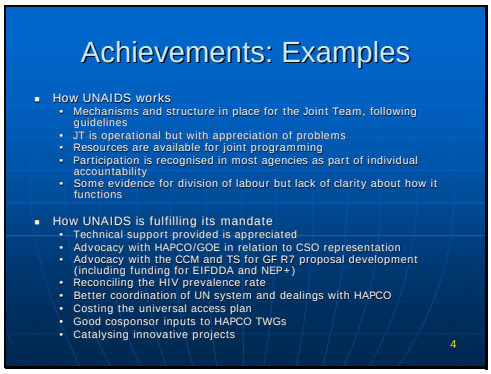
Annex 4: Material from the Feedback Workshop

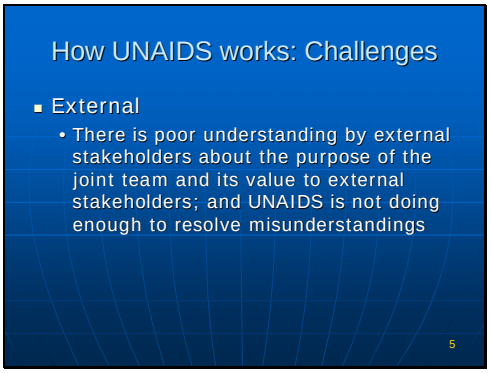
Power point slides presented by the team

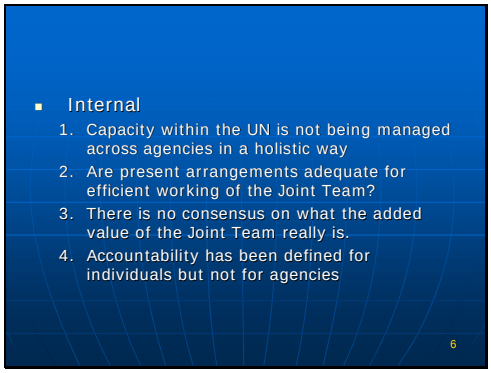












Feedback Workshop 'Future Challenges' Exercise

What will be the main challenge facing UNAIDS in the next 5 years?	How will UNAIDS need to respond?
Mobilising adequate technical and financial resources for the implementation of the joint programme.	UN agency HQs should focus on supporting country offices to mobilise resources.
Main challenge in the future is the competition from other key actors especially the bilaterals who have funds and technical resources.	Focus on technical expertise of the UN in key areas that others (bilaterals, government) may have difficulty in addressing; establish strong

What will be the main challenge facing UNAIDS in the next 5 years?	How will UNAIDS need to respond?
	partnership among all stakeholders and define roles and responsibilities of each stakeholder.
Marginalisation both because of other major (richer) players and because of reaction against 'AIDS exceptionalism'.	Respond by strengthening and unifying technical support and taking a more integrated approach to AIDS linking to other diseases and health promotion generally.
Long term financing of the AIDS response in a changing world.	Document strategic consequences of reduced AIDS funding for developing countries.
Institutionalising preventive measures and universal access.	More advocacy and financial resources and working with CSOs.
Remaining as important/relevant among existing and emerging HIV actors.	Capacity building; refreshing its values, principles and strengths accordingly.
To ensure that the global DOL is practically, flexibly and efficiently translated to effectively support the national AIDS response.	Better articulate and focus the role and responsibility of the Joint Team.
Relevance to the dynamic, complex national HIV response through UA 2010 and MDG 2015 will be UNAIDS' main external challenge; demonstrating added value of being a Joint Team (to ourselves and others) the main internal challenge.	UNAIDS needs to respond proactively; comprehensively; coherently; strategically and efficiently.
UN agencies want to keep identity at macro level versus country level joint programme requirements.	System of management.
Competing priorities other than HIV/AIDS.	Mainstream HIV in every sector and ensure sustainable resource mobilisation and mitigation approach.
Lack of information about how effectively organisations including civil society are working.	Strengthen information collection mechanism