

**AN EVALUATION OF
UNICEF'S POLICY
RESPONSE TO HIV/AIDS
IN THE NINETIES**

**The Use of Carrots, Sticks
and Sermons**

Prepared for the Evaluation Office
UNICEF New York

November 2001

Stein-Erik Kruse
Centre for Health
and Social Development (HeSo)
Norway

Kim Forss
Andante –
nation of policy implement □
Sweden

TABLE OF CONTENT

Abbreviations.....	i
Acknowledgements.....	i
Executive Summary.....	Error! Bookmark not defined.
1. INTRODUCTION.....	1
1.1. Background.....	1
1.2. Purpose and Key Questions.....	2
1.3. Methods and Limitations.....	3
2. POLICY INTENT.....	7
2.1. Status of the Policy Definition.....	7
2.2. Assessing Policy.....	11
2.3. The Policy Environment.....	16
2.4. Concluding Remarks.....	18
3. POLICY IMPLEMENTATION.....	19
3.1. Policy Instruments.....	19
3.2. Balancing Policy instruments.....	27
3.3. Organisational Response.....	28
3.4. Concluding Remarks.....	31
4. POLICY RESULTS.....	33
4.1. An Intensified and Expanded Approach.....	33
4.2. Achievements and Innovations.....	39
4.3. Replication and Scaling Up of Programmes.....	44
4.4. Strengthening New Partnerships.....	47
4.5. Improvements in Coordination and Communication.....	49
4.6. Capacity Building and Integration with National Plans.....	52
4.7. Evaluations and Evidence of Results.....	53
4.8. Concluding Remarks.....	57
Annex 1: Terms of Reference.....	59
Annex 2: References.....	63
Annex 3: People Met.....	65

Abbreviations

AIDS – Acquired Immune Deficiency Syndrome
AusAID – Australian Agency for International Development
CCA – Common Country Assessment
CDF – Common Development Framework
CIDA – Canadian International Development Agency
CO – Country Office
CP – Country Programme
CPA – Country Programme Adviser
CPMP – Country Programme Master Plan of Operations
EAPRO – East Asia Pacific Regional Office
EB – Executive Board
ESARO – Eastern and Southern Africa Regional Office
FHI – Family Health International
FinnIDA – Finnish International Development Agency
GAO – Government Audit Office (USA)
GPA – Global Programme of AIDS
GR – General Resources
HIV – Human Immune Deficiency Virus
IEC – Information, Education and Communication
M&E – Monitoring and Evaluation
MCH – Mother and Child Health
MTCT – Mother to Child Transmission
MTR – Mid Term Review
NAC – National AIDS Commission
NACP – National AIDS Control Programme
NGO – Non-governmental Organisation
PSI – Population Services International
RO – Regional Office
ROSA – Regional Office South Asia
SCF – Safe the Children Foundation
SPC – Strategic Programming Country
STD – Sexually Transmitted Diseases
SWAP – Sector Wide Approaches
TSG – Technical Support Groups
UBW – Unified Budget and Work-plan
UNAIDS – Joint United Nations Program on HIV/AIDS
UNDAF – United Nations Development Assistance Framework
UNDP – United Nations Development Programme
UNDCP – United Nations Drug Control Programme
UNESCO – United Nations Educational Scientific and Cultural Organisation
UNFPA – United Nations Population Fund
VCCT – Voluntary Confidential Counselling and Testing
WHA – World Health Assembly
WHO – World Health Organisation

Acknowledgements

The Evaluation Office (EPP) in UNICEF New York initiated this study of UNICEF's policy response to HIV/AIDS in the nineties. It would never have taken place without the persistent efforts and active involvement of Dr. Joseph Foubi. We would like to thank him for his generous technical and morale support. Without Dr. Annette Reinisch we would not have been able to identify and retrieve the broad range of documents from UNICEF HQ and four country programmes. She also prepared a useful database of all relevant publications and a desk study on the evolution of UNICEF's response to HIV/AIDS in young people in the nineties.

We would also like to thank the many people in Myanmar, Thailand, Uganda and Zimbabwe who gave of their time, experience and insights during the research for this report. Annex 3 provides a list of most of the people met with during the process.

We are grateful for being given an interesting and challenging task and hope that the report will be found useful.

Those who wonder why we refer to "The Use of Carrots, Sticks and Sermons", may start reading Chapter 3.1. However, it is easier to follow our arguments if you start with Executive Summary and Chapter 1.

Stein-Erik Kruse
Centre for Health and Social Development
Oslo – Norway
(sekruse@online.no)

Kim Forss
Andante – Tools for Thinking,
Strängnäs – Sweden
(kim.forss@mailbox.swipnet.se)

Introduction

Has UNICEF responded appropriately and effectively to the worsening AIDS epidemic?

This evaluation report goes a long way towards answering this important question. In 1992 the Executive Board recommended that UNICEF intensify and expand its support to HIV/AIDS prevention activities (E/ICEF/1992/L.11) by:

- focusing on programmes to reduce HIV transmission among young people,
- providing information and communication to reach youth to promote informed and responsible sexual behaviour and
- promoting improved reproductive health of women and youth.

The Board's recommendations can be taken as the most significant and pregnant expression of UNICEF's policies regarding HIV/AIDS.

This evaluation is an assessment of experiences from the last decade. It summarises major lessons learned and provides a platform for improved programming. It is primarily a policy evaluation of UNICEF's response to HIV/AIDS. It is *not* a programme or project evaluation – it does *not* assess the implementation and results of specific activities. The evaluation focuses on three questions:

(a) Policy intent:

- *What policies and goals have guided the UNICEF response?*
- *Are these "good" policies, that is, are they clear, comprehensive, focused, and flexible?*
- *Are they relevant in response to the size and severity of the epidemic?*
- *Are they co-ordinated with other policies in the organisation?*

(b) Policy implementation:

- *How were policies introduced, made operational and implemented in UNICEF at global, regional and country levels?*
- *What policy instruments were used? (Did UNICEF have a strategic and effective mix of instruments?)*
- *What were the main tools to ensure organisational learning – for dissemination of new knowledge and rapid replication of best practices?*

(c) Policy results: What is the evidence of results of an intensified and accelerated response?

- *in respect of programme resources,*
- *new and innovative approaches to the epidemic and*
- *new partnerships, integration with national programmes, etc.*

The evaluation was conducted between May and September 2001 and covers the period from 1992 to 2001. It builds on analysis of policy intent at the global level, followed by a review of how policy instruments have been applied at different organisational levels, from headquarters in New York, via Regional Offices, and to Country Offices. The evaluation methods consist of: (1) interviews with key

informants, (2) review and analysis of documentation, and (3), case studies of selected country programmes (Myanmar, Thailand, Uganda and Zimbabwe).

A/ Policy Intent

UNICEF's policy has evolved. There is not one policy intent, but several. It must be seen as emerging, and over the decade it was expressed in many documents. It is relevant to speak of a policy system, where the Board's recommendation of 1992 is followed by other communications from the Board, from the Executive Director, from Regional Directors, Programme Divisions, and other sources that have a major say in what the organisation does.

Policy intent has many dimensions, foremost of which are: how much to do (volume, quantity); priority areas; modes of operation and collaborating partners. The Executive Board was very clear in recommending that UNICEF intensify and expand its activities in HIV/AIDS prevention and control. However, later policy statements have not repeated this instruction, and *in practice* the organisation is uncertain about what this means and how the recommendation should be applied.

UNICEF's early policy focused on youth, and emphasised "communication" as a means of promoting responsible sexual behaviour. The policy was formulated from tried and tested approaches. It has continued to develop on the basis of experiences in a few countries that are at the forefront of developing HIV/AIDS projects. But towards the end of the decade, new project opportunities and modes of intervention were introduced: foremost of which are activities around mother to child transmission, care for aids orphans, and care for people living with AIDS.

The initial policy statements were clear in the overall approach, even though they did contain some internal contradictions. As the policy evolved during the 1990s, it incorporated new practices and became more comprehensive. The fact that new subjects were included indicates a flexible approach. But at the same time, the response became less focused.

There is actually no document that is entitled UNICEF's HIV/AIDS policy.

The main tenets of policy are well-known among UNICEF staff and it is also understood among co-operating partners - but few can refer directly to the key documents. There are also misconceptions about policy. Confusion is understandable, as policy is found under titles such as "programme approach", guidelines, or under specific subject titles.

The approach has been ambivalent in respect of monitoring and evaluation, the role of research, and the advocacy function. HIV/AIDS policies do not appear to be co-ordinated with other policies. Policy statements in the areas of health and education have few cross-references to HIV/AIDS work. Emerging areas of organisational practice, such as rights-based programming, have not been connected to the issue of HIV/AIDS.

Implications for Policy Intent

- What are the lessons brought out by the study?
- How can the expression of policy be improved?

First, UNICEF's approach to let field experience play a major role in policy formulation needs to be preserved. This is a guarantee that policies are relevant and can be implemented. It makes sure that the experience of people is used, and that the organisation learns.

Second, people inside as well outside the organisation would be well served by a document, which is actually entitled an HIV/AIDS policy. Such a document should be easily retrievable, and also explicitly updated when the policy changes.

Third, a policy document should be precise in its categories of analysis and action, and must not be contradictory. It is necessary to pay a great deal of attention to the dimensions of policy, and to subject it to a real test of how it is understood, what is included and what is excluded.

Fourth, the process of policy formulation should include a screening of other relevant UNICEF policies, and should make connections to these.

Fifth, a policy statement needs to be revised, and there should be a mechanism to visibly and explicitly and regularly update the policy statement.

In sum, the *lessons learned* here point to the need to make the "process" of policy formulation more transparent and better co-ordinated. Yet another lesson is that the rhetoric of policy must receive more attention, to make sure that policy statements are clear, precise and comprehensive.

B/ Policy Implementation

In the analysis of policy implementation, the evaluation works with three categories of policy instruments:

- **Regulations** – rules, directives, and the like, which force staff to act in accordance with what is ordered. Such measures are popularly called "**sticks**".
- **Resources** - instruments that involve "paying" - either the handing out or taking away of human and financial resources. These measures can be called "**carrots**".
- **Information** – or advocacy, motivation, exhortation, covers all attempts at influencing/convincing country programmes, governments and staff through the transfer of knowledge, the communication of reasoned arguments (negotiation) and persuasion. These measures are called "**sermons**".

When a new policy is designed, headquarters can in principle instruct (use directives), pay (use subsidies, provide resources) or persuade (use information) their country representatives, to make them comply with policy. The evaluation talks about these policy instruments in the broad categories of *sticks, carrots and sermons*.

It is difficult to trace the use of the "**stick**" as a policy instrument. The few orders and directives that can be documented concern administrative formalities. They do not apply to the core dimensions of HIV/AIDS policies; such as the volume of HIV/AIDS

project activities, priority areas, or mode of operation. However, we cannot exclude that there are subtle ways of instruction that cannot easily be refused. UNICEF has a strong organisational culture, which is what holds the decentralised operations together. In practice, it could be difficult to distinguish between a strong organisational culture that enforces policy, and orders that serve the same purpose. Towards the end of the decade, the evaluation found an increasing use of instructions and requests for feedback, in the communication between some Regional Offices and Country Offices.

There are examples of how “**carrots**” have been used to make the Country Offices respond to the HIV/AIDS policies, but these examples are few and far in between. It was not until 1997 that the Executive Board decided to set aside specific funds to accelerate programme priorities, and it was not until two years later that the first allocations were made of these. In the beginning of the decade, the technical support provided by the TSG was important, but lasted only between 1993 and 1995. It is only recently that headquarters has responded positively to Country Office’s call for funding of HIV/AIDS focal points. And recruitments to the regional offices are also recent. The most significant aspect of the “carrot” as a policy instrument lies in the organisational support to obtain supplementary funding. This may have been crucial to the intensified and expanded programme in some countries.

The evaluation found that **the most frequently used policy instrument was “sermons”**; Neither sticks nor carrots were used nearly as intensively as sermons. Still, it is worth remembering that all policy instruments were applied at all times, even if in different degrees. Policy implementation is a complex field and touches on all aspects of governance, management and leadership in the organisation. This is not a full-fledged study of management, and hence we only convey a partial and incomplete picture of policy implementation in respect of HIV/AIDS.

The evaluation counted more than 6.000 pages of publications and close to a hundred titles. Among these were some really significant, path breaking studies that are widely respected and quoted. Furthermore, the organisation uses other publications than those produced internally, hence the “sermons” can be based on UNAIDS, WHO, World Bank, or other publications. Conferences, workshops and internal seminars are common means to motivate staff members to take action in respect of HIV/AIDS (as well as on other issues).

It is also quite clear that *the use of policy instruments changed over time*. In total, the organisation was mostly subjected to policy instruments that “pushed” HIV/AIDS issues in two periods; the beginning and mid 1990s, and later in the final years of the decade. In between, there were distinctly fewer efforts to apply policy instruments. Even if the policies remained the same, there were fewer efforts to bring the intents to practice. The evaluation can thus provide an explanation of why UNICEF’s response to HIV/AIDS issues grew weaker in the period between 1996 and 1998. It was not because policies changed, but because the use of instruments to make the intentions happen were not applied to the same extent as before – and after.

Implications for the Use of Policy Instruments

What are then the lessons learned about the use of policy instruments?

We have not been able to document any particular processes that explicitly deal with the concept of policy instruments. Once the policies were formulated, different parts of the organisation coped with the policy intent as best as they could. Nobody framed the issue as a question of how to use a specific set of instruments to realise policy intents. We believe that a more explicit recognition of the selection and application of policy instruments could have reinforced policy intent. In order to increase the impact of policies, the following broad categories of study and organisational reform can be suggested:

First, much as it is easy to call for a coherent approach to policy instruments, practice is more difficult. It is generally believed that sticks and carrots are more effective policy instruments. But sticks and carrots are more centralised management tools, and the cost of centralisation may be high. Our study is one of the first policy evaluations in UNICEF. *There is a need to learn more about the comparative advantages of policy instruments.*

Second, it would be desirable to develop a coherent management approach to the choice of policy instruments, to make sure that sticks, carrots and sermons are used in a balanced way, to supplement each other, and reinforce the organisation's response to the policy intent. One suggestion would be to supplement policy statements with a note on implementation. Such a note could *suggest which instruments to be used in support of the policy*. It may even be possible to suggest budget allocations for specific policy instruments.

Third, sermons were the favoured policy instruments, and maybe there are reasons to believe they are the most appropriate instruments for UNICEF. *Is it possible to improve the efficiency of sermons as policy instruments*, given that they seem to be preferred, and better in harmony with decentralised modes of operation?

Fourth, there is a connection between policy issues and the level of change required. When there is a need to address large global issues and make fundamental changes in what the organisation does, *it is necessary to use the more effective policy instruments*, that is; directives and financial allocations (sticks and carrots).

In sum, it may seem as if *the lesson learned is that there is a lot more to learn*. The study shows that the organisational response to policy has been ad hoc. There has not been a systematic, comprehensive approach to realise policy. We have not been able to detect and document any application of managerial tools to explicitly realise policy intents. This is not to suggest that there are no such tools, but the daily, practical line management of the organisation does not always have a close and vibrant connection to the processes of policy formulation.

C/ Policy Results

- **Leadership Commitment**

Since 1992 UNICEF has aimed at expanding its approach to the epidemic. The *leadership commitment behind the process was uneven* during the nineties particularly in the latter half of the decade. While HIV/AIDS has become a priority for the organisation, it has not yet been matched with human and financial resources.

Globally, the TSG process contributed to raise awareness, commitment and knowledge about HIV/AIDS between 1993 and 1996 in a group of countries. With the turn over among key technical staff, internal reorganisation of the Health Section and change in top management of UNICEF, the *focus on HIV/AIDS especially on youth lost some of its momentum around 1996/1997*.

With the highly visible and dramatic impact of the epidemic in UNICEF programme countries and the increasing global political awareness and commitment, *HIV/AIDS has become a UNICEF programme priority*. The Executive Director speaks at major international meetings and events, advocating for increased attention and activities to combat HIV/AIDS. Regional Offices are taking a more active role and there are Country Programmes that have a stronger HIV/AIDS profile.

- **Human and Organisational Resources**

Few staff worked full time on HIV/AIDS during the nineties and it is recently (1999) that a separate HIV/AIDS Unit was established at global level. *UNICEF did not invest much in building technical and organisational capacity in the area of HIV/AIDS*.

- **Financial Expenditure**

The critical constraint is the lack of systematic data on expenditures. Strictly speaking, UNICEF is not in a position to assess to what extent the organisation has intensified and expanded its response to HIV/AIDS in terms of funding. Policies and priorities are not properly linked to the budgetary process. Without a baseline and data on intended and actual expenditure, UNICEF has a weak basis for setting and changing priorities. Policies tend to become sermons.

Estimated figures, however, indicate an increase in expenditure on HIV/AIDS, but not a rapid and dramatic increase (30% between 1996 and 2000). Expenditure on HIV/AIDS as compared to total UNICEF spending is relatively low. In 1999, UNICEF expenditure on education was \$ 120 million or 12.4% of global expenditure and 14.7% of programme expenditure. Comparison with expenditure on health would be even larger. The estimated average annual expenditure on HIV/AIDS between 1996 and 2000 was approximately US\$ 32 million.

Though UNICEF increased its global allocations to HIV/AIDS programmes during the nineties, *the increase remained relatively modest*. HIV/AIDS did not become a programme priority for the organisation in terms of funding from regular resources. Our case studies show an increase in expenditure in the four countries, but a decrease in Thailand and Zimbabwe at the end of the decade.

- **Geographical Expansion and Coverage**

The expansion of the response has been *geographically uneven and concentrated* in a few countries and regions – mainly in Eastern and Southern Africa and a few hard hit countries in Asia and Latin America. Tanzania, Uganda and Zimbabwe were the largest single recipients of funding.

- **Major Policy Achievements**

UNICEF introduced and supported at an early stage a broad societal, multi-sectoral and behavioural approach to the prevention of HIV/AIDS. *HIV/AIDS was taken out of the medical field and defined as a health and development issue.*

UNICEF prepared the ground for a stronger focus on HIV/AIDS in the context of adolescent health and youth. Since the epidemic hit young people stronger than small children, a new target group (with their own concerns and problems) were introduced to the organisation.

UNICEF's broad societal and inter-sectoral approach to HIV/AIDS prepared and supported the ideological platform which led to the formation of UNAIDS in 1997.

• Programme Achievements

There are examples of innovative programmes that were replicated and taken to scale such as:

- life-skills education in schools,
- Information, Education and Communication (IEC) initiatives and
- to a lesser extent youth friendly health services.

School Based Interventions - Life Skills Programmes absorbed the largest share of UNICEF's resources in the nineties. There are few in-depth evaluations of the performance of such programmes. They have made the environment for HIV/AIDS awareness and prevention programmes much more open, increasing the potential for positive behaviour development and change, but the actual change in attitudes and behaviour of young people is uncertain and unknown.

Out-of-school peer-to-peer education used young people to disseminate the message. Youth are educated in an effective context, one that includes teachers from their age range and culture. Peer education has a great potential and is presented as effective in Uganda and Zimbabwe, but peer education programmes have been even less rigorously evaluated than school-based programmes, so there is no solid basis for comparing results.

Information, Communication and Education programmes (IEC) was the second most important area of interventions. Several pilot projects were started and tested out in a broad range of countries - mainly in collaboration with NGOs and churches.

Youth Friendly Health Services was the third programme area. A key concern was to demonstrate the operational feasibility of going to scale with interventions that promoted and maintained sexual and reproductive health. We found examples of youth friendly health services approach in Uganda and Zimbabwe, but much less significant in volume and impact than life skills education and IEC programmes.

Each of the strategies are useful and relevant in their own right, but could have been stronger as part of a multi-strategy approach. A school-based programme is more likely to be effective if reinforced by other supporting strategies, such as policy, media, access to good services and supplies, etc. Single strategies are often too weak

to make inroads into the change of social norms, attitudes and behaviour. *In this area of multi-level strategies, there is scope for improvement in UNICEF.*

- **Replication and Scaling up of Programmes**

A key concern for UNICEF was to identify new programme ideas, test them out as pilot projects, summarise lessons learnt from country implementation, and scale up small projects to national coverage, and replicate successful projects in other countries.

There are several country examples where programmes were replicated and taken to scale. Myanmar, Zimbabwe and Uganda are countries where life-skills programmes were planned and implemented with national coverage. In Thailand, an early PMTCT initiative has been integrated in the national health system. Achievements in terms of coverage have also been impressive. Questions are more related to lack of information about outcomes and impact in classrooms and among children and youth.

There is a tension between innovation and scaling up. Innovations require a culture of research and experimentation, while scaling up calls for the capacity to implement. Within a scaling up strategy, UNICEF needs other types of expertise, another time perspective and more level of funding than when pursuing an innovative strategy. It is not obvious that the same organisation can do both - and do both well. In our view, UNICEF may have placed too much emphasis on scaling up a few key programmes - and less on searching for new ideas and approaches. It lost some of its innovative potential. UNICEF is not a research organisation, but not merely an implementer either. The concept of scaling up has often been too one-dimensional. Rather than scaling up one programme in one country, it would have been possible to scale up through different models, e.g. life skills education in schools in some districts, peer led programmes in others, etc. The point would be to *test out different alternatives and aim at national coverage through a range of models.*

- **Strengthening New Partnerships**

UNICEF broadened its range of partners during the nineties. In the early nineties it opened up a much more active collaboration with external partners and to included new and non-traditional partners.

- WHO was the main partner at a global level and interaction centred on UNICEF and WHO during the TSG process. Other UN partners were much less involved. In the latter half of the nineties, WHO's role was taken over by UNAIDS.
- UNICEF HQ expanded its partnerships with technical institutions and NGOs during the TSG process to implement an integrated and multi-disciplinary approach to HIV/AIDS. UNICEF HQ was not able to maintain those partnerships.
- Partnerships between UNICEF and NGOs have been better maintained and have also expanded rapidly within country programmes. Private sector and technical institutions have played minor roles.
- UNICEF's programmes and mode of operation were not significantly changed as a result of UNAIDS at the country level. In the early period of UNAIDS, UNICEF could hardly be called an enthusiastic cosponsor. Attitudes and practices have changed slowly and UNICEF has emerged as one of the most active cosponsors (in the four case countries).

- **Improvements in Co-ordination and Communication**

UNICEF HQ provided weak global support and co-ordination to HIV/AIDS in the latter part of the nineties. A new central HIV/AIDS Unit has been recently established.

Regional Offices from the beginning played a marginal role in supporting HIV/AIDS programmes, but the mandate of ROs has changed. The Regional Management Team in the Eastern and Southern Africa Region meets, for instance, two to three times a year to determine how best global policies and priorities can be introduced and applied within country programmes, and to monitor progress in the implementation of the regional HIV/AIDS work plan.

UNICEF during the nineties was actively involved and supportive in efforts to consolidate various **global co-ordinating mechanisms**, including:

- (a) The UN System Strategic Plan for HIV/AIDS 2001-2005. The first plan presents, to a large extent, a summary of what the individual parts are doing.
- (b) UNAIDS Unified Budget and Work plan (UBW 2002-2003) has mainly included global and regional HIV/AIDS activities – not UNICEF's and other cosponsors regular country budgets. This means in practice that a major part of multilateral funding for HIV/AIDS at country level is not included and reflected in the UBW.
- (c) The UN System Integrated Work plans (IWPs) on HIV/AIDS, prepared under the auspices of the UN Theme Groups, are joint prioritisation and planning exercises at the country level. Developed within the overall system of UN Development Assistance Frameworks (UNDAF), the IWPs are intended to include all of the HIV/AIDS-related actions of the UN system in support of national HIV/AIDS plan. In our case countries, UNICEF have played an active role in the preparation of Common Country Assessments (CCA) and UNDAFs advocating children's and women's rights, but it was difficult to track the importance of such plans and processes.
- (d) HIV/AIDS Theme Groups have become fora for communication and co-ordination among UN agencies. In an increasing number of countries, there are Expanded Theme Groups with participation of bilateral agencies and NGOs. UNICEF has gradually increased its involvement in national theme groups and more inter-agency collaboration. In January 2001, UNICEF chaired 19 Theme Groups compared to 16 in 1998. An opinion seems to prevail that the Theme Groups are wanting in strategic direction and analytical depth.
- (e) Country Programme Advisers (CPAs) are facilitators of more active collaboration and joint initiatives within the framework of national strategic plans. CPAs have played and continue to play important co-ordinating roles, but the role of UNAIDS and CPAs are not clear to cosponsors at the country level - including UNICEF.

- **Capacity Building and Integration with National Plans**

UNICEF has been criticised for seeking visibility and being reticent about collaboration. UNICEF has had a tendency to take on a "prime moving role" - not sufficiently ensuring ownership and leadership of national governments.

The country case studies present a more multifaceted picture in which UNICEF works more consistently with capacity building, policy development, processes of consultations and integration of programmes in local structures.

- **Evaluations and Evidence of Results**

UNICEF is increasingly pressured to measure and document outcomes and impact – in order to demonstrate for donors that the organisation provides an effective and efficient response to HIV/AIDS. But existing M&E systems have their limitations:

- UNICEF initiates an increasing number of evaluations, but there is no systematic approach to evaluation in the organisation where evaluations of a cross-section of projects are carried out at regular intervals.
- Most evaluations are undertaken of individual projects and programmes. Data and information are not available for broader thematic or geographic areas.
- Assessments of impact mainly use qualitative methods. Results are consequently based on impressions and less on quantitative data and analysis. There is not much information on “how much and how well”.

- **Changing Country Trends on Outcomes and Prevalence**

Official figures on numbers of HIV positive and reported AIDS cases in Myanmar indicate that the rate of transmission is growing. The same is true for Zimbabwe. The most recent data from Thailand suggests that the numbers of new HIV infections peaked in the early 1990's and since then has declined by more than 80%. There has also been a positive reduction in Uganda.

The varied experience raises some key questions around evaluation in UNICEF. The Thai national programme for HIV/AIDS prevention has been considered very successful. The same is true in Uganda. The transmission of HIV has been significantly reduced, and there are clear changes in sexual behaviour.

It would be misleading to assess UNICEF's performance by using prevalence as an indicator. There is no direct causal link between increase or decrease in prevalence rates and UNICEF performance. The role of the international organisations in general and UNICEF in particular, is hard to pin down. UNICEF has no doubt contributed to many of the activities that took place. It has had an important role as an advocate for change, and for pioneering efforts in communication with youth. But we cannot know for sure what the relative importance has been. In particular, *the weakness of the monitoring and evaluation system, the lack of critical examination of project and programme results, make any such estimate mere guesswork.*

D/ Implications for Policy Results

The review shows that the results are considerable, but what are the lessons in terms of policy formulation and implementation? *Can the results be attributed to policy and the choice of policy instruments, and if so, to what degree?* There can hardly be any doubt that the results to some extent depend on other factors than policies.

In some countries, results were achieved even before policies were formulated, let alone implemented. In other countries, it can be assumed that there are no results at

all, even if policies have been around for some time. Yet in other countries, there is a close causal connection between the formulation of policies, application of policy instruments, organisational response, and results. Myanmar appears to be a prime example.

Is the lesson that policies are neither necessary nor sufficient to produce results in respect of practical action to combat HIV/AIDS? No, the situation when policies were not necessary belongs to history (Thailand and Uganda 10 to 15 years ago). In later stages, policies have encouraged people to take action, has legitimated initiatives to develop HIV/AIDS projects, while at the same time allowing different responses. However, *policies alone are not sufficient*. In particular, the process of policy formulation must be followed up with the application of policy instruments. Policies do not make a difference in their own right, particularly not in a policy rich environment. When many issues claim the attention of decision makers it is even more important to provide directives on the most significant areas of work. In the end, *if policies are to provide results, there are financial implications*. Policy formulation can be more or less closely linked to budget allocations. The closer the link is, the larger will the impact of policy formulation be.

To make policy happen with the help of sermons can be quite costly (there are both direct costs involved in preparing and delivering the message, as well as opportunity costs). Could the same results be produced by using a more cost-effective policy instrument? More cost-effective policy instruments are centralised, standardised and less flexible. However, it must be remembered that the costs involved are not only monetary, they also come in terms of organisational values and preferences.

1. INTRODUCTION

1.1. Background

In 1992 UNICEF's Executive Director responded to the worsening AIDS epidemic by recommending that UNICEF should intensify and expand its support to HIV/AIDS prevention activities (E/ICEF/1992/L.11). In particular, "efforts should focus on programmes to reduce HIV transmission among young people, information and communication to reach youth to promote informed and responsible sexual behaviour and promotion of improved reproductive health of women and youth". The document suggested that while it may not be possible to stop the transmission of HIV during the nineties, stabilising the transmission rate of HIV and containing the epidemic appeared to be achievable.

The key message in 1992 was to intensify and expand UNICEF's response to the rapidly worsening HIV/AIDS epidemic – and in particular focus on reducing HIV transmission among young people. There was a clear sense of urgency in the message. UNICEF had to move fast to reach its targets by the end of the decade.

This was an ambitious goal for UNICEF. The organisation had started some HIV/AIDS projects in Uganda in 1986, but the expansion was slow, incremental and focused on only those countries hardest hit by the new epidemic. UNICEF had also limited experience and competence in HIV/AIDS programming. Only a few staff had relevant technical expertise.

UNICEF also needed to identify its proper mandate in the area of HIV/AIDS vis-à-vis the other UN organisations. WHO and the Global Programme of AIDS (GPA) were dominant leaders in the area and had, to some extent, monopolised HIV/AIDS in the UN family. They had identified it as a major health concern. Gradually, it became obvious that the epidemic would impact on the mandate for most UN organisations and in particular women, children and young people requiring a multi-sectoral approach. Hence, there was a need – and considerable pressure on UNICEF to 1/ define its actual and potential strengths in the area of HIV/AIDS prevention, 2/ scale up its activities and 3/ work out a strategy of collaboration with WHO.

Lastly, the Executive Directive introduced a new primary target group for the intensified and expanded approach – **youth** in addition to women¹. UNICEF is an organisation for children. According to the Convention on the Rights of the Child, children include everyone between 0 and 18 years while youth usually covers the 15 to 24 age-group. Because of the characteristics of the epidemic, UNICEF decided to focus more of its attention on a new age group – young people. They being between children and adults faced particular challenges and problems.

In 1999, the number of infected people far exceeded the predictions of 1992. Fifteen years after the onset, the epidemic has a continuing intense impact on young people which at current infection rates put *young* people at the epicentre of the epidemic.

¹ Different terms have been used. WHO defines Adolescents as 10-18 years, Youth as 15-24 years and Young People as 10-24 years.

The proportion of young people who will die of AIDS is appallingly high. In virtually any country where 15% or more of all adults are currently infected with HIV:

- at least 35% of boys now aged 15 will die of AIDS;
- in Zimbabwe, 50% of boys aged 15 could expect to die of AIDS before the age of 50 (Report on the global HIV/AIDS epidemic, UNAIDS 2000).

IMPORTANT QUESTIONS

- How then to explain that after 15 years of the acquaintance with AIDS, the epidemic is still growing in many countries?
- How is it that AIDS has claimed the lives of 10.3 million young people despite UNICEF's ambitious goals from 1992?
- Or had the situation been much worse in many countries without UNICEF's ten-year efforts?
- What has characterised UNICEF's response to HIV/AIDS?
- How were intentions translated into programmes?
- What have been the successes and failures?
- How to improve and build a stronger response for the next decade?

These are important questions for this evaluation.

In a proposal to the General Assembly for achieving the World Summit for Social Development +5 target, the Secretary-General has requested UNAIDS and its cosponsors "*to undertake a process of further clarifying their roles and responsibilities of their specific comparative advantages with regards to interventions for the prevention of HIV among young people.....*" (A/AC.253/16/Add.9). Evaluating the response of UNICEF and its partners to the epidemic in the past decade is a valuable way to learn from the past and further develop clear strategies for the future.

Targets for the next decade are not less ambitious: HIV prevalence in young people should be reduced by 25% in the most affected countries by 2005 and by 25% globally by 2010. This has been agreed upon at the ICPD +5, World Summit for Social Development +5, by and the OECD/DAC and the G8. Strategies for achieving this outcome have been identified in the respective documents and a global strategy was submitted to the General Assembly in February 2000 by UNAIDS.

1.2. Purpose of This Evaluation and Key Questions Asked

This evaluation should be forward looking. It should provide a critical assessment of positive and negative experiences from last decade. It should summarise major lessons learned while providing a platform for improved programming. The Terms of Reference provide a three-fold purpose for the evaluation:

- (a) *Identify the gaps* between policy statements (made by the Executive Board) as applied in programming guidelines from Headquarters to the Regional and Country Offices.
- (b) Address UNICEF's *strengths and weaknesses* in:
 - accelerating programming for reducing HIV/AIDS in young people following a societal and behavioural approach,
 - building and strengthening partnerships for accelerating programming for HIV/AIDS reduction in adolescents in light of the evolution of policy response to HIV/AIDS in young people.
- (c) *Draw critical lessons*, which should be formulated in a way to inform the development of UNICEF's Global Strategic Plan on HIV/AIDS.

This is primarily a policy evaluation of UNICEF's response to HIV/AIDS. It is not a programme or project evaluation – assessing the implementation and results of specific activities. A policy evaluation should address at least three questions and a number of sub questions:

(a) Policy intent: *What policies and goals have guided the UNICEF response?*

- What is the status of the policy definition?
- Is the policy clear, consistent and achievable?
- Is the policy in line with UNICEF's strengths and mandate vis-à-vis other UN agencies?

(b) Policy implementation: *How were the policies introduced, operationalised and implemented in UNICEF at global, regional and country levels?*

- What policy instruments were used to effectuate the policy intentions - regulations (sticks), resources (carrots) and information (sermons)?
- Did UNICEF have a strategic and effective mix of instruments?
- How were the different levels of the organisation used in the expanded response?
- What were the main tools to ensure organisational learning – for dissemination of new knowledge and rapid replication of best practices?
- What M&E systems and tools were put in place to monitor the progress of the response, evaluate experience and ensure continuous learning and development?

(c) Policy results: *What is the evidence of results of an intensified and accelerated response in the following areas*

- Increased political and financial commitment within UNICEF at global and country level?
- Increased coverage (more countries with HIV/programmes)?
- Replication and scaling up of pilot programmes?
- New partnerships established and strengthened?
- Better integration with national plans?
- New methods and approaches for providing technical support developed?
- Innovative programme profile (more focus on young people, more societal, behavioural and multi-sectoral approaches)?
- Evidence of programme impact at the country level?

1.3. Methods and Limitations of the Evaluation

Policy evaluation is considered a particularly difficult task, as the object of study –the policy – is an abstract entity. Furthermore, the ways that a policy can influence an organisation are many, and it is often quite difficult to establish a causal connection between policies and observed outcomes. Policies are part of a multi-causal pattern that explains real events. The link between policies and events is non-linear, meaning that the event does not bear any specific relation to the causal factors either in time, in space nor in proportion.

The first step in the present evaluation process was to develop an analytical framework of how policy is put to work in the organisation, and to trace the impact of policy onwards to organisational change, transformation of programming, and impact from country and regional activities. The analytical framework consists of a set of three models:

- (a) a model to describe, analyse and assess policy formulation (chapter 2),
- (b) a model to distinguish policy instruments (chapter 3), and
- (c) a model to trace the application of policy instruments to regional and country levels in the organisation (chapter 4).

Model design is thus one of the key evaluation tools, although it is not a method in the sense of “methods of data collection”. As an organising tool for the evaluation task, model building is essential. The three models mentioned above are introduced in the text where they are applied in the analysis of UNICEF’s policy response.

The data collection to support the analysis of the policy response can be described in two categories: 1/ a desk study of documentation and 2/ interviews. The documentation of policy is an important process². The period studied here covers around 10 years, from the formulation of a policy up to the present. The documents selected for analysis consist of several categories of papers such as:

- (1) Documentation of Executive Board meetings
- (2) Policy statements in other sectors/areas
- (3) General publications relating to HIV/AIDS
- (4) Programming instructions relating to HIV/AIDS
- (5) Regional strategy papers
- (6) Country strategy papers
- (7) Project documents
- (8) Monitoring and evaluation reports

These documents allow us to trace policy influence through the organisation. They are reliable sources of data, as they are – by definition – documented. They illustrate how intents are – or are not – formulated. They allow us, in several cases, to establish causal connections between intents and practical results. But there are also problems with documents. The main problem lies in selection. Our approach has been to read everything there is, and in theory that is the only valid approach. Otherwise we might miss a source of influence, or a neglected aspect of communication. However, we cannot be absolutely sure that we found and understood all relevant documents.

In respect of interviews two kinds of data were collected. First, we looked for interviews with key informants, who had been placed in key posts at headquarters, in the regions, and in country offices during the nineties. We expected that a significant number of them would be found in New York, and conducted around fifteen interviews among experienced staff members. Second, we also traced and interviewed people who had left the organisation and now work in bilateral aid agencies, in

² A database with most relevant publications had been prepared and a profile of the evolution of UNICEF’s response to HIV/AIDS in young people in the nineties (Reinisch 2000&2001).

UNAIDS, or as consultants/researchers. Annex 3 contains a list of persons interviewed.

As the study covers the process from policy formulation to implementation, through the hierarchical levels of the organisation, country studies and regional studies were significant. It can always be discussed how many country studies and regional visits are necessary to produce valid and reliable findings. A study should of course not collect more information than is necessary. In consultation with UNICEF management, we selected two regions and four countries for in depth study. These were to reflect areas where the HIV/AIDS “problematique” is particularly virulent. hence Eastern Africa and South East Asia (Nairobi and Bangkok) were selected. The country studies were taken in close proximity, and we suggested in this case Zimbabwe and Uganda in Africa, and Thailand and Myanmar in East Asia.

In each country, the visit consisted of meetings and discussions in the UNICEF office, with other UN agencies, and with government representatives (ministries of health and education, research centres, as well as NGO communities).

The approach of using both documents and interviews allowed us to let the two sources of data supplement each other. The interviews helped us understand the role and limitations of the policy documents, and helped us assign them their proper place in policy implementation. The analysis of documentation allowed us to verify the information provided in interviews, or indeed, at times to disregard or challenge such information.

The major limitation in this study may be an inherent bias to over emphasise the importance of UNICEF’s policy response. The regions and countries chosen are examples of areas where the HIV/AIDS epidemic is important and where there is a response to the policy. In other parts of the organisation, the policy response may look quite different. It is also possible that we over emphasise the role of formal policy-making, and the explicit use of policy instruments. The study actually has most to say about policy formulation and implementation in a context where these processes are quite explicit, where there is a general consensus about the topic, and where there is a history of documentation.

It is important to keep in mind that this is primarily a formative evaluation – trying to identify lessons learned and contribute to strengthening the future response to HIV/AIDS. It is not a summative evaluation of individual programmes or an in depth organisational diagnosis. We have studied policy-making in the context of HIV/AIDS, but in practice this is part of overall governance, management and control in the organisation. We have not penetrated these issues in depth.

The evaluation report is presented in two volumes. The first volume contains the general discussion of UNICEF’s policy response, which is split on three chapters. Chapter 2 (following this introduction) presents an analysis of policies that have guided UNICEF’s response. Questions about policy definition, quality of policy and the policy environment are discussed. Chapter 3 addresses implementation and starts with a definition of three instruments for translating policies into action (sticks, carrots and sermons). This classification is then used to assess and characterise UNICEF’s response. Chapter 4 looks at policy results and to what extent UNICEF has

been able to produce results. The second volume contains the four country studies. These can be read separately and independently.

2. POLICY INTENT

2.1. Status of the Policy Definition

The dictionary defines the noun *policy* as “a plan of action adopted or pursued by an individual government, party, business, etc.” (The New Collins Concise English Dictionary). Interestingly, the dictionary provides a second meaning of the word, namely “wisdom, shrewdness or sagacity”. The root of the word policy comes from Latin “politia”, meaning administration. But it can also be compared to the root “polis” signifying politics. The meaning of the concept includes the more abstract identification and establishment of political choice, as well as the administration of that choice in practical action.

Can there be a policy without a policy statement? The word itself suggests that a policy can be the accumulated experience and activities of an organisation. Hence, policy could be analysed as an organisational culture, with its embedded norms, values and attitudes. In that sense, an organisation could possess a policy, even if there is no written policy document. We could speak of tacit - or emerging - policy, as much as we speak of tacit knowledge. The common use of the word policy, presupposes a combination of explicit attention to an issue in verbal form, and activities that follow suit. An issue can be a policy even though it is not explicitly called a policy - a strategy, a plan of action, a list of organisational priorities, all signify that the organisation has a policy.

Consequently, there are many ways to approach the process of policy formulation in an organisation. On the one hand, we can look for one clear and distinct policy statement. On the other hand, policy can be interpreted as information contained in various documents emanating from management that serve to explain what the organisation does in a field³. We have the choice of either looking for *the* policy, or interpreting a number of documents and/or events that express policy. The table below describes three different approaches to the definition of policy in the organisation. Let us now look at UNICEF’s policy through each of these approaches.

Table 3. 1. Three approaches to the definition of policy.

Policy as a consolidated statement.	Policy as expressed through a set of documents	Policy as expressed through documents <u>and</u> action
Identify the policy statement, analyse it, describe how the policy is disseminated, and find out if it is well-known and understood in the organisation and among its stakeholders	Define and identify the components of the policy system, analyse co-ordination and consistency, communication and acceptance in the organisation	Analyse and interpret the activities of the organisation, and define what happens as an expression of policy. The policy is understood “from the bottom and up”

³ WHO (2000) chooses to refer to a policy system, where policy is defined in Executive Board (EB) resolutions and decisions, EB official records, EB documents, World Health Assembly (WHA) resolutions and decision, WHA official records, WHA documents, programme budgets over several years, and proposed programme budgets for the future.

Policy as a Consolidated Statement

Taking the first approach, UNICEF does not possess any policy on HIV/AIDS. There is no such thing as a document entitled "policy", which sets forth the general principles of what the organisation is expected to do in respect of the epidemic. The closest one can get is the Executive Board document from 1992 (E/ICEF/1992/L.11). This contains information normally found in policy statements, such as; connecting the problem and its issues to UNICEF's mandate, outlining possible modes of operation, defining priorities. But it is not entitled a policy. It bears the title "programme approach".

In theory, it may be of limited consequence that the "programme approach" is not called a policy. As long as people in the organisation interpret it as a policy, it serves its purpose (and many do speak of it as a policy). However, as there are other policies in the organisation, that is, Executive Board documents that formally define policies, it might lead to confusion when there are policies that actually do not bear that name – but are meant to be understood as policies.

The reason why the document (E/ICEF/1992/L.11) is not called a policy is, according to our interviews, related to the division of labour among UN organisations. When the issue was debated in the Executive Board, there were board members who insisted that only the WHO could have an HIV/AIDS policy. Other organisations in the system would have to use other words to encapsulate and communicate their intents within the field. In this sense, there is a wide bridge between the common understanding of "policy" and the approach in the Executive Board's debate.

Policy Expressed Through a System of Documents

Following the second approach, the programme approach (E/ICEF/1992/L.11) can be supplemented by other written documentation, such as board documents, new versions of programme approaches, EB directives, etc. The table below gives an example of documents that define and elaborate on UNICEF's HIV/AIDS policy. The main problem here is one of selection. Which documents and statement should be included?

History introduces a bias. In our search we found statements and speeches by the present Executive Director from 1999, 2000 and 2001, but not from previous years. But it is likely that the former Executive Director also spoke on the subject, and also that the present Director made speeches before 1999. We have not found these documented, and there are reasons to believe that sources further back in time reflect some selection process. However, we are fairly sure that the main elements of UNICEF's HIV/AIDS policy are found in the documents in the table on next page⁴. Many of them repeat the same messages, and as we will see later, the inherent

⁴ Our study builds on the review of literature done by Annette Reinisch of the EES. She has collected a large number of documents from within the organisation (as well as from other organisations) that deal with HIV/AIDS. These include board documents, evaluations, strategy papers, minutes from management retreats, workshops and conferences. The information is gathered in the form of an analytical paper, as well as in a database. The database provides a guide to main findings, and has comments on the different reports that are useful to understand context. There are key words for each document listed, and hence the database can be used to search for literature on a number of HIV/AIDS related topics.

contradictions are not that different from those of the single policy document (E/ICEF/1992/L.11).

Table 2.1 UNICEF's policy system in respect of HIV/AIDS

(E/ICEF/1992/L.11) ECOSOC, UNICEF programme approach to the prevention of HIV/AIDS
I/ICEF/ 1993/2 Report of the Executive Director
E/ICEF/1993/L.10; ECOSOC, Progress Report on UNICEF activities in the prevention of HIV and in reducing the impact of AIDS on families and communities
E/ICEF/1994/L.14; ECOSOC, UNICEF support to the proposed UN Joint and Co-sponsored Programme on HIV/AIDS
E/ICEF/1994/L.15; ECOSOC, HIV/AIDS programme
UNICEF biennial report on HIV/AIDS prevention and care, 1993 – 1994
UNICEF; AIDS: The Second Decade – A Focus on Women and Youth
UNICEF; Young People in Action (Report from the VIIIth International Conference on AIDS in Africa, Marrakech, 1993)
UNICEF; Action for Children Affected by AIDS – Programme Profile and Lessons Learned
UNICEF; Report of the Technical Support Group Meeting, June and October 1993; Mass Communication and Mobilisation for Youth Health and Development
UNICEF; 1995, Report of the meeting: UNICEF Approaches to Children and Families Affected by HIV/AIDS
UNICEF 1995, Children and Families Affected by HIV/AIDS
UNICEF; 1995, Report of the meeting: UNICEF Approaches to Youth and Women's Health
UNICEF 1997. Youth Health - for a Change. UNICEF Notebook on Programming for Young People's Health and Development
CF/AI/1998 – 002; Programme Directives, Notebook on Programming for Young People's Health and Development
UNICEF Statement to the World Conference of Ministers Responsible for Youth; Lisbon 1998.
CF/AI/1988-002; Administrative Instructions, UNICEF Guidelines for UNAIDS Collaboration
1998 – Key Programme Reference Material, UNICEF's Role within UNAIDS Programme
UNICEF, 1998; Programme and Policy Briefs; Young People's Health and Development
UNICEF, 2000; Programme Approaches to HIV/AIDS
Statement by Carol Bellamy at the 13 th International AIDS Conference, Durban 11 July 2000

Policy as an Emerging Phenomenon

Finally, at the extreme end of the model, policy could be interpreted as all of the above, plus more loosely structured communications and activities. There are evaluation reports that contain policy recommendations, general studies of the HIV/AIDS problematique – published by UNICEF alone or jointly with WHO, UNAIDS, the World Bank, or UNDP. In addition, there are communications on the web page about HIV/AIDS, press releases, etc. Management literature suggests two major approaches to policy development which may help to illustrate our findings (see for example Mintzberg, 1998; Clegg et al, 1996). In the first approach, policies represent clear and deliberate intentions for the future – distinct written ambitions and plans. Such an approach has several characteristics:

- Policy formation is a deliberate process of conscious thought where action flows from reason: good policies derive from a tightly controlled process of human thinking.
- Policy should appear fully formulated as perspectives. The “big” picture must be clear from the beginning. There is little room for “incrementalist” views which allow formulation and adaptation to continue during and after implementation.

- Policies can first be implemented when they are clearly formulated. There is a distinction between formulation and implementation. Thinking is separated from acting.

This approach to policy is prevalent in rational management sciences and is widely accepted, not least in the UN organisations, and often perceived to represent the only or “correct” approach to policy making. An alternative school of thought presents policy as a pattern. Organisations evolve patterns out of the past. This is emergent policy – where an observed pattern was not expressly intended. Actions were taken in the organisation, one by one, which converged over time to a consistent pattern. This form of critical thinking about the role and nature of policies suggest that:

- Clear policies can serve as a set of blinders to hide potential uncertainty and dangers. Setting out on a predetermined course in unknown waters may lead into an iceberg. In an area like HIV/AIDS where the epidemic is complex, it is often difficult to know the most effective action in a changing environment.
- A given policy can become too heavily embedded in the fabric of the organisation. There may be no peripheral vision to open up other possibilities. Policy formation has more to do with learning than with conception.
- Policies formulated at the top are either too general to be relevant or too specific and detailed – hiding complexity and holding back variation.
- Creativity thrives on inconsistency and some level of uncertainty. A policy may become a simplification that distorts reality.
- Organisations with too tight controls from the top, high reliance on formalised procedures, and a passion for consistency may lose the ability to experiment and innovate.
- A whole range of possible relationships between thought and action are required. During and after major shifts in the environment learning may be a better word than planning for the future. We often think in order to act but organisations also act in order to think – immerse themselves in the situation while being able to abstract the strategic messages from it.

In reality, few policies are purely deliberate, just as few are purely emergent. One means no learning, the other means no control. Policies have to form, as well as to be formulated. If we analyse UNICEF in order to define dominant policy processes, there is a strong element of emerging policy. Priorities and direction are set at country level – given by specific needs in individual countries and interpreted by Country Representatives. Policies emerge from below and form a pattern over time.

The question then is if it matters what approach we take? Is there any approach that is better, or more correct, than the others? It is tempting to follow the first approach, and to assume that UNICEF policy is contained in the EB document of 1992 – and which still remains the programme approach, as another has not officially replaced it. However, we are afraid that this would give a limited understanding of the system. Even though many recognise the importance of the Executive Board document, we are not sure that all see it as the single statement of policy. It would also set us on a path of static interpretation of policy, which does not reflect the truth in the organisation.

2.2 Assessing Policy

A key question is whether a policy is a "good" policy or not. The question can be answered both in substantive terms, that is, by those who are experts in the field and who have a good grasp of whether the policy identifies the important challenges, whether its outline of action is the right solutions to the problem, etc. A policy can also be assessed in rhetorical terms; that is, whether it communicates a message well, if it is clear and consistent. We suggest that the criteria in Figure 2.1 (our model of quality criteria) are used to analyse and assess policy.

Figure 2.1 *Quality criteria of HIV/AIDS policy*

<i>Comprehensiveness</i>
<i>Clarity</i>
<i>Consistency</i>
<i>Flexibility</i>
<i>Focus</i>

The criteria illustrate that policy formulation is a balancing act. On the one hand, consistency is a virtue, as people need directives that do not fluctuate back and forth, but allow them scope for long-term planning. On the other hand, a policy must not become static, it must allow the organisation to redirect attention to new threats and opportunities. A good policy covers all relevant areas of a field of action - it is comprehensive. But it must not be scattered over all possible modes of operation. It must be focused in order to provide economies of scale in operations and to achieve demonstrable impact. With these criteria in mind, we will now turn to the content of UNICEF's HIV/AIDS policies, whether seen as one single document, as a policy system, or as emerging policies.

Approach 1: Assessing a Policy Statement

The document adopted by the Board in 1992 (E/ICEF/1992/L.11) had grown out of several years observation of the effects of the HIV/AIDS epidemic, particularly in Central and Southern Africa. People in the organisation had witnessed the impact that the epidemic had on the well being of children and drew the necessary conclusion – that UNICEF had to respond. In addition, other organisations were developing programmes in the field, particularly the WHO. Many signals reached the organisations that here was an area where it was necessary to take action. The emerging response was not a policy introduced by the top levels of the organisation. On the contrary, the policy formulation had the characteristics of a bottom-up approach.

However, even though policy development was a bottom-up process, the movement was not universal in the organisation. In a global perspective, it was an initiative coming from a handful of country offices, supported by some officials at headquarters, in regional offices, and among researchers. Some Executive Board members supported the concern for HIV/AIDS, which is seen by the Executive Board

documents (E/ICEF/1988/L.7.) that analysed the impact of the epidemic on women and children, and called for a UNICEF response.

E/ICEF/1992/L.11 lent legitimacy to the work that already occurred in the organisation and meant that new resources could be added, and new priorities could emerge at country levels. If we treat E/ICEF/1992/L.11 as the verbal formulation of policy, this can be analysed in terms of its clarity, consistency, comprehensiveness, as well as of its operational possibilities. The document contains 24 pages of text. The nine first pages are a historical overview of the epidemic. The following four pages delineate the obstacles to be overcome in preventing/containing its spread during the 1990's. The next two pages discuss the role of UNICEF in comparison with other organisations, then another eight pages elaborate the programming approach. The last page contains recommendations to the organisation from the Board, which essentially summarises the previous discussion.

The policy is clear in that it leaves no room for doubt concerning the extent of the HIV/AIDS threat and its impact on children. It connects the mandate of the organisation to activities in this field in unambiguous terms. It outlines a number of possible modes of intervention. It is said that UNICEF should intensify and expand its support to HIV/AIDS prevention activities. Four priority areas are identified:

- (a) programmes to reduce HIV transmission among young people,
- (b) information and communication to reach youth to promote informed and responsible sexual behaviour,
- (c) protection of children from sexual exploitation,
- (d) promotion of improved reproductive health of women and youth.

Furthermore the policy identifies how UNICEF is to operate in these fields, namely *"for a strengthened role of NGOs and creative community-based approaches to provide support and social services required by AIDS orphans and families affected by HIV/AIDS."* The latter could actually be seen as both an area of activities and a mode of operating.

In one sense, the four areas mentioned are clear, but at a closer scrutiny one may raise a number of questions. What form would programmes to reduce transmission take? Would such programmes not build on information and communication to reach youth? In that case there is an overlap between the first and second category. Furthermore, the category of improved reproductive health (d) must in practice be synonymous to (b). The apparent clarity of the priority areas obscures the fact that practically speaking, it is hard to distinguish one area from the other. Consequently, it would also be difficult to operationalise these as distinct modes of programming.

The text makes it clear that the focus of UNICEF should be on youth. Three out of the four statements above relate directly to youth (a, b and d). The third area of intervention names children, but as objects of sexual exploitation, these would often also be youth. Compared to other possible target groups and activities, such as mother to child transmission, care of orphans, there is a clear sense of priority in the programme approach – and that priority lies on youth, responsible sexual behaviour, and communication.

The programming approach emphasises work with NGOs and communities. However, as the Country Programmes build on a bilateral relationship, this may be difficult to operationalise in many contexts. In practice, UNICEF will identify projects and programmes with government authorities, and through these it may be possible to extend co-operation to NGOs and communities. But it would seem that the policy does not pay sufficient attention to the actual mode of operation in many countries. The policy would have been more applicable if it also contained directions on other modes of intervention.

The aim of the policy is to be operational, but the question is if operational projects and programmes are the sole activities of the organisation. The Board's recommendations do not mention any advocacy role, hence there is no opening for a UNICEF response when a government may choose to neglect the epidemic. The recommendations do not mention research. Hence, our conclusion is that the policy is actually not comprehensive; there are possible areas of intervention, modes of operation, and roles for the organisation that are not explicitly elaborated.

The policy document places HIV/AIDS prevention activities firmly on the map of the organisation. It provides legitimacy for projects and programmes that are ongoing and it suggests a number of priority areas. But the statements of these are overlapping, and there is no comprehensive set of activities for UNICEF to adopt under different circumstances. The policy is clear when it recommends UNICEF to intensify and expands its support to HIV/AIDS prevention. This is repeated several times. It can be interpreted as a continuous growth of programme resources, as a constantly increasing share of programme resources, and as activities that cover new fields, that is, a qualitative expansion.

Finally, the E/ICEF/1992/L.11 specifies that UNICEF-supported programmes should "focus on efforts that relate most directly to achieving measurable goals in the reduction of HIV transmission among young people". The emphasis on young people is repeated but the statement (which is actually the first in the elaboration of the programme approach (p.24, §76 (a) introduces a dilemma - that the focus should be on achieving measurable goals. All who have some practical experience of HIV/AIDS work know that communication programmes to reach youth and affect behaviour change are among the most difficult from which to measure impact. It would be far easier, in that case, to direct efforts at health services, STD clinics etc. So, if the organisation was to take the recommendation on measurable goals seriously it would probably not develop innovative communication programmes.

Approach 2: Assessing a Policy System

We will now turn to a similar assessment of the policy system. In doing so we follow-up the key elements of the E/ICEF/1992/L.11 and analyse to what extent these are supported, elaborated, or contradicted by subsequent documents in the policy system. The first aspect of the policy is the issue of volume and quantity. Nowhere else have we seen it as clearly expressed that the organisation should "*intensify and expand*" its support to HIV/AIDS prevention as in E/ICEF/1992/L.11. Other documents do not provide any guidance on the volume of efforts, or the change in such volumes. While the recommendation is not contradicted, it is on the other hand, not reinforced. The consequence is actually that it is diluted. As there are so many new documents, the clarity and focus of that initial statement is forgotten and obscured by other messages.

The second aspect of the policy relates to the priority areas. Again, E/ICEF/1992/L.11 has a clear focus on youth and women, and responsible sexual behaviour. The policy elaboration that has followed has not shifted those priorities. If anything, they were reinforced throughout the 1990s. Several meetings were devoted to the issue of youth health. The meetings were documented, and the reports were treated by the Executive Board, and disseminated in the organisation (ECOSOC, 1995 Session). Table 2.1 shows that there are guidelines for programme development (Notebook on Programming for Young People's Health and Development). Looking at the documentation, more than three quarters of the titles, and an even higher proportion of the texts deal with this target group.

However, the policy system also introduces other subjects. As the situation of the epidemic changes, it is logical that the response of the organisation changes. In parallel to the focus on young people and sexual behaviour, these new areas are in particular the prevention of mother to child transmission (PMTCT) as well as prevention and care for families, orphans, people living with HIV/AIDS. There is no doubt that UNICEF has a role to play in these fields, and in many contexts it is necessary to design programmes in response to these challenges. But, it is equally clear that these are different efforts from projects that may be directed at youth, and hence the policy intent is less focused, but more comprehensive.

The UNICEF Programme Approaches to HIV/AIDS, published in June 2000, illustrate the change in focus. It is relevant to compare, as the E/ICEF/1992/L.11 is also a "programme approach". The document consist of 30 pages and the most interesting section for this comparison is the third chapter, UNICEF priority programme areas. Six areas are identified:

1. Prevention of Mother to Child Transmission (5 pages)
2. Young People's Health and Development (4 pages)
3. Children and Families Affected by HIV/AIDS (3,5 pages)
4. Schools and Education (2 pages)
5. Communication (3 pages)
6. Caring for Staff (1 page)

As the figures between brackets indicate, the major focus is on PMTCT. There is not an overwhelming focus on Youth, as there was in the document of 1992. On the other hand, these priority areas are more comprehensive as they explicitly identify several modes of programming. The categories are not overlapping as they were in the other document. The final priority area seems to be an anomaly. It could hardly be a priority programming area for an international organisation to care for its own staff. That must belong to the domain of personnel policy, staff development, internal health care, etc. It cannot be an issue of weight as part of a global response to HIV/AIDS.

Later documents reinforce the mode of operation, that is, the emphasis on community based and participatory approaches and close co-operation with NGOs. This is not contradicted by programme content that would indicate other partners or by any other demands. We have not seen the request for measurable targets repeated with the same emphasis and priority as in E/ICEF/1992/L.11. The UNICEF Programme Approach of 2000 does not contain any directives on monitoring and evaluation. Other documents

have occasional references to the desirability of targets and measures but there is nothing that requests these with the urgency of the E/ICEF/1992/L.11.

Approach 3: Assessing Emerging Policy

UNICEF has a number of policy documents, but these are, to a large extent, systematisations of existing thinking and practices, and serve subsequently to legitimise the same. Policy and strategy formulations are also relatively general and open – allowing a high level of flexibility when it comes to country adaptation. We are not saying that policies and strategies do not matter in UNICEF. Loyal Country Representatives want to be in line with important messages from Headquarters, but UNICEF as an organisation has few or weak techniques to ensure support and effectuate implementation. Rules and regulations are linked up with few formal sanctions – which may be one reason for the regional and country variation of the UNICEF response. *As a decentralised organisation, UNICEF has few means to rapidly and effectively expand and intensify action across the entire organisation.* This is a logical price for decentralisation.

The assessment of policy as an emerging phenomenon can only be completed when we look at the results and in our exposition of the subject we have decided to postpone that discussion to chapter 4. However, it should not come as a surprise that when the total response of the organisation is taken into account, there is neither a clear sense of priorities, nor a comprehensive response. The local variations are large.

At this stage, it may be relevant to refer to two of the country case studies in particular, namely Uganda and Thailand. In both these countries the response to HIV/AIDS came early, in the late 1980s. These experiences fed into the formulation of global policies. The analytical work undertaken by the organisation in preparation for the Executive Board document of 1992 refers to projects in Uganda and Thailand (as well as in a few other pioneering countries). The experiences of these two countries show how policy travels from the bottom-up, is incremental and how action comes before policy.

Table 2.1 summarises our comparison of the quality of UNICEF policies, whether identified as a policy document, as a policy system, or as emerging policy. It is not surprising that the broader we define policy, the broader is the content and hence less focused, less clear, but more comprehensive. *The dilemma is between being clear and focused, or comprehensive and flexible.*

Table 2.2 Assessing UNICEF policies

	Approach 1. A policy statement	Approach 2. Policy Documents	Approach 3. Emerging policy
Comprehensiveness	Some important aspects of work are not considered	Quite comprehensive	Quite comprehensive
Clarity	Clear	Some documents clear, others vague	Not very clear
Consistency	Definitely, yes	Shifting over time and space	Shifting
Flexibility	Allows for different responses	Flexible	Very flexible
Focus	Distinct focus	Focus can be interpreted	Focus can be interpreted

2.3. The Policy Environment

UNICEF's HIV/AIDS policy must also be understood in relation to other policies in the organisation. The scope and impact of any one policy is determined by what other policies there are, and how the co-ordination between policies is established. The first question is if the UNICEF environment could be described as policy rich. If there are many other policies around in the organisation, the need for a HIV/AIDS policy to be clear, consistent – and loudly proclaimed – rises. If it is an environment with few “competing” policies, then even a vaguely formulated policy may have a considerable impact. In a sense, policies compete and if competition is fierce then the “strongest” policy could be expected to win (that is, to be more widely known, and hence more often implemented).

There can hardly be any doubt that the UNICEF environment is “policy-rich”. The organisation possesses a number of explicit policies in different fields of operation. Some are policies in the form of “policy statements” (approach 1, in the model above). But there are also policies in the sense of a series of documents, established practices, etc. Any HIV/AIDS policy thus faces considerable competition.

This raises the question of how policies are co-ordinated. In particular, the HIV/AIDS policy would need to be co-ordinated with education policies, health policies, gender policies, possibly also with human development policies, and staff development policies. We have not been able to document any particular mechanism for policy co-ordination. On the contrary, this appears to be an ad hoc process where it is assumed that a new policy does not counteract other policies. Those responsible for policy formulation are expected to know other policies, and in their preparatory work make sure that there is sufficient co-ordination.

It is nevertheless a weakness that important policies, such as in health and education, do not explicitly make reference to the HIV/AIDS policy. The health policy (E/ICEF/1995/11/REV.1; Ex Board – Plans, Policies and Strategies, Health Strategy) contains some few passages about HIV/AIDS, less than two paragraphs in a document of around 20 pages. The message about the importance of the epidemic and the priority of a UNICEF response is thus not consistent between the two policies.

The Implementation plan of the Health Strategy (E/ICEF/1997/3) makes no reference to HIV/AIDS policies and only mentions HIV/AIDS twice in 16 pages. Another important document (Emerging Issues in Health for UNICEF) makes more explicit reference to HIV/AIDS. Following chapters on Immunisation, Vaccine Independence Initiative, Malaria and Helminth Control (23 pages), there is a chapter on Young Peoples Health (3 pages) which also takes up HIV/AIDS. Later on, there is a full chapter on HIV/AIDS (5 pages). In a document of 45 pages, there are thus eight pages devoted to HIV/AIDS. This shows that while this is an issue of concern, it does not convey the impression that it is a priority area. The UNICEF Notebook on Programming for Young People's Health and Development (1997 edition) has several examples of HIV/AIDS projects, but here too, it is only a small share of the total text. It does not emerge as a priority area.

Turning to the field of education, the basic premises of the policy are set out in the document from the Executive Board “*UNICEF Strategies in Basic Education*”

E/ICEF/1995/16. The document has one reference to HIV/AIDS issues, which is under the subject of children in emergencies (paragraph 50):

“Children with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) present a new, complex and growing challenge to society in a growing number of countries and to organizations such as UNICEF, which promote the protection of these children. Support will be provided for community-based programmes that recognize the rights and dignity of children with HIV/AIDS in order to enable these children to participate in education activities.”

Apart from these few lines, the education policy makes no reference to how its priorities and focus should or could be integrated with a focus on HIV/AIDS prevention. Yet another important document is “UNICEF’s Global Girls Education Programme”, which does not contain any mention at all of HIV/AIDS. However, the document “Girl’s Education: A Framework for Action” (dated 2000) contains two references to HIV/AIDS, such as;

“special assistance to the most vulnerable of children who are being denied their right to a basic education, including girls who work, girls in emergencies, girls with disabilities, girls affected by HIV/AIDS, and pregnant school girls. Appropriate approaches to ensure the right of adolescent girls who need to “catch up” a basic education are essential”

This is mentioned as item 13 on a list of 15 main features of the UNICEF programmes. Even if it connects to HIV/AIDS, it hardly does so in the form of an organisational priority. These few examples indicate that there are few references between HIV/AIDS policies and policies in the field of education. We are of course not in a position to evaluate these policies as such. Maybe it is not relevant to make more explicit references to HIV/AIDS. However, we would hypothesise that the HIV/AIDS policies would be more likely to be implemented, if it were clear how the issues were to be addressed in other policy fields.

It is particularly interesting to consider how HIV/AIDS policies relate to the concept of rights based programming. This is an area that raises many ethical problems of high theoretical complexity and with great practical implications. Again, we found that the documentation on the rights based approach makes few direct references to HIV/AIDS issues.

It is worth noting that the Medium-Term Strategic Plan 2002 – 2005 (Draft version 4.5, 6 September 2001), introduces HIV/AIDS as one of five priority areas in the organisation and says that:

“The five organisational priorities are also inter-linked. Progress towards one of them can contribute to progress in one or more of the other priorities. In many cases, the same programme or activity can simultaneously promote two or more of these organizational priorities. Prevention of HIV/AIDS transmission, for example, is inseparable from good education and improved child protection. Prevention of micronutrient deficiencies through Immunization Plus will contribute to better early childhood development and to learning outcomes in education later on.”

Practice in UNICEF as well as in other organisations imply that cross-sectoral links develop slowly and inadequately if they are not actively pursued. It would thus be essential to elaborate in policies and programme instructions exactly how these links

shall be formed. We should emphasise that it is not only other policies that lack links to HIV/AIDS policy. The latter is not explicitly linked to policies in education, health or other areas, nor is it expressed in the documents of more recent years what the rights-based programming will mean in HIV/AIDS.

2.4. Concluding Remarks

The analysis in this chapter has circulated around the subject of policy intent. We have shown that policy intent can be interpreted in several ways. To do justice to the organisation and to undertake a relevant and realistic assessment we have worked with parallel approaches to the subject.

UNICEF's policy intents have several strengths. They do have a focus on youth, and they do emphasise communication as a means of promoting responsible sexual behaviour. The policy was formulated on the basis of tried and tested approaches and it has continued to develop on the basis of experiences in a few countries that are at the forefront of developing HIV/AIDS projects. An active search for the relevant documentation of policy will lead to a selection of some 20 key documents that encapsulate (and repeat) the main tenets of policy. The initial policy statements were clear in the overall approach, even though they did contain some internal contradictions (see page 12). As the policy evolved during the 1990s, it incorporated new practices and became more comprehensive. The fact that new subjects were included indicates a flexible approach. But at the same time, the response became less focused.

There are also weaknesses in the policy. The policy is not clear in one crucial area, the issue of priority and what an intensified and expanded response means. Even though these words are clear enough in the document E/ICEF/1992/L.11, this emphasis is not followed up in other policy documents nor is it reflected in emerging policy. The policy has also been ambivalent in respect of such issues as monitoring and evaluation, the role of research and the advocacy function. HIV/AIDS policies do not appear to be co-ordinated with other policies and emerging areas of organisational practice, such as rights-based programming, have not been connected to the issue of HIV/AIDS. The main tenets of policy appear to be well known among UNICEF staff and among co-operating partners, but few can refer directly to the key documents. There are also many misconceptions about policy, for example, whether UNICEF can be active in the field of condom promotion, if so, what can be done?

How can the expression of policy be improved? UNICEF's approach of letting field experience play a major role in policy formulation needs to be preserved. This is a guarantee that policies can be implemented and that they are relevant. It makes sure that the experience of people is used and that the organisation learns. However, people inside as well outside the organisation would be well served by a document which is actually entitled an *HIV/AIDS policy*. Such a document should be easily retrievable and explicitly updated when the policy changes. A policy document should be precise in categories of analysis and action and must not be contradictory. The process of policy formulation should include a screening of other relevant policies and should connect to these.

3. POLICY IMPLEMENTATION

3.1. Policy Instruments

In the previous chapter we looked at the policy intent. The next step in the analysis is to find out how those intents were realised. What instruments did the organisation use to put these policies into practice? The first issue is to look at what policy instruments are available to the organisation. Then we can proceed to look at how they were used.

There is also a systemic level of analysis. We look at the mix of policy instruments. It is probably not enough with one policy instrument when management wants to move a complex organisation in a policy rich environment. It is important to have a balanced mix of instruments. We will address whether the mixture is actually well balanced or if there are instruments that are not used, or indeed, if the signals of different policy instruments actually convey the same message.

Table 3.1 Model of the policy instruments

POLICY INSTRUMENTS	1. Regulation STICKS	Executive Board Documents
		Executive Directives
		Programme Guidelines
		Strategy notes
	2. Resources CARROTS	Additional resources
		Earmarking of existing resources
		Redirection of resources
		Additional staff
		Redeployment of staff
		Organisational structures
	3. Information SERMONS	Statements by the Director
		Meetings and workshops
		Training/motivation
		Web page messages
		New publications
		Press releases
Recommendations from evaluations		
Informal communication		

The issue of choosing the appropriate combination of instruments is one of the most intricate and important in planning. That choice makes a significant difference in terms of making change happen. It is also important to keep in mind that organisations have preferences for certain instruments and combinations depending on their culture, traditions and structure. It is convenient to distinguish three classes of policy instruments (Vedung, et al, 1998):

- (a) **Regulations** - measures decided by the organisation in the form of rules and directives which mandate its staff and stakeholders to act in accordance with what is ordered in these rules and directives. Such measures are popularly called “sticks”.
- (b) **Resources** - involve either the handing out or taking away of human and financial resources for specific purposes. By making HIV/AIDS a special priority, UNICEF could make additional resources available, earmark general funds and/or redirect existing resources towards HIV/AIDS. In this case, country programmes

and governments are not obligated to take the measures involved which makes those instruments principally different from regulations. These measures can be called “carrots”.

- (c) **Information** – advocacy, motivation, exhortation, covers all attempts at influencing/convincing country programmes, governments and staff through the transfer of knowledge, the communication of reasoned arguments (negotiation) and persuasion. The information may concern the nature of the problem at hand and reasons why people should respond. However, no more than transfer of knowledge or persuasive reasoning is offered to influence people to do what UNICEF globally deems desirable. These measures are called “sermons”.

In brief, when a new policy is designed, headquarters can in principle instruct (use directives), pay (use subsidies, provide resources) or persuade (use information) vis-à-vis their country representatives to make them comply with policy. In the following, we will talk about these policy instruments in the broad categories of sticks, carrots and sermons.

The “Stick” is not Used as a Policy Instrument, or...?

An interesting question is why some organisations seem to favour some policy instruments and not others? From an effectiveness and efficiency point of view, the “stronger” instruments (directives and resources) should be favoured. In UNICEF policy instruments are selected on the basis of other criteria. Formally speaking, headquarters have limited powers to instruct Country Representatives (even Executive Directives recommend) about anything and instructions have a weak legitimacy in the organisation.

UNICEF is decentralised. Its Representatives (CRs) are responsible for negotiating with national governments the country strategy that will best achieve the overall goals and the Convention on the Rights of the Child. During our interviews with CRs, it became quite clear that they see themselves as first and foremost accountable to the children of the country they work in. Hence, the welfare of the children is their foremost concern. It seems that this approach is supported by the organisational culture and it cements a long history of decentralised operations. Headquarters and other levels in the organisation may help the CR and his or her team to achieve their targets in respect of children’s welfare, but it is quite clear who calls the tune.

The organisation has developed a programming practice, which is more guided by what works best than by a central edict. The Country Programme Note, which is supposed to guide the elaboration of a new CP, has its origins in the CO. It does not come to the CO from headquarters or regional offices. The CP is elaborated in the CO, and then it is screened through a process of peer review before going to the Board. But our interviews revealed that there were seldom any objections to the draft CPs suggested by the COs.

The broad goals and guidelines are there but not the binding operational strategies. We have also looked for directives in the organisation but we have not found any. There are no orders to make the Country Offices comply with policies. *We have not been able to document any attempt to force COs to intensify and expand their HIV/AIDS activities.* UNICEF tends to take a pragmatic, operational action oriented

approach to issues - more based on an assessment of needs and opportunities than overall policy and strategies.

This being said, there are of course some instructions that COs must follow. CF/AI/1988-002 contains administrative instructions called “UNICEF Guidelines for UNAIDS Collaboration. These provide guidelines on the use of funds and state that there will be a yearly report on the use of funds. The COs will have to produce that report. CF/EXD/1999-03 similarly compels the organisation to produce indicators for HIV prevalence, disaggregated by gender and age, and indicators for monitoring sexual behaviour. There was also a policy document dealing with division of labour between UNICEF and UNFPA in respect of condom promotion. However, as we have seen in Myanmar, the two organisations could find a practical way of collaborating, and UNICEF actually took over UNFPA’s role for a few years, when it was convenient to do so (for both organisations). The policy was applied pragmatically – meaning that it was broken when it was better for the programme to do so.

We have also heard that Regional Offices (ROs) may use “sticks” to ensure that COs comply with policies. The only example we have found is from ESAR. A new Director felt strongly that many COs did not respond fully to the HIV/AIDS epidemic. Indicators in respect of projects and programmes in HIV/AIDS were developed, and these were followed up during regional conferences. From around 1998, the ESAR thus put considerable pressure on the COs to make them expand HIV/AIDS programmes.

It would be naive to discount the importance of reputation and trust. A Representative who does not take the advice of senior managers may well find him or herself with very different career prospects than a loyal team member. Hence, the pressure that Regional Directors and Special Advisers and Section Chiefs can put on Country Representatives could still be considerable, even if there are no “sticks” in the formal sense. Similarly, sections of UNICEF organise thematic conferences, and invite Country Offices to send representatives. As we saw in Myanmar, participation usually involves the CO in project preparation. But we were not able to find out what would happen if such invitations were refused. Would that reflect negatively on the persons concerned? If there is a perceived risk, then an “invitation” to a conference may be more of a “stick” than the word suggests.

In sum, it is difficult to trace the use of the “stick” as a policy instrument. The few orders and directives that can be documented concern administrative formalities. They do not apply to the core of policy implementation, namely the volume of HIV/AIDS project activities, priority areas, or mode of operation. However, we cannot exclude that there are more subtle ways of instruction that cannot easily be refused - orders presented with a velvet glove. UNICEF has a strong organisational culture, which is what holds the decentralised operations together. In practice, it could be difficult to distinguish between a strong organisational culture that enforces policy, and orders that serve the same purpose.

Using Economic Policy Instruments – Who Controls the Purse?

The Executive Board document (E/ICEF/1992/L.11) says that HIV/AIDS activities should be intensified and expanded, but it does not say anything about where the

money should come from. It is possible to imagine several kinds of economic policy instruments (incentives, carrots) that could support the policy:

1. UNICEF could make money available for projects in the form of earmarked HIV/AIDS money, which could be controlled at regional or central levels, and which the COs could apply for;
2. UNICEF could earmark staff positions and make money available for HIV/AIDS focal points, or teams, in the COs, at regional offices, or at headquarters;
3. UNICEF could provide economic incentives in kind, for example technical support, earmarked consultancy funds, library and internet facilities specifically geared to HIV/AIDS programming work;
4. UNICEF could also centrally negotiate trust funds for HIV/AIDS projects;
5. UNICEF could assist the COs locate, negotiate and manage trust funds from bilateral donors or other organisations for project activities.

In theory, there are also financial disincentives that belong to this policy category - such as taxes, charges, tariffs on the behaviour - which one wants to discourage. But these would have little relevance for this discussion. UNICEF used all the different forms of “carrots” mentioned above.

There are two occasions on which financial resources have been provided globally. During 1993-95 HQ was managing Global HIV/AIDS. Seed money was given to pilot countries by HQ (up to 33 countries) to encourage their involvement in HIV/AIDS programming. The practice was discontinued and then resumed again through the Executive Board Decision of 1997 (E/ICEF/1997/18) making special and earmarked funds available for HIV/AIDS projects. The Board’s decision was to establish a “Set -Aside Fund” from Global (general) Resources *“available for programmes for the support of strategic acceleration opportunities for the programme priorities of the MTP, and for additional special needs”*, based on criteria which were defined in the decision. Although the general category of “programme priorities” and “additional special needs” may include more than HIV/AIDS projects, these could certainly also be covered by the fund. However, we have not been able to trace any impact of the fund at local levels. None of the projects in Thailand, Myanmar, Uganda or Zimbabwe were financed from the Set - Aside Fund.

Support from the Set - Aside Fund did not become available to the organisation until 1999 when the first 7% from the Global General resources were made available. A total of USD 21.4 million was made available and some 11% of this was provided to programmes, mainly in ESAR and South Asia, for accelerated measures against HIV/AIDS. 11% of 21.4 million USD amounts to USD 2.35 million, so it may not seem as that much of an acceleration, particularly not when dispersed over such wide regions. The “carrot” illustrated by the seed money available in the period 1993 to 1995 was more significant, not least because it was used together with other policy instruments - the TSG process.

The funds were used in three main areas; PMTCT of HIV, life-skills education and community level care of children orphaned due to AIDS. While the funds were thus used in line with the “policy system”, they were not used with the clear and strong focus on youth in the EB 1992 document. In conclusion, the total funds made available for HIV/AIDS projects to support the policy intents of 1992 were USD 2.35

million, decided by the Board in 1997 and allocated first in 1999. We may conclude that this policy instrument has not been used much. It has not lent any forceful support to the policy intention.

Looking at the Human Resources in the organisation, the situation has changed, and different regions, as well COs have different experiences. In Myanmar, the Human Resources in the CO expanded slowly but steadily throughout the period, and the expansion of personnel resources is closely correlated to the expansion of the programme. It takes working time and professional competence to intensify and expand HIV/AIDS projects. The resources in the COs were multiplied by eight between 1992 and 2001 as the office went from one part-time Programme Officer to a team that contributes four person years of work annually. The experience in Thailand was similar but reversed. The CO had professional staff and skills in the beginning and mid 1990s, but the HIV/AIDS focal point was cutback in 1998. The projects subsequently declined but are increasing again in 2001. UNICEF provided resources for a new post of a HIV/AIDS Programme Officer and this enables the CO to play a more substantial role in HIV/AIDS prevention.

Regrettably, we have not been able to find any global figures on staff competence and background. The cases of Thailand and Myanmar show the importance of having/making available staff resources to develop a programme. If there were no persons to develop projects at field level, the organisation would not be able to take advantage of the opportunities to use Set-Aside Funds, or to approach bilateral agencies for Trust Funds.

The EAPRO also illustrate the importance of staff competence and how resources have been deployed. A HIV/AIDS regional adviser has been part of the Health section in EAPRO since the early 1990s but until recently he or she worked alone. During 2000 and 2001 a team has been built up, which now consists of four persons, all with solid professional backgrounds in various aspects of HIV/AIDS work. EAPROs ability to support the local offices and to supervise regional projects has become much stronger.

Human resources could also be deployed at Headquarters or dispersed and kept together in the form of a network. The Health Promotion Unit in New York launched the Technical Support Group (TSG) in 1993 to support programming approaches. The objective was to operationalise a broad societal approach to the HIV/AIDS epidemic, to learn and document what works in what settings for broader dissemination of experience to UNICEF offices. The experience of the TSG process is documented in *“Strengthening programming through organisational learning”* (UNICEF, 1997) and *“Strengthening organisational learning through accelerated programming”* (UNICEF, 1999)

In conclusion, the TSG was launched in 1993, discontinued in 1995, evaluated in 1997 and the evaluation report published in 1999. The evaluation found that the TSG process identified and introduced innovations but was detached organisationally from country programmes and did not produce a coherent conceptual and programmatic framework. But it was found to create an extremely helpful atmosphere and identified opportunities for future co-operation, e.g. with WHO. Also, the short duration of the process received critique. Adequate implementation would need more time than two

years. As a policy instrument (it was a “carrot”) it did provide incentives for COs. But it was of short duration and the total resources used for the TSG network were rather small.

Let us finally analyse whether UNICEF Regional Offices and Headquarters have supported COs to get access to supplementary funding. The Country Programme in Myanmar allocates a small share of General Resources to the HIV/AIDS activities. The major part of these is financed by supplementary funds (Australia, Japan and Netherlands, Rockefeller Foundation, etc.). The Mekong regional project is the organising framework. The practical work in fund raising for the project, in monitoring and evaluation, reporting to the donors is done in co-operation and with a division of labour between the CO and EAPRO. We cannot be sure but it does seem unlikely that the CO – with due respect for the considerable resources available there – would have been able to identify, establish contacts with and raise funds from so many sources. The isolation of Myanmar, the lack of funding agencies in Yangon alone makes this implausible.

The situation in Thailand is different. A major share of the HIV/AIDS activities in the CO is also included in the Mekong regional project and hence the supportive capacity of the EAPRO would have been determinant for these activities. A large part of the remaining funds are mobilised on the domestic scene and here we would not expect that the EAPRO has any major role. In sum, our interviews and field visits indicate that the Regional Offices have had a role to play in assisting the COs get access to supplementary funds. But it is also clear that in many countries, it is actually the CR and his or her team who must mobilise funds as best as they can.

As a policy instrument, this particular aspect of “carrots” has been used, but only partly, and late. In the beginning of the decade, the technical support provided by the TSG was important but lasted between 1993 and 1995. It is only in the year 2000 (as documented in our country case studies) that Headquarters have responded positively to COs call for funding of HIV/AIDS focal points and recruitments to the regional offices are also recent. During the first seven years following the EB recommendation to intensify and expand activities no specific funds were made available either and the amounts allocated from 1999 were small. The most significant aspect of the “carrot” as a policy instrument lies in the organisational support to the COs to obtain supplementary funding and this may have been crucial to the intensified and expanded programme we saw in Myanmar.

Headquarter policies could also be counterproductive (from the HIV/AIDS activities’ point of view). In 2000 UNICEF launched a strong campaign at the board level to persuade funding agencies to raise their contributions to the organisations General Resources rather than to provide funds in trust for specific favoured projects. Many responded positively, among them the Netherlands. However, the Dutch government thus cut back its financing of the Mekong regional project and added the amount to its General Resource Contribution. However, the funds did not trickle back to the Mekong project, hence that suffered a severe set back.

Sermons as Policy Instruments - Does Anybody Listen!?

Table 3.1 gives a preliminary overview of the efforts to communicate policy and to persuade the organisations and its stakeholders about the priority of HIV/AIDS

activities. The starting point of the analysis was to make a simple count of the number of documents on HIV/AIDS in each year. The first row presents the result. It is a very simple measure. It says nothing about the information content, the volume of the communications, or whether there is an audience. However, in all its simplicity, it suggests that the use of this policy instrument started at a low level, increased to a high in 1995, came to a full stop in 1996 and then gradually increased again.

Our source of information is the database and subsequent report by Annette Reinisch, which we have used in other parts of this study. The question is if it contains all information or whether there is some bias. It is surprising that the quantity of publications has dropped in recent years. Perhaps the explanation lies in the growth of the Intranet. Communication in this channel could be a substitute for other forms of publication. There is no doubt that the web pages of 2001 convey a strong message about the priority of HIV/AIDS. However, we have not been able to compare the message here to that of previous years.

However, it is not only the amount of documents that matter, but also the quantity. Some of the documents can be quite thin and not so significant. Others are substantial. We have summarised the quantity in the second row in table 3.2. 1999 saw the most frequent publishing efforts, when some 1,250 pages of text on HIV/AIDS issues were published and disseminated in the organisation. We should mention that this only relates to publications where UNICEF stands as one of the co-authors. There are, of course, publications from other sources but they are not counted here.

Table 3.2. Text on HIV/AIDS in the EES database between 1990 and 2000

	90	91	92	93	94	95	96	97	98	99	00*
Number of documents on HIV/AIDS	3	4	6	12	13	15	6	11	9	16	9
Quantity of text (number of pages)	180	90	210	480	880	970	210	720	430	1,250	540
Text in "Progress of Nations"				Major	Major	Major	Minor	Minor	Minor	Major	Major
Texts in Annual Reports	Minor	Minor	Major	Major	Major	Major	Minor	Minor	Minor	Major	Major
Significant studies	1	1		2	1	1		1		3	1
Workshops, meetings and conferences	1			8	6	6	1	2	3	4	-
Rank order*	1	4	5	8	10	8	1	6	3	11	7

Note: The rank order is built on a compilation of the rank of each year, in respect of each row. For example, there were most documents in 1999, hence that year was assigned rank 11 that year; 1995 was assigned rank 10 and so on. The same procedure was repeated in respect of each row. The ranks were then added, and reduced to a single scale. The rank order in the last row shows that there were most efforts to persuade the organisation through these various means of communication in 1999, second most in 1995 and so on, and least in 1990 and 1996.

* The database was built in 2000, hence not all documents may have been delivered in time to be included. Documents ready by the end of the year would not be found in the database. The real numbers are probably larger than indicated here.

UNICEF's Annual Report could also be analysed in respect of how much and what it says about HIV/AIDS. The Annual Report of 1995 contains more than two full pages

of text about AIDS and Children (pp. 43 and 44). There is a rapid assessment of the situation followed by some examples of UNICEF projects. The emphasis is on mass communication and social mobilisation and on efforts to reach youth and there are case studies of projects in several countries.

The Annual Report of 1997 contains less than one third of a page on HIV/AIDS (page 15) and the information provided is very thin. The text notes that UNICEF works with WHO and UNFPA and the text refers to two projects in West Africa. The treatment does not in any way suggest that this could be a priority area of the organisation. The Annual Report of 1999 has increased the level of attention to HIV/AIDS and refers to activities on several pages; in connection to "Helping Children Learn" (p. 11), "Protection from Armed Conflict" (p. 13) and "Children and Women in Need of Special Protection" (pp. 14 and 15). We must emphasise that the review is selective, and that messages may come across differently to different audiences. It would not necessarily have a greater impact if the same messages were repeated every year. But it is also striking that the quantity of text in the Annual Reports falls into the same pattern - a gradual increase in the first half of the 1990s - a decrease in the latter half, followed by an upward turn at the very end of the decade.

We have presented the activities of the Technical Support groups (TSG) above and we will return to them later when we discuss policy results. We classified the TSGs as an example of the policy instruments that create incentives by providing resources to the organisation. However, we can also look at the concrete activities of the TSGs. What they did was often to convey information, to negotiate and persuade the organisation to develop HIV/AIDS projects. In that sense, this was also a policy instrument, which was developed and used in the period 1993 to 1995 and then abandoned. Meetings, conferences and workshops are occasions to inform about the HIV/AIDS policy. The meetings listed in row 5 of table 3.1 were often convened by the TSGs. We cannot be sure that we captured all meetings. In all likelihood we have underestimated the numbers greatly. However, we have listed meetings that were documented, and even if incomplete, they show a trend; a peak of activities in 1993 to 1995, followed by a decrease and later a revival of activities.

During our country studies, we were told that the communications at different regional meetings and workshops, where researchers were invited to speak about HIV/AIDS, was a strong reinforcement and one of the things that triggered action. Regrettably, we have not been able to gather data on such meetings. Otherwise, it would have been interesting to see whether the exposure of staff to research in this field changed over the years. However, several of the interview respondents pointed to the importance of conferences as an instrument to convey policies.

A review such as ours tends to be quantitatively oriented. Still everybody knows that some studies, papers, or reports have a much larger impact than others. In row 5 we have listed significant studies. These are studies that were widely quoted, and which are still often seen in the organisation. They have in common a sound and comprehensive situation analysis, which breaks new ground, analysis of issues and often ideas and visions of action. Among these "significant reports" we have included:

- Children and Aids – An Impending Calamity (1990)
- AIDS and Orphans in Africa (1991)
- Action for Children Affected by AIDS
- Children and Families Affected by HIV/AIDS (1995)

Studies such as these often require several years of preparation, ample time to conduct fieldwork and time for publication. From beginning to end, we may speak of two to three years. The production reflected in the columns indicates that 1995 to 1997 were years of little activity in this respect and thus confirms the overall pattern.

However, we may risk not seeing alternative patterns of communication, in particular the new modes of technologies (web pages, newsgroups, chat-sites, etc.). As an example, the page "Information Newline" under UNICEF's web page contained a call for "war of liberation" against HIV/AIDS in July 2000, in a series of very strong linked pages. This also linked to the Progress of Nations 2000 report, which also devoted unusually much attention to HIV/AIDS issues that year. The Progress of Nations report could also be used as an indicator of the attention given to HIV/AIDS. Whereas it has been an issue raised in the report throughout the decade, the intensity of the message has varied. However, we do not want to deduct any ideas about priorities based on that, as other concerns in corporate communication must influence the choice of messages. However, an overview suggests that more text, and a more urgent appeal on the subject is found in the reports of 1993, 1994 and 1995, to be followed by a more general treatment of HIV/AIDS in the subsequent years. Towards the end of the decade, and in 2000 and 2001, there is new urgency in the communication.

In sum, there is ample evidence that "sermons" have been a common and prevalent policy instrument. We have only captured a small part of the instrument here, as we cannot have a complete overview of UNICEF publications, meetings, workshops and conferences. Furthermore, the organisation uses other publications than those produced internally, hence the "sermons" can be based on UNAIDS, WHO, World Bank, or other publications. There are many sources of information on the HIV/AIDS epidemic that could be used to persuade staff members of the need to take action. We can also see that the policy instrument has been applied differently over the years. It was used more frequently in the beginning and middle of the decade, less frequently for some years thereafter and more frequently at the end of the decade.

3.2. Balancing Policy instruments

In conclusion, our review suggests that UNICEF primarily used "sermons" (information, negotiation and persuasion) to introduce and promote the accelerated HIV/AIDS response. "Carrots" (human and financial resources) were to some extent also available, but HIV/AIDS did not generate substantial extra budgetary resources to UNICEF. Executive Directives and programme guidelines have also been issued, but played more the role of legitimising and supporting directions and actions already agreed to in meetings and workshops. Table 3.3 summarises the discussion above on how the policy instruments have been used over time.

Table 3.3 Prevalence of the different policy instruments

	Sticks (regulation)	Carrots (resources)	Sermons (rhetoric, information)
1991	Low	Low	Medium
1992	Low	Low	Medium
1993	Medium	Medium	Medium
1994	Medium	Medium	High
1995	Medium	Medium	High
1996	Low	Low	Low
1997	Low	Low	Medium
1998	Low	Low	High
1999	Medium	Medium	High
2000	Medium	Medium	High

The table should be read as a qualitative summary of the previous discussion. It is not presented as an accurate quantitative measure of the use of policy instruments. The subject is too complex to be analysed like that. The table can be used to emphasise some conclusions about policy.

First, the most frequent policy instrument was "sermons" - that is, rhetoric, communication, information, persuasion. Neither regulation nor resources were used nearly as intensively as this category of policy instruments.

Second, the use of policy instruments has changed over time. In total, the organisation was subjected to policy instruments that "pushed" HIV/AIDS issues in two periods; the beginning and mid 1990s and final years of the decade. In between, there were distinctly fewer efforts to apply policy instruments. Note that the policies remained the same, there were just fewer efforts made to bring the intents to practice.

Third, it is worth remembering that all policy instruments were applied at all times, even if in different degrees. Also, the concepts are overlapping. Activities such as the TSG groups could be seen as resources for HIV/AIDS work, but their outputs are sermons. The subtle pressure they exercised could be interpreted as directives. On some occasions; the sticks, carrots and sermons are actually mixed in one and the same channel of communication.

The question is: *would the organisation have been better served by another mix of policy instruments?* An interesting empirical question is if the differences in application of the policy instruments also show in the HIV/AIDS activities? Is there a striking slow down in HIV/AIDS project implementation following the reduced efforts to apply policies? We will now turn to a review of the organisational response before those issues are discussed.

3.3. Organisational Response

Let us first look at the overall history and context of the organisational response to the epidemic. Working within the framework of the WHO/GPA Global AIDS strategy, UNICEF was active in the support of HIV/AIDS prevention and care activities from the mid-1980s. The first UNICEF AIDS prevention education project was started in 1986 in Uganda. A UNICEF AIDS Task force was established mid-1987 and a full-

time project officer was appointed in November 1987 to work with AIDS policy and programme development.

In 1987, a report was presented to the Executive Board expressing concern about the epidemic and the need to ensure appropriate sterilisation of all equipment used in immunisation programmes. The Executive Board encouraged greater involvement of UNICEF in combating AIDS, but expressed also caution about the potential diversion of resources from other child health interventions.

UNICEF's commitment to act on HIV/AIDS was first declared by the Executive Board in its 1988 "Review of the impact of immunodeficiency syndrome on women and children and the UNICEF response (E/ICEF/1988/L.7). It was followed later that year by a "Progress report on UNICEF activities in 1988" and a series of Executive Board decisions (1988/7, 1990/18 and 1991/23) which endorsed the Executive Directors' recommendation that UNICEF expand its programme efforts to combat HIV/AIDS particularly among women and children.

New data from regions outside Africa, particularly in Asia, made it clear that the rapid expansion in the developing world was not confined to Africa. The Executive Board approved a global interregional fund for the period 1990-92 to accelerate programme design and initiate activities in those countries where the impact of the epidemic was likely to be greatest (E/ICEF/1993/L.10). In addition to interregional programme funds, country resources were used to expand UNICEF participation in HIV/AIDS programming in an increasing number of countries (E/ICEF/1993/L.10).

But the 1992 strategy document (E/ICEF/1992/L.11) prepared the ground for rapid and substantial acceleration of new operational strategies focusing on young people's health and development, communication and social mobilisation. This approach is described in the UNICEF publication: "The Second Decade – A Focus on Youth and Development". The new approach was built on several lessons from the first decade promoted strongly through the TSG process and by key actors in the Health Promotion Unit:

- that the major impact of the AIDS epidemic will be on women, youth and children, especially young women and girls,
- no single intervention is sufficient in itself to contain the epidemic – an insight leading up to a multi-sectoral approach in programme planning,
- the low level of available support was insufficient to substantially slow the epidemic,
- improved co-ordination is a key to future success (E/ICEF/1993/L.10).

It seems that UNICEF lost its momentum in the area of HIV/AIDS at global level in the mid '90s. The organisation went through an important transition and several changes happened at the same time. There was a change of Executive Director, the Health Promotion Unit (with a high HIV/AIDS profile) disappeared as a separate unit, several key staff members left UNICEF, the Health Section experienced a succession of people in key positions. Also in 1996 UNICEF became one of the six founding co-sponsoring organisations of UNAIDS which also absorbed former UNICEF staff.

In parallel HIV/AIDS became increasingly a concern in countries seriously affected by the epidemic. Funding to HIV/AIDS projects multiplied but the awareness, motivation and growth was uneven across regions and countries. The response was more driven by the diversity of country needs and the interest of Country Representatives than a global policy saying that HIV/AIDS is a corporate priority.

The active support and follow up from UNICEF HQ was also weakened with the lack of a global focal point. In the “Medium-term plan for the period 1998-2000” (E/ICEF/1998/13) and the “1998-2000 Programme Priorities” (CF/PRO/1998-003) HIV/AIDS did not appear as an explicit programme priority but as a sub-objective of concern for a group of countries⁵.

It is also interesting to observe that the Programme Directive from 1998 presents improving young people’s health and development as an “emerging priority area” – which seems to imply that it had not been a priority so far. This may represent loss of institutional memory. A strong youth focus was implied in key Board documents from the first half of the nineties and also underlying the TSG process. In a report to the Executive Board in 1993 (E/ICEF/1993/L.10) it is for instance stated firmly that “*the UNICEF response to HIV/AIDS is youth-focused, recognising that two thirds of HIV/AIDS infections occur in young people under 25 years of age. The Convention on the Rights of the Child and the Convention of All Forms of Discrimination Against Women provide a powerful and compelling framework for the societal action required to alter the underlying conditions which foster the spread of HIV and respond to those families already affected by AIDS*”.

Reviewing HQ documents, an impression is created that UNICEF for a period forgot its broad societal and youth oriented approach and focused on more targeted child interventions. Whether such a change was also reflected in funding priorities at country level can only be documented through in depth country studies. The central financial monitoring systems do not allow tracking such changes.

With the escalation of the epidemic in Eastern and Southern Africa and the visible human suffering and deaths - also among UNICEF's own staff - HIV/AIDS became the top programme priority in the region together with malaria from the late nineties. The need for a change in priorities emerged in pressures from below and within the epidemic itself. UNICEF had no choice but to make HIV/AIDS a top priority.

During the last two to three years international conferences, UN and bilateral agencies - and not least mass media - has increasingly focused on HIV/AIDS as a global threat. UNICEF's Executive Director has spoken at international conferences on how the epidemic is undermining the survival and development of children. Increasing financial resources are available for AIDS projects from bilateral donors and Foundations. There is a sense in UNICEF HQ of not doing enough and not doing it well. There is a felt need for accelerating and expanding the organisation's response to the epidemic. A new HIV/AIDS Unit is established. A senior staff member is asked to lead the initiative. It is suggested to start a new TSG process - almost ten years after

⁵ To reduce the impact of AIDS on children in most affected countries was mentioned under “Reduction of Exploitation, Abuse and Harm of Children” in CF/PD/PRO/1998-003. HIV/AIDS is mentioned and implied in the Medium term plan, but it is not presented as a major priority.

the last one - to motivate and educate, to renew alliances with technical partners, be innovative in terms of programme development - and do more - rapidly and broadly.

So overall there is recognition in UNICEF that HIV/AIDS is undermining the child survival and development gains of the past decades. To respond to these threats, UNICEF's new Medium Term Strategic Plan 2002-2005 (draft) focuses attention on five organisational priorities. One is the combat of HIV and AIDS but the others are also reducing vulnerability and risk to HIV infection and to strengthening capacities to ensure protection, care and support for children and families living with HIV and AIDS (UNAIDS 2001, Summary of UN System Organisation Plans).

This is an uncompleted and biased version of how the UNICEF response evolved in the nineties. Important nuances are lost, but an important topic for this policy evaluation is illustrated: UNICEF is responsive. But UNICEF could also be seen as reactive - changing priorities when they have to - when HIV/AIDS is a hot topic in media and international conferences. But it responds when needs emerge from countries affected. The organisation is also flexible - it is able to adjust and adapt its priorities when needed.

3.4. Concluding Remarks

It is now time to conclude examination of policy implementation. *What is the role of policy?* One possible interpretation is that policy development plays a marginal role. It serves mainly to systematise and legitimise existing principles and practices and communicate those to the organisation, which may listen or ignore the messages. But it is also possible to interpret the history of the '90s as though policy sets direction - includes and excludes programme priorities and represents a binding priority for all parts of the organisation.

Where is UNICEF on this continuum which is the most correct interpretation of events? The 1992 policy was broad, but it had a vision and also a direction. Through the TSG process UNICEF sought to carve out a mandate for the organisation and to some extent it did. But the "pressure from below" has been much stronger than formal policies in shaping the level and forms of programming. UNICEF is not a "policy driven" organisation in the sense that HQ directives are automatically translated into practice. It is more of a "field or needs driven" organisation with strong Country Representatives knowing and respecting the formal and informal "rules of the game" - which means that HQ Directives are not unimportant. It should also be added that UNICEF is more than driven from below. Mass media, the international agenda and funding opportunities have its impact on programme priorities.

Whether UNICEF has found the right balance between "policy and pragmatism" is another question including to what extent UNICEF should be more policy driven in the future? There are pros and cons. A stronger policy focus may facilitate a more consistent and coherent response across the organisation but may not be an effective approach for motivating and involving countries for rapid expansion and new learning. A weak policy may not convince the non-believers, not affect the allocation of financial resources and create an image of an organisation without identity and sufficient resilience. To find the right balance represents the art of management - informed by an analysis of what are the most burning needs of the organisation.

Even though UNICEF has responded to the HIV/AIDS epidemic, the response has varied over the organisation. Does this represent lost opportunities? Would it have been better if the organisation had intensified and expanded its activities to prevent HIV/AIDS transmission (in line with Executive Board recommendations)? If the answer to that question is "Yes", then it is necessary to revisit the discussion of policy instruments. Several issues could be raised in order to apply policy instruments more forcefully and effectively.

First, it would be desirable to develop a coherent management approach to the choice of policy instruments, to make sure that sticks, carrots and sermons are used in a balanced way, supplement each other and reinforce the organisation's response to the policy intent.

Second, much as it is easy to call for a coherent approach to policy instruments, practice is more difficult. It is generally believed that sticks and carrots are more effective policy instruments, but we would not lend support to that in an organisation such as UNICEF. Sticks and carrots are more centralised management tools and the cost of centralisation may be high. There is a need to generate knowledge on which instruments that work best, in which situations.

Third, it would also be appropriate to develop knowledge on how to mix policy instruments for optimal persuasion and effect. The period between 1993 and 1995 would be useful to study as we saw a more fully developed use of policy instruments at that time. The application of policy instruments was high again in 1999 and 2000, but the question is if this is more accidental than planned.

Fourth, the sermons were the favoured policy instruments and maybe there are reasons to believe they are the most appropriate instruments for UNICEF. Is it possible to improve the efficiency of sermons as policy instruments, given that they seem to be preferred, and better in harmony with decentralised modes of operation? We cannot answer that question here but propose it to inspire future efforts to improve the policy process.

4. POLICY RESULTS

This chapter looks for *results of policy formulation and implementation*. As discussed in the introduction, there is no direct causal relationship between policy and results - a broad range of factors determine outcomes and impact. On the other hand, a policy without results is not of much value. Findings are based on information collected at UNICEF HQ and four country offices and may not be valid for all Country Offices nor provide a complete picture of UNICEF globally.

4.1. An Intensified and Expanded Approach

The first critical question is to what extent UNICEF managed to intensify and expand its approach to HIV/AIDS during the nineties? Did UNICEF increase its political and financial commitment at global and country level? Is it possible to observe an expansion in quality and quantity - in depth and breadth?

Our main findings are:

- **There is currently strong political commitment and support from UNICEF leadership to HIV/AIDS but the commitment was uneven during the nineties. HIV/AIDS has only recently (from about 1999) become a top priority for the organisation but not yet matched with human and financial resources.**

Globally, the TSG process contributed to raise awareness, commitment and knowledge about HIV/AIDS between 1993 and 1996 in a large group of countries and among UNICEF's partners. The process was skilfully driven by a small group of staff with top-level support and could document significant results. The TSG process did not involve the entire organisation and was not sufficiently followed up by other networking mechanisms.

With a heavy turn over among key technical staff, internal reorganisation of the Health Section and change in top management of UNICEF, the focus on HIV/AIDS and in particular youth lost some of its momentum around 1996/1997. With the rapidly escalating impact of the epidemic in UNICEF programme countries and the increased global political awareness, HIV/AIDS has become a UNICEF programme priority at global and country levels. The Executive Director speaks at major international meetings and events, advocating for increased attention and activities to combat HIV/AIDS. Regional Offices are taking a more active role and new Country Programmes have a strong HIV/AIDS profile.

- **The expansion of UNICEF's response was weakly supported by human and organisational resources during the nineties. Few staff worked full time on HIV/AIDS at all levels and it is just recently (from 1999) that a separate HIV/AIDS Unit was established at a global level to co-ordinate and support the work.**

Historically, HIV/AIDS related activities were housed within the Health Section. In 1992, the Health Promotion Unit was formed and drove the TSG process. This Unit remained in the Health Section until 1995 when staff was mainstreamed into technical sections, such as health, education, child protection, gender and partnership, etc.

There was a frequent succession of global focal points for HIV/AIDS. In 1999, the post of Principle Adviser HIV/AIDS was created and located in the Programme Director's Office. This post was filled late 2000 and all HIV/AIDS activities are supposed to be co-ordinated under in the new Unit.

Number of full and part time staff working on HIV/AIDS has recently started to increase. Each Regional Office (7) should have a Regional HIV/AIDS Adviser and additional advisers are being recruited to provide technical support to country programmes. UNICEF HQ could not provide a complete up dated list of personnel working on HIV/AIDS but the recruitment process is said to be delayed and uneven. The inter-sectoral nature of programming is often reflected in the UNICEF job descriptions and HIV/AIDS is not necessarily referred to in the title. Staff devoted to HIV/AIDS activities include Health Officers, Child Protection Officers, Communication Officers, Education Officers, etc.

The situation in Country Offices has followed a different pattern. The CO in Zimbabwe used to have a strong HIV/AIDS Section but the responsibility for HIV/AIDS was mainstreamed and became less visible from 1998. The CO in Uganda maintains a strong HIV/AIDS support section - in particular in MTCT. The CO in Bangkok had a strong HIV/AIDS focal point in the early and mid 1990s but the post was abolished in 1998. It has recently been re-established. The CO in Myanmar has increased its personnel resources for HIV/AIDS throughout the 1990s, and now has a strong team. There are also processes and structures for cross-sectoral work.

- **There is a lack of systematic financial data on programme expenditure in UNICEF but available information shows that the organisation increased slowly and modestly its global allocation to HIV/AIDS programmes during the nineties. HIV/AIDS did not become a major programme priority for the organisation in terms of funding from regular resources. This is now changing. HIV/AIDS is emerging as a corporate priority for UNICEF.**

A major constraint in the assessment of expansion is the lack of systematic financial data on global, regional and country level expenditure. There is no easy way to document whether there has been an increase or not – and the level of expansion.

Global expenditure

The current coding system does not capture all HIV/AIDS activities (the H 11 code)⁶. The same codes are also used differently. The H 11 code is, for instance, not used at the country level which leads to major underestimation of expenditure. HIV/AIDS is also a component of education and health projects and the relative expenditure on HIV/AIDS is not measured and coded. There is currently no reliable method to measure the aggregate level and flow of financial resources to HIV/AIDS but it is possible to make informed estimates.

A global effort to measure overall level and flow of national and international resources to HIV/AIDS for 1996-97 (Harvard School of Public Health 1999) concludes that UN agency spending on HIV/AIDS is difficult to monitor primarily

⁶ A new coding system is prepared which is more sophisticated, but may also face problems in aggregating financial expenditure in a programme area like HIV/AIDS.

due to the lack of a central monitoring system of country budgets and expenditure. The agencies are also increasingly funding integrated activities in which HIV/AIDS are difficult to track.

UNICEF began its first HIV/AIDS project in 1986 in Uganda. In 1990 the Executive Board approved a global HIV/AIDS inter-regional programme, with supplementary resources for modest, but flexible funding of country programmes. UNICEF support gained more momentum from 1991/92. In addition to inter-regional funds, country programme resources were used to expand HIV/AIDS programming in an increasing number of countries. Most of the funds came directly from bilateral agencies as a result of successful fundraising in countries and not from UNICEF's regular budget.

The years from 1992 to 1995 saw an increase in the number of UNICEF supported programmes in the funding of these activities and in the amount of staff and staff-time devoted to HIV/AIDS. By 1996 most country offices had programme activities focusing on HIV/AIDS – even if we do not know exactly how many and how much. Through 1996 and 1997, it is our impression that the expansion slowed down and actually reversed in some countries (e.g. Thailand and Zimbabwe).

There is a dearth of information about financial expenditure but some estimates are available. GAO (Joint UN Programme on HIV/AIDS 2001) presents the following figures⁷:

Levels	Total Estimated	
	1996-2000	2001-2005
Global	\$ 12 million	\$ 42 million
Regional/inter country	\$ 21 million	\$ 78 million
Country	\$ 131 million	\$ 480 million
TOTAL	\$ 164 million	\$ 600 million

With such estimates, average annual expenditure during 1996 to 2000 becomes approximately \$ 32 million. The Harvard Study (1999) estimated that UNICEF spent a total of \$ 3.5 million in 1996 and \$ 6.7 million in 1997. These figures are based on general resources and supplementary funding for global, regional and country-level activities for HIV/AIDS specific activities only. Hence, the actual expenditure for all HIV/AIDS related work in multi-sectoral programmes are much higher.

In response to the GAO report UNICEF HQ has tried to estimate past expenditure based on two methods:

- taking a percentage of total UNICEF expenditures in related areas (per cent of health, education, child protection, etc.)
- compiling and validating estimates through discussions with Regional Advisers.

The following figures represents 4.3% of total programme expenditure in UNICEF and 3.7% of total global expenditure.

⁷ Source of information and methods used to prepare the estimates are not described in the report.

	4.3% of programme expenditure (US \$)	3.7% of global expenditure (US \$)
1996	29 million	31 million
1997	28.9 million	30.4 million
Sub total	57.9 million	61.4 million
1998	27.7 million	29 million
1999	35 million	36 million
Sub total	62.7 million	65 million
2000	37.6 million ⁸	

These figures assume an equal percentage each year, but the expenditures have most likely increased and the percentage was lower in 1996.

At any rate, the figures indicate an increase in expenditure over time but not a rapid and dramatic increase (30% between 1996 and 2000). Expenditure on HIV/AIDS, as compared to total UNICEF spending, is also relatively low. HIV/AIDS did not become a global priority during this period. In 1999, UNICEF expenditure on education was \$ 120 million or 12.4% of global expenditure and 14.7% of programme expenditure. If we had used health as an example, the differences would have been much higher. If HIV/AIDS is to become a global priority, spending should increase to about 10% of global expenditure, which will give the following projections:

	2001	2002	2003	2004	2005
Projected budget adjusted for gradual increase	80 million	105 million	130 million	140 million	150 million

Country level data

[Country level data are based on information from four countries only and taken mainly from Annual Reports and checked during country visits.]

In Zimbabwe, almost 25% of the country frame was spent on HIV/AIDS from 1992 to 1996 - 80% from supplementary funds. From 1997 the level of funding dropped significantly mainly due to new strategies and loss of bilateral support. The low level of support from regular resources has reduced the chances of sustaining core UNICEF programmes. In Uganda, an expansion in terms of financial expenditure has most likely taken place but there is no data to verify pattern of expenditure.

In Myanmar, the share of HIV/AIDS activities has differed from one year to another, from a high of 17% in 1996, to a low of 4% in 2000. However, these annual changes in expenditure level do not reflect differences in commitment. They are due to vagaries and bottlenecks in implementation. Over a longer period of time, there has been a steady increase in expenditures on HIV/AIDS, reaching a high level of USD 1.3 million in 2001.

The programme in Thailand was at its most expansive in the beginning and mid 1990s, but since around 1996, it has been difficult to secure supplementary funds (bilateral donors do not see Thailand as a priority country for bilateral assistance). The amount of regular resources going to HIV/AIDS has always been low, and has not

⁸ Estimate based on discussion with regional advisers.

changed much. In recent years, the overall share of CO resources going to HIV/AIDS activities has increased. The CO has mobilised funds in Thailand and these are put to use for HIV/AIDS activities. At the same time, the overall level of funding has gone down, and hence the relative share of HIV/AIDS has increased quite drastically, even if the overall level is quite low compared to previous periods.

- **The expansion of the response has been geographically uneven and concentrated in a few countries and regions – mainly in Eastern and Southern Africa and some countries in Asia and Latin America. In those countries UNICEF was one of the first and became one of the most significant international donors to HIV/AIDS. The epidemic became “a priority among priorities” for UNICEF in Eastern and Southern Africa from 1999.**

The response was strongest in East and Southern Africa and South East Asia but weaker and to some extent much weaker in South Asia, West- and Central Africa, Central and Eastern Europe, the Caribbean and Latin America (UN System Strategic Plan). It is not wrong that the response varied and was strongest in the worst hit countries. On the other hand, UNICEF’s HIV/AIDS policy was meant to be a policy for the entire organisation - also for countries denying the epidemic or in need of early prevention. The policy instruments (see chapter 3) were too weak in order to introduce and implement a flexible but consistent and systematic response to HIV/AIDS across countries.

There is no doubt that Africa has received most resources and for instance Tanzania, Uganda and Zimbabwe were shown to be the largest single recipients of funding (Harvard School of Public Health 1999). UNICEF HQ has prepared the following estimates for expenditure on HIV/AIDS in 2000⁹:

Region	Expenditure 2000	% of Expenditure
CEE/CIS	1 million	3 %
EAPRO	5 million	13%
ROSA	1 million	3 %
MENA	0.2 million	1 %
ESARO	20 million	53 %
WCARO	4.5 million	12%
TACRO	2 million	5%
HQ	3.9 million	10 %
TOTAL	37.6 million	

The figures are not exact but show a trend: Eastern and Southern Africa is a clear winner while most of the other regions have relatively small expenditures. HIV/AIDS has become a major concern for UNICEF in those countries and regions where the epidemic has hit hardest. In those countries, UNICEF was one of the first and became one of the most significant international donors to HIV/AIDS.

⁹ Data collected as part of preparing the United Budget and Work plan (UBW) with UNAIDS.

Documents available indicate the following regional patterns:

Eastern and Southern Africa

The ESAR Regional Management Team decided to make HIV/AIDS one of the two top programme priorities beginning in 1999 (ESARO Regional Office Management Plan). HIV/AIDS was defined as “the single most important impediment to the fulfilment of children’s and women’s rights” (ESARO Regional Analysis Report 1999).

The HIV/AIDS programmes in all countries were given a boost when the RMT’s regional working group on HIV/AIDS established a five-point strategy that helped focus programme support:

- Breaking the silence that surrounds HIV infection and AIDS and reducing the stigma.
- Preventing HIV/AIDS infection among young people.
- Preventing HIV transmission from mother to child.
- Care and support for children orphaned by AIDS.
- Care and support for infected and affected children and women.

West and Central Africa

The impact of the epidemic remains less than in the Eastern and Southern Africa Region. There is a UNICEF strategy from 1999, but the UNICEF response has been constrained by weak political commitment and a lack of understanding of the need for a multi-sectoral approach.

East Asia and Pacific

The HIV/AIDS epidemic reached Thailand early and spread rapidly. But a quick and effective response from the government slowed down the transmission rate, and this is often quoted as one of the success stories in combating the epidemic. However, there are still severe effects of the disease in Thailand, and the transmission continues even if at a relatively low level. In many neighbouring countries, it is approaching epidemic proportions, such as in Myanmar, Vietnam, Cambodia, Laos and China. Because of the size of the population in many of the countries in the region, it is a major concern. The regional strategy gives a high priority to HIV/AIDS programmes and the EAPRO has recently been strengthened to a team of four programme officers (including the regional adviser).

Middle East

The epidemic has so far been slow, but shows an accelerating pattern. UNICEF priorities reflect the reality of the region – where so far the response of the governments and other regional bodies has been weak and sometimes inappropriate.

South Asia

The epidemic in this region has been and is diverse, localised and shown different trends over time. HIV/AIDS is a new programming area for UNICEF (Regional Position Paper 2001). UNICEF’s contribution to HIV/AIDS prevention has so far been limited. There was scarce mention of HIV/AIDS related prevention activities in Annual Reports for the year 2000. Country programme activities have mainly been ad hoc.

There is still lack of commitment from country representatives, limited understanding of the impact of AIDS on child survival and development, limited technical capacity in the country offices and limited or non-availability of resources (Regional Position Paper).

CEE/CIS & Baltics

Of the 27 countries in the region, HIV/AIDS strategic planning processes have been completed in seven countries and are underway in thirteen. UNICEF has been actively engaged in a region-wide strategy development process with UNAIDS co-sponsors and other partners. It is said that UNICEF still lacks technical expertise in many of the relevant intervention areas and lack of consensus on how to prioritise resources.

4.2. Achievements and Innovations

What were major achievements at policy and programme level in the nineties? A detailed programme evaluation has not been carried out and the following findings emerge from a review of documents and four country case studies. One of the objectives of the TSG process was to identify international best practices and introduce those practices in country programmes. UNICEF needed a new body of knowledge for global policy and strategy development and ideas as well as approaches for country level programming.

The cross fertilisation of ideas among COs was found effective. The evaluation concluded that the TSG process identified and introduced, but did not generate or replicate innovations as successfully (Strengthening Organisational Learning 1999, p.59). This means simply that the TSG did not invent a new body of knowledge that did not exist before. But a mechanism was created to identify such knowledge, adopt and internalise it as UNICEF “property” and channel new ideas to countries where they did not exist before.

At the policy level the most important achievements are:

- I. **UNICEF introduced and supported at an early stage a broad societal, multi-sectoral and behavioural approach to the prevention of HIV/AIDS. HIV/AIDS was taken out of the medical field and the health sector and defined as a broad health and development issue.**

Today this sounds rather obvious, but represented a sort of paradigmatic shift in the early nineties for UNICEF staff with mainly a health orientation to HIV/AIDS. In a period where the Global Programme on AIDS (GPA) was the dominant player on the international scene the shift in policy was a major achievement.

- II. **UNICEF prepared the ground for a stronger focus on HIV/AIDS in the context of adolescent health and young people. Since the epidemic hit young people stronger than small children, a new target group with its own concerns and problems was introduced to the organisation.**

Adolescent health became a major concern in the early nineties. The close personal links¹⁰ between UNICEF and WHO in the area of adolescent health contributed to shape the agenda and raise the awareness and systematise new knowledge. The focus on young people was maintained during the nineties, but had to increasingly compete with other priorities in the latter half of the decade and was to some extent diluted.

- III. **UNICEF’s deliberate broad societal and inter-sectoral approach to HIV/AIDS prepared and supported the ideological platform which led to the formation of UNAIDS in 1996.**

The major ideological elements in the TSG process were well in line with the thinking behind UNAIDS – among others the move from a medically or health oriented GPA to a multi-sectoral and multi-agency approach to HIV/AIDS prevention. It is also

¹⁰ UNICEF placed in 1996 a youth advisor in WHO who later returned to UNICEF, but maintained close links to WHO.

interesting to note that several key staff left UNICEF and took active part in the formation of UNAIDS. The TSG process was also replicated in what UNAIDS later called Technical Resource Networks.

A recent report (GAO 2001) states that UNAIDS was established in 1996 in recognition of the need for a multi-sectoral response to the HIV/AIDS epidemic – **and** the inherent limitations in WHO's medically based approach. UNICEF in general and the TSG process in particular were early advocates and mid-wives for the broad multi-sectoral approach.

This does not mean that the relationship between UNICEF and UNAIDS has been without tensions. UNICEF is one of the main co-sponsors of UNAIDS and plays an increasingly important role in Theme Groups at country level, but the organisation provided weak support during the process when UNAIDS was established. The country experience was mixed as analysed later in this chapter.

Programme Achievements

UNICEF concentrated its thematic work in a few areas. There are also examples of innovative programmes that were replicated and taken to scale.

IV. Innovative programmes were introduced and institutionalised in a number of countries through the TSG process and later, but results and long-term impact are uncertain and to a large extent unknown.

Five thematic areas were selected for TSG groups and used as a basis for innovative programming. After completing the three-year process major ideas and lessons learned were summarised in a programming notebook ("Youth Health – For A Change. A UNICEF Notebook on Programming for Young Peoples Health and Development" 1997).

V. Youth Health and Development Promotion - Got Adolescents on the Map

This was the overall concern for the architects behind TSG - to address HIV/AIDS within the broad context of adolescents and women's health. The aim in this area was to get adolescents "on the map" in UNICEF, agree on a programme framework and use HIV/AIDS as an entry-point for programming with adolescents in a broad range of areas – not limited to HIV/AIDS.

This was to a large extent a success, but difficult to measure and evaluate due to lack of clear goals and measurable indicators (HIV/AIDS Strategy Position Paper 2001). There is also a strong sentiment in some corners of UNICEF that the organisation gradually lost its focus on adolescents. New and competing priorities were introduced – in particular MTCT. Sensitive issues pertaining to youth, like condoms, abortion, violence, sexual abuse, etc. were often found difficult to handle in a basically child and consensus-oriented organisation.

WHO was a strong UN partner in the area of adolescents, but few other agencies were involved. Collaboration with WHO was important mainly at a global level and remained weaker in the countries.

VI. School Based Interventions – Life-Skills Programmes

There is no exact data to support our conclusion that life skills programmes absorbed the largest share of UNICEF's resources to HIV/AIDS during the nineties. The main target groups were in - and out of school youth. Focus was placed on "life-skills education". There were several levels of life-skills including: (a) basic psycho-social life-skills (e.g. creative and critical thinking, self awareness, communication and inter-personal relationships), (b) situation specific life-skills (e.g. negotiation, conflict resolution, assertiveness and self-esteem), and (c) applied life-skills – expressing young people's ability to avoid high-risk behaviour.

School based life-skills education was originally introduced in many countries through UN, bilateral agencies and NGOs. In UNICEF, country programmes in Myanmar, Namibia, Zambia, Uganda, Zimbabwe, Thailand, Cameroon, Caribbean and the regional Mekong project introduced and supported life-skills programmes (Youth Health – For A Change 1997).

Despite evidence regarding the potential effectiveness of life-skills based education, a review from Eastern and Southern Africa concluded that *“the approach is mainly implemented on a pilot basis and often through ineffective infusion approaches instead of more substantial implementation strategies – such as a carrier subject”* (Gachichi 1999). There are few evaluations to verify such a conclusion. A general sentiment is, however, that life-skills is a noble concept with impressive achievements in terms of outputs, but more dubious outcomes. Critical voices argue that teachers internalised and used the life-skills approach to only a limited extent. Messages never reached the classrooms and young people did not change their behaviour as a result of life-skills education.

School programmes are presented as successful in internal documents – even if their relative importance is unknown (HIV/AIDS Strategy Position Paper 2001). It is found in process evaluations that life-skills programmes have made the environment for HIV/AIDS awareness and prevention programmes more open. It increased the potential for positive behaviour development and change to take place in the long run (ESARO Regional Analysis Report 1997), but actual results are uncertain and to a large extent unknown.

Increasingly, UNICEF has also focused on out-of-school peer-to-peer education. By using young people to disseminate the message, youth are educated in an effective context, one that includes teachers from their own age range and culture. Peer education has a great potential and is presented as effective in Uganda and Zimbabwe, but such programmes have been even less rigorously evaluated than school-based programmes. So there is no solid basis for comparing results.

An informative case study was prepared on AIDS prevention in schools in Zimbabwe in 1995 (O'Donoghue 1995). AIDS education had already been introduced in schools in the country in late 1991 and UNICEF became involved from 1992. The AIDS Action Programme for Schools has a number of important achievements to its credit:

- AIDS education was made compulsory in all primary and secondary schools in Zimbabwe.
- In less than four years, high quality materials were produced and introduced into schools.
- All national, regional and District Education Officers received training through the Programme.
- AIDS education was introduced as a compulsory subject in all tertiary colleges.
- An effective research and monitoring component was built up and data generated for the system.

The report states that replication of the Zimbabwe experience in other countries is possible, given the will and the organisation, but unique features have to be taken into account. It is possible to argue that this is a programme, which if taken to scale – could have a national coverage. Several country delegations came to visit and learn from the Zimbabwe School Programme which provided broad inspiration.

The Mekong Project has extended the application of a life-skills approach to embrace many objectives for in and out of school youth and women. The project is perceived as innovative and has stimulated regional- and inter-regional collaboration. The same is true for the life skills approach in Uganda. Evaluations in Myanmar indicate that the life-skills training led to change in behaviour – not only to increased knowledge. The evaluation used control groups to verify the impact in selected communities. However, there is no such thing as a perfect programme. The mid-term review in 1998 meant that even though behaviour change was documented, the programme did not fully reach the high-risk groups. It mainly reached youth who were likely to protect themselves anyway and who were less risk-taking.

Evaluations in Thailand indicated that teachers training projects that introduced teachers appreciated life kills training, but that few of them actually transferred the training to schools. Many obstacles were quoted, such as lack of peer group support, lack of educational material, etc. including incentives. However, this was a minor and preliminary evaluation from 1996, and it has not been followed up or verified at a higher level.

VII. Mass Communication and Mobilisation - Innovative Information, Communication and Education programmes (IEC)

The second most important area was a broad range of IEC interventions. The point of departure was how various types of information, communication and education programmes could play an effective role in changing social norms and conditions that assist in the spread of HIV. Several pilot projects were started and tested out during the process – through newspapers in Kenya and Uganda, through radio in Malawi, Mauritania, Cote d'Ivoire and Russia, through television in South Africa and through entertainment, such as the Sara Initiative (ESARO). Collaboration between UNICEF and the Episcopal Conference of Latin America fall within the trend of growing alliances between UNICEF and religious associations. In Mexico, UNICEF took the advantage of non-traditional social networks, such as beauty salons and pharmacies to spread information to the adolescent population.

UNICEF's participatory programme for young people in Namibia based on a set of materials called "My Future is My Choice" reached over 40,000 young people and has helped influence the national AIDS control plan and focus of the UN country team (ESARO Regional Analysis Report 1999).

Zimbabwe had a strong IEC programme in the area of HIV/AIDS during most of the decade - mainly in collaboration with NGOs. The same is true for Uganda and several small and innovative projects were tested out and some replicated and scaled up. It is also important to emphasise that most IEC projects were implemented by NGOs.

Evaluation of the Sara Communication Initiative

Sara Communication Initiative is an "enter-education" strategy, which seeks to harness the drawing power of popular entertainment to convey educational messages. Animated films, radio broadcasts and printed materials have been developed around a central character named Sara. This multimedia effort seeks to raise the public's awareness about the themes associated with the Rights of the Child.

In 1999, UNICEF-ESARO commissioned a series of research studies on the Sara Initiative. To determine outcomes, a survey was conducted in Tanzania of girls 10-18 in a sample of districts. A principal finding was that 32% of the girls surveyed were able to identify a picture of Sara - which is judged as very good. Data also suggested that Sara and Juma had become role models for boys/girls relationships and fostered girl's participation in development (Craig Russon 2000).

UNICEF worked extensively with NGOs in Thailand and Myanmar in the field of IEC. Several NGOs in Myanmar worked with sophisticated communication strategies, and used different media - from traditional to modern - to reach youth. The Myanmar projects are ongoing, and most started in the 1990s. The projects in Thailand go further back in time, but in the early 1990s, they were probably as dynamic, multifaceted and innovative as they are in Myanmar at present. However, there is an almost total lack of evaluation so it is not possible to document impact in either country.

VIII. Sexual and Reproductive Health Promotion - Youth Friendly Health Services

This was a third area of achievements. A key concern was to demonstrate the operational feasibility of going to scale with interventions that promoted and maintained sexual and reproductive health. Knowledge of sexual and reproductive functions, the skill and empowerment to make informed decisions free from coercion, access to condoms and not least access to what is called "youth friendly" health services. The latter was based on the assumption that young people are likely to use health services only if they are "youth-friendly": i.e. attractive, not too showy, accessible in terms of physical location and hours of operation, affordable, confidential, credible to both users and health providers, and able to meet a range of health needs (Youth Health - For A Change 1997).

Youth-friendly health services, including training and peer involvement were tried in Uganda, Kenya, Zambia, Botswana, Swaziland, Costa Rica, Nicaragua and Russia. We found examples of youth friendly health services approach in Uganda and Zimbabwe, but much less significant in volume and impact than life skills education and IEC programmes.

IX. Family and Community Care - little attention and action.

The fifth TSG group was supposed to concentrate on family and community-care issues, but the group ceased to operate after the first meeting and not much happened later in this area. Issues of care seem to have been neglected.

Each of the strategies are useful and relevant in their own right, but could have been stronger in a multi-strategy approach. A school-based programme is more likely to be effective if reinforced by other supporting strategies, such as policy, media, access to good services and supplies, etc. Single strategies are too weak to make inroads into the change of social norms, attitudes and behaviour. In this area of multi-level strategies there is scope for improvement in UNICEF.

4.3. Replication and Scaling Up of Programmes

One of the objectives of the TSG process was to identify new programme ideas, test them out as pilot projects, summarise lessons learnt from country implementation, and scale up small projects to national coverage, and replicate successful projects in other countries. Replication often refers to cases where a pilot project moves from one country or context to another, and scaling up – to cases where a pilot project is multiplied and expanded within the same country.

Replication and scaling up are important concerns for UNICEF. The critical question is whether such replication and expansion have taken place, what strategies have been applied and to what extent they have been successful.

The TSG evaluation found few clear examples of replication (Strengthening Organisational Learning 1999), but criticised a simplistic “best practice” and replication strategy – which implies that a number of success factors from one project setting more or less automatically would create similar outcomes in a new context. Two contexts are never identical. The adaptation processes are always unique and at the end, outcomes are to a large extent determined by quality of implementation. On the other hand, there has been significant sharing of information and best practices across countries - with active support from UNICEF. Best practices in one country have provided new ideas and inspiration for other countries with general lessons about factors enabling new programmes.

Life Skills Programmes

It was recognised early that education systems had to respond to challenges of HIV/AIDS. They had to take on an essential role in reversing the epidemic that threatened it. Young people, especially those between 5 and 15 years were perceived as the “window of hope” in stopping the spread of HIV/AIDS. Life-skills programmes were at an early stage and should insert a new dimension in traditional school curricula. They aimed at fostering positive behaviours across a range of psychosocial skills. Life-skills programmes in schools were one way of helping children, youth and their teachers respond to situations requiring decisions affecting their lives.

There are few systematic impact evaluations of life-skills programmes, but a recent report assesses a large sample of evaluations from countries in Eastern and Southern Africa (Gachuhi 1999). The report starts with referring to research in Kenya, which

suggests that family life education, yield significant and positive reproductive health benefits and behaviours (Johnston 1999). Other studies refer to certain positive effects but also to examples of negligible or no effects at all (Zimbabwe, Namibia, Uganda, Lesotho, Malawi, Botswana, Swaziland).

The review of the life-skills programmes does not question the potential positive effects of well designed and implemented programmes. The challenge is more that there are still too few life-skills programmes in the region that are targeting children and young people with information about HIV/AIDS and meeting criteria of effectiveness.

Many countries in the region are just beginning to explore the concept of life-skills and how to advocate for such programmes within the education system (Gachuhi 1999). In brief, there are too few life-skills programmes. They are too scattered and have weak impact on children and youth in the classrooms.

AIDS EDUCATION IN UGANDA

An impact assessment using control groups was carried out of a UNICEF supported school-based AIDS education programme in rural Masaka, Uganda. The reports starts by stating that “the body of evidence suggests that AIDS education for young Africans works, but it does not always work”.

The statistical data showed very little effect – seven of nine key questionnaire variables showed no significant increase in score after the intervention.

The explanation for lack of effect is interesting: The project faltered in implementation. The programme theory was good – but implementation poor. “Unless teachers are somehow obliged to cover the subject, similar programmes may simply fail due to incomplete implementation, even if they are theoretically and sociologically sound”.

Another constraint is that few impact evaluations are carried out of life-skills programmes. There are evaluations of individual projects documenting satisfactory performance but few studies of short and long-term effects on a broader scale.

UNICEF has supported life-skills projects in a number of countries. Zimbabwe and Uganda are two countries where life-skills programmes were planned and implemented with national coverage as an aim. The achievements in terms of coverage have also been impressive. Questions are more related to outcomes and impact in classrooms and among children and youth. The level of replication is difficult to measure but the sharing and dissemination of information and best practices across countries extensive.

There is strong support in UNICEF for replicating and taking innovative projects to scale but are there sufficient incentives and is scaling up always a good approach for UNICEF? A Programme Officer is mainly accountable to his or her programme area and an important success criteria for UNICEF staff is to have their names associated with successful innovations. If so, there could be a disincentive in replicating and expanding innovations. A replicated innovation is not innovative anymore. There is little credit in repeating what others have already successfully carried out. A small innovative project usually attracts attention and interest while a large-scale programme represents institutionalised practice – and loses its innovative sensation. Pilot projects tend to be good and limited in scope. National programmes are large in scale but limited in impact.

There is also an inherent tension between innovation and scaling up. Innovation requires a culture of research and experimentation with small-scale initiatives, while scaling up requires solid capacity for the implementation of plans already developed. In brief, within a scaling up strategy UNICEF would need other types of expertise, another time perspective and not a lower level of funding than pursuing an innovative strategy. It is not obvious that the same organisation can do both - and do both well. In our view, UNICEF has placed too much emphasis on scaling up a few key programmes - and less on searching for new ideas and approaches. UNICEF has, to a large, extent stuck to what they believed in and was good at - and may then have lost new opportunities.

UNICEF is not a research organisation, but not merely an implementer either. The concept of scaling up has often been too one-dimensional. Rather than scaling up one programme in one country, it would have been possible to scale up through different models, e.g. life-skills education in schools in some districts, peer led programmes in others, etc. The point would be to test out different alternatives and aim at national coverage through a range of models.

Another problem is the lack of operational strategies for replicating and scaling up innovations. UNICEF is to some extent trapped in the same dilemma as many NGOs: Small and beautiful, but insignificant! Many small-scale successes are secured and well documented, but they do not add up to make a change in surrounding systems and structures. Impact is often highly localised and transitory.

One of the failures is to make the right linkages between micro-level efforts and wider systems. UNICEF should be better placed than NGOs to make those linkages, but *UNICEF supported projects seem to remain "islands of success"*.

STRATEGIES FOR SCALING UP

The question is how to find the most effective strategies for maximising impact. Several studies have emphasised that expansion should not only be assessed in terms of size and scope. Clarke (1991) differentiates between "project replication", "building grass roots movement" (or organisation building) and "influencing policy reform".

The important distinction to be made lies between "additive strategies", which imply an increase in size of budgets and number of activities. On the other hand, "multiplicative strategies", which does not imply growth, but seek to increase impact through other means, like:

- (a) deliberate lobbying and advocacy,
- (b) organisation building,
- (c) networking with like-minded partners,
- (d) working through existing national programmes,
- (e) policy reform.

UNICEF pursues all the strategies, but the choice and mix of strategies should emerge from an analysis of the relevant context in order to make micro- and macro-level mutually supportive and effective. The key challenge is often to strengthen the "complementarities" between the levels of intervention, so that action at each level can support and inform the other. This kind of analysis seems to be missing in UNICEF.

4.4. Strengthening New Partnerships

When the HIV/AIDS policy was prepared in 1992, UNICEF had neither the experience nor the knowledge to design effective and technically sound strategies and programmes. UNICEF was primarily an operational agency with scarce in-house expertise. In the early nineties, UNICEF was in need of external partners - both technical partners to provide expertise and implementing partners for rapidly scaling up the response.

UNICEF had a reputation of being relatively independent from the rest of the UN system in terms of public image and operational activity which made UNICEF less ready to co-ordinate with other agencies and created a reluctance to attribute achievements to collaborative efforts (DFID 2000). One interesting aspect of the TSG process was the deliberate effort to bring external partners on board and make active use of their skills and experience.

There are often few examples of constructive collaborative arrangements between research and donor agencies and between donors and NGOs. The internal rivalry between UN agencies at global and country level is also well known. UNICEF should therefore be commended for its active efforts in the early nineties to open up for much more active collaboration with external partners and to include new and non-traditional partners. The first and logical choice was WHO and GPA. UNICEF needed WHO's biomedical and technical expertise, as well as their competence in initiating and formulating health policies.

But UNICEF was also in need of partners with broader approaches, including NGOs with knowledge and experience in field situations and understanding of the socio-cultural dimensions of HIV/AIDS. They were also in need of technical partners in the five thematic areas selected for the TSG process: mass media, youth health, school based interventions, etc.

The evaluative questions were - *to what extent new partnerships were established, if they were successful, whether they were institutionalised and sustained, abandoned or replaced with others.?*

Our main findings are:

- **WHO was the main partner at global level and a lot of interaction took place between UNICEF and WHO during the TSG process. Other UN partners were much less involved. In the latter half of the nineties, WHO's role was taken over by UNAIDS.**
- **UNICEF was in need of expanding its technical alliances and partnerships to implement an integrated and multi-disciplinary approach to HIV/AIDS. UNICEF HQ was not able to maintain partnerships with technical institutions and NGOs established through the TSG process.**

Several technical agencies and NGOs became involved with UNICEF at global and country level in the early nineties. Their role and responsibilities were not sufficiently clarified from the outset of the process and incentives and systems for regularly "keeping in touch" not introduced. Partnerships depended to a large extent on

friendship and informal loyalties. They were not institutionalised. When individuals disappeared - networks disintegrated.

- **Partnerships between UNICEF and NGOs were better maintained and have also expanded within country programmes. Private sector and technical institutions have played minor roles.**

At country level, UNICEF had a more direct and immediate need for NGOs as implementing partners. UNICEF has also increased its collaboration considerably with NGOs during the last decade - as an important supplement to government partners. In all the four country case studies, NGOs played significant roles in all country programmes during the nineties.

The private sector has played a minor role (in the four case countries) except for Thailand and to some extent in mass communication.

There is a trend towards working more with national technical institutions but we have found few examples of active and long-term collaboration with universities, research centres, groups of consultants, etc. and links to international centres of excellence in relevant programme areas.

In Eastern and Southern Africa, a regional HIV/AIDS network followed the TSG process. This network served some technical functions and was a mechanism contributing to organisational learning. The network ceased to exist in 1998. Except for ad hoc meetings and seminars, we have not found regular and more formalised networks in the last few years serving purposes of exchange of information, technical support and organisational learning.

- **New partnerships were established and strengthened between UN agencies with the establishment of UNAIDS but UNICEF's programmes and mode of operation were not significantly transformed.**

UNAIDS was established in 1996 as the UN system's concerted effort to strengthen the global and national response to HIV/AIDS. The TSG process was found to prepare UNICEF for the UNAIDS era and both new partnerships and mechanisms for better co-ordinated action at global level has come as a result of UNAIDS.

UNAIDS will be discussed in the next chapter. The country level experience is mixed, but our findings are not conclusive. In the early period of UNAIDS, UNICEF could hardly be called an enthusiastic co-sponsor. In Zimbabwe, for instance, UNICEF felt the imbalance between what they had to offer and the little they felt they could gain from joining the partnership. Slowly attitudes and practices have changed and UNICEF has become one of the most active co-sponsors (in the four case countries). The number of UNICEF Representatives serving as chairpersons of Theme Groups has also increased rapidly, but it is our impression that UNAIDS has not changed UNICEF programmes or mode of work in any significant way. It has added new dimensions and insights to the value of working more together with other agencies, but "business" continues more or less as usual through country programmes.

4.5. Improvements in Co-ordination and Communication

Before presenting country findings, we will briefly review relevant global processes pertaining to co-ordination and communication in UNICEF and between UNICEF and other UN agencies.

Internal Co-ordination

At the global level – within UNICEF, priority setting and co-ordination is articulated through the Global Management Team (involving Regional, Divisional and Executive Directors).

UNICEF HQ provided weak global support and co-ordination to HIV/AIDS in the latter part of the nineties. A central HIV/AIDS Unit was established in 1999 within the Programme Division. This Unit is supported by an inter-divisional working group to facilitate communication and co-ordination of work plans for divisions and staff involved with HIV/AIDS. It is too early to judge the work and impact of this Unit and to what extent it will be able to lead, promote and co-ordinate UNICEF's HIV/AIDS work.

Regional Management Teams in UNICEF are meeting two to three times a year to determine how best global policies and priorities can be introduced and applied within country programmes and to monitor progress in the implementation of the regional HIV/AIDS work plan. This has started to bear fruit in particular in Eastern and Southern Africa Region (ESAR).

Global Mechanisms

UNICEF was actively involved and supportive during the nineties in efforts to consolidate various global co-ordinating mechanisms, including:

- (a) the strengthening of the Inter Agency Advisory Group on AIDS (IAAG), the main forum for co-ordination of HIV/AIDS programmes between UN and bilateral agencies, NGOs and others,
- (b) working with WHO/GPA in the first half of the nineties to develop and implement prevention and care approaches focusing on women and youth and on the reduction of the impact of HIV on children,
- (c) involving UN agencies, technical institutions and NGOs in programme development in the TSG process,
- (d) establishing UNAIDS as a joint co-sponsored UN programme on HIV/AIDS.

The major mechanisms for priority setting and co-ordination with other UNAIDS co-sponsors are:

- UN System Strategic Plan and Unified Workplan and Budget (UBW),
- the Committee for Co-sponsoring Organisations (CCO),
- Inter-agency Task Teams set up to advise on particular policy, technical or programming issues.

The UN System Strategic Plan for HIV/AIDS 2001-2005 makes a deliberate effort for closer integration between UN agencies (UN System Strategic Plan for HIV/AIDS 2001-2005). It identifies key functions of the UN system in support of national efforts and describes the approach and priorities of the participating organisations. Twenty-

nine UN organisations contributed to this plan through the development of individual agency strategies.

The Plan draws its focus from the Global Strategy Framework, in particular the Leadership Commitments, to which key actors have been encouraged to subscribe. The first Plan is broad and represents to a large extent a summary of what the individual parts are doing. The quality of contributions is varied. The Plan is a small step towards more integration of the UN response, but its main function so far is to explain and express common UN intentions.

There is a relatively well accepted and functioning distribution of responsibilities among the co-sponsors. But it should not be ignored that several of the agencies have overlapping mandates in need of further clarification. There is also a concern among the main donors to UNAIDS about *“the inflexibility of the co-sponsors’ field structures in responding to the new priorities represented by the HIV/AIDS challenge ... the protection of established turfs... and the failure to reallocate within their own budgets resources to meet the HIV/AIDS funding challenge”* (UNAIDS Financing Study 2000).

For example, UNICEF's involvement in adolescent health overlaps with UNFPA and UNAIDS. Safe motherhood overlaps with UNFPA and WHO, child labour with ILO and education with UNESCO. In a recent review, DFID requests UNICEF to clarify its mandate, role and responsibilities with reference to other UN and international development agencies.

UNAIDS Unified Budget and Workplan (UBW 2002-2003) builds on the Global Strategy on HIV/AIDS and the UN System Strategic Plan. So far, it has included only global and regional HIV/AIDS activities, the UNAIDS Secretariat and some funds for acceleration of country activities. UNICEF's and other co-sponsors regular country budgets are not included in the Unified Budget and Workplan. This means in practice that a major part of multilateral funding for HIV/AIDS at country level is not reflected in UBW. Core programmes and systems for allocating regular resources have not changed (UNICEF Guidelines for UNAIDS Collaboration C/AI/1998-002).

The last UBW included co-sponsor estimates of regular budgets/general resources for activities at global, regional and country level. UBW is an important document for UNAIDS, but much less important for UNICEF and other cosponsors. UNAIDS is in the process of making UBW a basis for performance monitoring – not only of global activities but also agency specific projects. This is a constructive exercise, but UNAIDS will not be able to make such a tool useful and complete – unless all co-sponsors contribute effectively to the process and issues of accountability are resolved.

Country Level Co-ordination

Several mechanisms are established at country level to strengthen UN co-ordination. The UN System Integrated Workplans (IWPs) on HIV/AIDS, prepared under the auspices of the UN Theme Groups, are joint prioritisation and planning exercises at the country level. Developed within the overall system of UN Development Assistance Frameworks (UNDAF), the IWPs are intended to include all of the HIV/AIDS-related actions of the UN system in support of national HIV/AIDS plans.

Zimbabwe has an IWP, but the document provides only general direction and could hardly be called a "living" or important document for any of the agencies. Uganda has not prepared such a document.

UNICEF took an active role in UNAIDS activities in both Myanmar and Thailand. The actual structures and working processes differ between the two countries, but the level of UNICEF involvement is similar. There are Joint UN plans in both countries, and UNICEF has a role in each. However, we observed that UNICEF – as well as the other agencies – developed projects much in line with its obvious character and there was only a limited interaction with other UN agencies in project implementation. The scope of work in the theme group was more of an elaborate mechanism of sharing labour according to the traditional mode of operation of each partner.

In both Uganda and Zimbabwe UNICEF has played an active role in the preparation of Common Country Assessments (CCA) and UNDAFs advocating children and women rights.

HIV/AIDS Theme Groups

National Theme groups have become fora for communication and co-ordination between UN agencies. In an increasing number of countries there are also Expanded Theme Groups with participation of bilateral agencies, NGOs and government. UNICEF has gradually increased its involvement in national Theme Groups and more active inter- agency collaboration at country level. In January 2001, UNICEF chairs 19 Theme Groups compared to 16 in 1998 (UNICEF/UNAIDS Programme Review).

There is an Expanded Theme Group in Uganda with UNICEF as the Chair. An opinion seems to prevail that Theme Groups lack strategic direction. Agendas are over-crowded with sharing of information. Expanded groups are large and difficult to use as instruments for reaching consensus and act on common issues.

UNICEF in Zimbabwe finds the HIV/AIDS Theme Group useful, but also too much dominated by sharing of information and wanting in terms of strategic and analytical depth. We are not in a position to judge to what extent UNAIDS more generally has contributed to a better co-ordinated UN response to HIV/AIDS. The assessment from UNICEF staff is moderately positive.

In theory, improved co-ordination may occur through standardisation (division of labour according to comparative advantage), through planning (somebody deciding in advance who will do what, where and how) or through mutual adjustment (a process of formal and informal communication). The presence of UNAIDS has facilitated the co-ordination among the UN agencies, but the major feature of that co-ordination is standardisation – each agency works according to its own niche in the international community. In that sense, so far it adds little value. Its primary contribution is to explain and make visible the logic of the division of labour between the UN agencies. On the other hand, for those who did not see the difference between agencies, this may bring a better understanding of their potential contribution.

Country Programme Advisers (CPAs)

UNAIDS Programme Advisers are the facilitators of more active collaboration and joint initiatives within the framework of national strategic plans. There is so far not

much evaluative material documenting the success of UNAIDS at country level. However, there is a general perception that efforts of co-ordination at the country level are weaker than at global level with considerable variation between countries (GAO 2001).

It is our finding that CPAs have played and continue to play important co-ordinating roles, but are facing severe structural constraints. The role of UNAIDS and CPAs are not clear to co-sponsors at the country level - including UNICEF. And from some corners of the agencies the roles may be less clear than necessary. It is also a question about incentives and what UNAIDS can offer. UNAIDS is not in a position to offer massive financial resources or technical support. PAF¹¹ funds do not play any significant role for UNICEF Country Offices. Co-ordination and facilitation are elusive concepts and criteria and standards of success difficult to define. Achievements depend to a large extent on co-sponsors' willingness to collaborate and on CPAs individual diplomatic skills.

4.6. Capacity Building and Integration with National Plans

UNICEF has been criticised for seeking visibility and being reticent about collaboration (DFID 2000). This has led to difficulties in some countries in building deeper and stronger relationships between UNICEF and national governments. It has limited UNICEF's contribution in strengthening national capacity. UNICEF has had a tendency to take on a "prime moving role" - not sufficiently ensuring national government owner and leadership.

The country case studies present a more multifaceted picture. The time has come to revise traditional orthodoxies about UNICEF's effort in national capacity building and integration – even if the organisation has a long way to go.

In Uganda, UNICEF provided (at an early stage) technical, moral and financial support to the National AIDS Commission and has been involved in several policy development initiatives. Capacity building was also one of the pillars in the BECCAD programme – targeting capacity at various levels of society. The processes of consultation were extensive and efforts were made to integrate UNICEF funded activities into local structures. Intentions were right. Results more dubious and difficult to verify.

In Zimbabwe, the NGO programme had a strong capacity building component (building of a NGO HIV/AIDS network) which was later found to be seriously flawed. In the life-skills programme, UNICEF was a strong mover – compensating for weaknesses in partners' capacity. UNICEF was never successful in building the capacity of the Ministry of Education, Sports and Culture. From 1997/98, there was a change in strategy – placing much more emphasis on mainstreaming and integration of HIV/AIDS activities. It is difficult to assess to what extent the new approach has led to more and better results.

The case from Myanmar points to the fact that the national plan is general and still quite rudimentary. Also, there are practically no funds available from the Government budget for HIV/AIDS. Hence, the question of integration with a national plan is

¹¹ Project Acceleration Funds (PAF) – managed by UNAIDS.

hypothetical. UNICEF is found to have played an important role in formulating the response to the epidemic.

In Thailand, the present priority areas of the national strategy are not exactly UNICEF's priorities. The strong emphasis on condom use and commercial sex, drug users and opportunistic infections, are not UNICEF's priority categories of action. On the other hand, they are supplementary, and there is nothing in them that goes against the policies of UNICEF.

UNICEF's work in the field of HIV/AIDS prevention and care in Thailand is found at another level of impact. It played a major role in supporting the government's pilot activities in PMTCT, and it continues to do so but is now framed within a larger undertaking by the Ministry of Health. In particular, the school-based activities in life skills training are also part of education policy and of the national curriculum.

4.7. Evaluations and Evidence of Results

This is an evaluation of UNICEF policy and not an assessment of programme outcomes and impact. In chapter 1.3. it is explained that a policy can influence an organisation in many ways. It is difficult to establish a causal connection between policies and observed outcomes. Policies are part of a multi-causal pattern that explains real events.

A good policy does not automatically translate into high impact. Positive impact may even result from poor or non-existing policies. Research on educational innovations has demonstrated that implementation often determines outcomes: How a policy or process of change is put into practice determines, to a large extent, how well it fares – much more than policies themselves (Fullan 1991).

This is not to reduce the importance of good policies. They help to focus attention and prepare the ground for effective action.

Previous chapters have demonstrated evidence of impact of UNICEF's response and country studies provide more details. Agencies like UNICEF are increasingly pressured to measure and document outcomes and impact – in order to demonstrate for donors that the organisation represents an effective and efficient response to HIV/AIDS.

Monitoring & Evaluation

Documented evidence of results builds on solid and effective M&E systems. Hence, before we are able to focus on results, the strengths and weaknesses of UNICEF's M&E systems need to be discussed.

A summary of mid-term reviews and major evaluations of country programmes focusing on HIV/AIDS in the Eastern and South African Region was presented to the Executive Board in 2001 (E/ICEF/2001/L.50). The purpose was to summarise results achieved, lessons learned and needs for adjustments in the area of HIV/AIDS. The document refers to 77 studies on HIV/AIDS undertaken in 14 countries in the last ten years. About one half was carried out during the last two years and the best 23 evaluations were included in the review.

This summary reflects some of the inherent strengths and weaknesses in UNICEF's M&E practices:

- An increasing number of evaluations are initiated by UNICEF and carried out in country programmes, but there is no systematic approach to evaluation where evaluations of a cross-section of projects are carried out at regular intervals. There is still a weak evaluation culture and practice in UNICEF (Kruse, Managing knowledge. Review of UNICEF's evaluation database 2001).
- Most of the evaluations are undertaken of individual projects and programmes. Data and information are infrequently available for thematic or geographic areas and larger groups of projects.
- A value of evaluations is their ability to identify lessons learned, but some of the lessons are relatively general and obvious: “*..participatory approaches are essential, but not easily achieved*”, “*community involvement is important*”, etc.
- Assessments of results and performance are mainly using qualitative methods and results are consequently based on impressions and less on quantitative data and analysis. Findings are often phrased like: “*The region made progress towards breaking the silence. There is now a high level of awareness about HIV/AIDS...Most countries have already greatly increased their understanding of the knowledge, attitudes, beliefs and practices that contribute to the spread of HIV/AIDS*”. An evaluation of the Sara Communication Initiative confirms that “*a well-planned, well-researched, high-quality entertainment/education strategy is very successful, especially when combined with facilitative teaching and discussion.*”(E/ICEF/2001/P/L.50)
There is less information on how much and how well.
- In cases where changes are measured through indicators, results (e.g. change in behaviour) can hardly be ascribed to programme interventions.
- M&E is more difficult in health promotion projects than in service delivery because they require measuring changes in values and beliefs, social norms, policies and individual knowledge and behaviour.

THE MEASUREMENT PROJECT

This is a joint UNICEF/WHO project that seeks to define effective ways to measure (within programmes in countries) if adolescents are going to be healthy and have positive development outcomes. It has brought together practitioners from seven countries, leading scientists and international resource persons. The aim has been to strengthen capacity within these countries to implement, monitor and evaluate common approaches to programmes for adolescents. We were not able to observe any use and impact of this project in any of the countries.

M&E Country Experience

The experience in the four country cases is quite diverse. Even though the HIV/AIDS project in Myanmar is a major share of the CP, it does not figure prominently in either Annual reviews or in the Mid-term review. The Mid-term review gives a picture of project components that are quite successful, and it does not point to any difficult issues arising during the process of co-operation.

Few evaluations are undertaken in Myanmar. Ten reviews and assessment reports and four donor reports were counted. However, many of these are summaries of others, build on the others, or are not directly meant as assessments of the Myanmar CP. In fact, there are only two substantive evaluation reports, that is, reports that systematically gather and analyse data and reach conclusions about the object being studied. The level of evaluation activities continues to be low, and there is also a

considerable backlog. Studies that were actually completed several years ago were only made public in 2000 and 2001.

In Thailand very few evaluations were carried out. Even those listed as evaluations, have the character of general reviews, future oriented studies, needs assessments and position papers. The analysis suggests that there were four “proper” evaluations. The other documents listed may well be pieces of writing of outstanding quality, but they are not evaluations in the traditional sense of assessments of worth or merit of projects and programmes. They do not provide lessons learned for UNICEF, nor do they contribute to the accountability of the organisation.

A major weakness in UNICEF’s response to HIV/AIDS from the initial start in Uganda was the lack of documented data and information about results and impact. UNICEF has been guided by all the right intentions, approaches and strategies, but not been able to provide systematic evidence on results. There are most likely results, but no M&E system has been in place to measure and document changes, and whether results are reasonable compared to investments.

Despite efforts to make research and M&E central to programming in the last CP for Zimbabwe, mechanisms for monitoring implementation and impact have been inadequate (UNICEF Master Plan of Operation 2000-2004). Useful evaluations were carried out of individual projects, but few broader studies of outcomes and impact. It should be mentioned that an impressive number of project evaluations were carried out in the mid-nineties as part of the Operational Research Programme. In the new CP several baseline studies will be conducted.

Annual and donor reports tend to exaggerate positive achievements - without a basis in empirical evidence and downplay under achievements or outright failures. This could be a successful short-term marketing strategy, but not for providing a solid basis for improving existing strategies and performance.

Evidence of Impact

We have not been able to measure the increase in funding of HIV/AIDS programmes during the nineties. It is even more difficult to assess quality and impact. In other words, UNICEF is doing more on HIV/AIDS in certain parts of the world, but we do not know how much or how well.

The organisation has been supporting hundreds of small and large scale projects, each of which reached proportions of the target population with information, participation, treatment, care and support. UNICEF is able to document a large number of such project successes.

Micro-successes have been achieved, but it has not been possible to analyse and assess aggregate results and macro effects. UNICEF’s evaluation system is neither sufficiently systematic nor broad to synthesise and aggregate results within a country, regional or global programme area.

It would be misleading to assess UNICEF’s performance by using HIV/AIDS prevalence and incidence rates. The long-term aim is to reduce transmission of the virus, and UNICEF should be as effective as possible in contributing to such

reduction, but there is no direct causal link between increase or decrease in prevalence rates and UNICEF performance. On the other hand, it represents a dilemma for UNICEF that an increasing number of young people are dying of AIDS in most programme countries. The increase could of course have been stronger without UNICEF's involvement. *The most critical problem is the lack of knowledge about the relative effectiveness of UNICEF's programmes.*

Country Trends on Outcomes and Prevalence

The official figures on numbers of HIV positive and reported AIDS cases in Myanmar indicate that the rate of transmission is growing. Comprehensive surveillance data is missing, but in all likelihood the epidemic is still in its early phases and there is no proper response of scale. The total UNICEF contribution since the HIV/AIDS project started has been around USD 5 million. Even though it is a substantial amount of money, it is obviously not enough to have an impact on an epidemic of this scale.

In Zimbabwe, UNICEF's analysis from 1998 concluded that the most serious threat to the survival, protection and development of children was the high rate of HIV/AIDS infection. It is affecting an estimated 25% of adults between 15 and 49 years, and over 10% of the entire population and figures are not going down. UNICEF presents its' programmes as successful in Annual Reports and donor reviews. But in the long run it is problematic that increasing prevalence rates tells another story about the aggregate effectiveness of preventive activities at country level.

The most recent data from Thailand suggests that the annual number of new HIV infections peaked in the early 1990s and has declined by more than 80%. Since 1993, an estimated 200,000 fewer people have been infected with HIV than would otherwise have been the case. The experience of the programme in Thailand and Uganda raise some key questions around evaluation.

The Thai national programme for HIV/AIDS prevention has been considered very successful. The transmission of HIV has been significantly reduced, and there are clear changes in sexual behaviour. The combined effects of the Thai society's response, lead by its government and to some extent supported by international organisations has produced these results.

Uganda is presented as both among the worst and most promising countries in terms of HIV/AIDS. On the one hand, it is a country with close to 1.5 million people infected with HIV/AIDS . On the other hand it's a country where the rate of infection seems to have stabilised on around 30% in the worst affected areas, and even a reduction in prevalence in selected areas and among certain age groups (HIV/AIDS Surveillance Report 2000). In major urban areas, this trend has been observed since 1992. In more rural areas where trends have exhibited a mixed pattern, prevalence rates now seem to be in decline.

But the role of the international organisations in general, and in our case UNICEF in particular, is hard to pin down. UNICEF is part of the picture. It has no doubt contributed to many of the activities that took place. It may have had an important role as an advocate for change and for pioneering efforts in communication with youth, in particular, but we cannot know for sure what the relative importance has been. In particular, the weakness of the monitoring and evaluation system, the lack of

critical examination of project and programme results, make any such estimate mere guesswork.

4.8. Concluding Remarks

This chapter has tried to assess the results of UNICEF's response to HIV/AIDS during the nineties. UNICEF set out in 1992 with the aim of expanding its approach to the epidemic. Findings are that the leadership commitment was uneven during the nineties. HIV/AIDS has only recently become a priority for the organisation. The expansion process was also weakly supported by human and organisational resources. Global and country allocations to HIV/AIDS have most likely increased moderately, but there is a lack of data to document actual expenditure. The expansion was geographically uneven and in some countries allocations were even reduced.

The critical challenge is the lack of financial data and systems to collect such information. Strictly speaking, UNICEF is not in a position to assess to what extent the organisation has followed its own policies – in this case to what extent the response to HIV/AIDS has been intensified and expanded during the nineties or not. Without a baseline and data on intended and actual expenditure, UNICEF has a weak basis for setting and changing priorities. Policies become merely sermons – weakly linked to the budgeting process and actual patterns of expenditure.

UNICEF introduced and supported at an early stage a broad societal, multi-sectoral and behavioural approach to the prevention of HIV/AIDS preparing the ideological platform for UNAIDS. The epidemic was taken out of the medical field and defined as a development issue. The organisation also prepared the ground for a strong focus on adolescents. These were major achievements for UNICEF at the policy level.

In the area of programmes, UNICEF introduced and institutionalised a number of innovations – in particular life-skills education in schools, a number of new and experimental Information, Education and Communication (IEC) initiatives and to a lesser extent youth friendly health services.

Some programmes were also replicated and taken to scale in a number of countries. There is, however, a tension between innovation and scaling up. Innovations require a culture of research and experimentation, while scaling up calls for capacity of implementation. Within a scaling up strategy, UNICEF needs other types of expertise, another time perspective, and not least, a level funding for pursuing an innovative strategy. It is not obvious that the same organisation can do both - and do them well. In our view, UNICEF has placed too much emphasis on scaling up a few key programmes - and less on searching for new ideas and approaches.

UNICEF has clearly broadened its range of partners during the nineties. UNAIDS has become the main partner for UNICEF at the global level. The organisation has not been able to maintain partnerships established with NGOs and technical institutions during the TSG process. Partnerships between UNICEF and NGOs have expanded rapidly at country level while private sector and technical institutions have played minor roles. New partnerships were also established through UNAIDS as a co-sponsored programme, but UNICEF programmes and mode of operation were not significantly changed. In brief, UNICEF is slowly becoming a partner organisation, but does not always see the value and benefits of this change.

UNICEF takes part in new global and country level mechanisms for improved communication and co-ordination. Most of UNICEF programmes and funds are not included in the Unified Budget and Workplan (UBW) compiled by UNAIDS globally. UNICEF takes active part in HIV/AIDS Theme Groups in countries and UNICEF chairs an increasing number of these groups. UNICEF Country Offices have gradually learned to accept and appreciate the work of UNAIDS and CPAs in countries, but are not convinced that UNAIDS represents “added value” by contributing to a more effective and better co-ordinated UN response.

A major challenge for UNICEF is the lack of systematic evaluations and documented evidence about outcomes and impact of UNICEF interventions. There has been an increase in project evaluations, but fewer efforts in assessing programme performance in a thematic or geographical area.

It would be misleading to assess UNICEF’s performance by using data on HIV/AIDS incidence and prevalence. On the other hand, the weaknesses of the M&E systems, the lack of critical examination of project and programme results, make any such estimate and assessment of UNICEF’s impact mere guesswork.

Annex 1: Terms of Reference

Evaluation of UNICEF's Response to HIV/AIDS in Young People in the Nineties

Background and Rationale

Historical Perspective

As a response to the worsening AIDS pandemic and to the request of the Executive Board (E/ICEF/1991/15), the Executive Director recommended in 1992 that UNICEF intensify and expand its support to HIV/AIDS prevention activities (E/ICEF/1992/L.11). In particular, *efforts should focus on programmes to reduce HIV transmission among young people*, information and communication to reach youth to promote informed and responsible sexual behaviour and promotion of improved reproductive health of women and youth. The document suggested that it might not be possible to stop the transmission of HIV during the 90s. However, in light of the considerable knowledge acquired on both, HIV/AIDS and social mobilisation for health programmes, the *stabilisation of the transmission rate of HIV during this decade*, and therefore, the containment of the epidemic appeared to be *achievable*.

But in 1999, the number of infected people exceeded the predictions of 1992 by far. Fifteen years after the onset, the epidemic has a continuing intense impact on young people to a degree that current infection rates have put *young people at the epicentre of the epidemic*. The proportion of young people who will die of AIDS is appallingly high in many countries: in virtually any country where 15% or more of all adults are currently infected with HIV, at least 35% of boys now aged 15 will die of AIDS; in Zimbabwe, 50% of boys aged 15 could expect to die of AIDS before the age of 50 (Report on the global HIV/AIDS epidemic, UNAIDS 2000). Infection rates should never have reached such catastrophic levels. How is it that, after 15 years of the acquaintance with AIDS, the signs are evident in too many countries? How is it that AIDS has claimed the lives of 10.3 million young people despite UNICEF's ambitious goals from 1992?

Implementing Global Commitments to Reduce HIV Prevalence in Young People

Being aware of the increasingly serious threat to human development, a target to reduce HIV prevalence in young people by 25% in the most affected countries by 2005 and by 25% globally by 2010 has been agreed upon (with small variations in the target) at the ICPD +5, World Summit for Social Development +5, by and the OECD/DAC and the G8. Strategies for achieving this outcome have been identified in the respective documents and a global strategy was submitted to the General Assembly in February 2000 by UNAIDS.

In a proposal to the General Assembly for achieving the World Summit for Social Development +5 target, the Secretary-General has requested that UNAIDS and its co-sponsors "undertake a process of further clarifying their roles and responsibilities of their specific comparative advantages with regards to interventions for the prevention of HIV among young people...." (A/AC.253/16/Add.9). Evaluating the response of UNICEF and its partners to the epidemic in the past decade is a valuable way to learn from the past and further develop clear strategies for the future.

Contributions of the Evaluation Section at UNICEF Headquarters

In preparation for the United Nations General Assembly Special Session in 2001, the UN General Assembly requested Governments and relevant organisations to undertake reviews of progress achieved since the World Summit for Children in 1990 (United Nations General Assembly Resolution 54/93). The Workplan of the Evaluation Section for the year 2000 will contribute to this review through a number of global thematic evaluations of UNICEF. The themes are either directly derived from the goals of the 1990 World Summit or from the factors that have been recognised as comprising progress in the realisation of children's rights, e.g. HIV/AIDS and armed conflict.

Assessment of UNICEF's Response to HIV/AIDS in the nineties

The 1992 Executive Board Recommendation (see above, E/ICEF/1992/L.11) gave a detailed outline of UNICEF's programme approach to the prevention of HIV/AIDS, in particular in young people. However, despite many alleged success stories, high HIV-prevalence rates in young people in many parts of the world offer a sharp contrast to UNICEF's goal of containing the epidemic by the year 2000, provoking a series of unanswered questions.

In collaboration with the Health Section and the HIV/AIDS Group, Programme Division, the Evaluation Office is undertaking an evaluation of UNICEF's Response to HIV/AIDS in Young People in the nineties. The purpose of this evaluation is to 1) identify the gap between policy statements made by the Executive Board as applied in programming guidelines from Headquarters to the Regional and Country Offices; 2) address UNICEF's strengths and weaknesses in: a) accelerating programming for reducing HIV/AIDS in young people following a societal and behavioural approach and b) building and strengthening partnerships for accelerating programming for HIV/AIDS reduction in adolescents in light of the evolution of policy response to HIV/AIDS in young people. More importantly, this evaluation aims at 3) drawing critical lessons which should be formulated in a way to inform the development of UNICEF's Global Strategic Plan on HIV/AIDS which will be finalised in April 2001 and again incorporated into the Mid-Term Strategic Plan.

This consultancy will be the second phase in the evaluation following the development of: a) an annotated database and outline focusing on UNICEF's policy response to HIV/AIDS in young people in the nineties and b) an outline of country level response of several key countries, c) the illustration of key stages in the response and d) the identification of key questions to be addressed in the evaluation. The proposed evaluation will be based on the above developed materials, key informant interviews, and will take advantage of the planned regional meetings to develop strategies for HIV/AIDS in the next months.

Tasks:

- 1) Develop an analytical framework of the "vertical linkage" between organisational levels to illustrate how policies translated into practice for prevention of HIV/AIDS in young people and to facilitate the analysis of the "vertical linkage" between UNICEF Executive Directives and programme implementation at the country level. Identify the role of Regional and Country Offices in informing UNICEF guidelines and policies

2. Based on the analytical framework, prepare a desk review report on the findings of the prior evaluation stages (see above), addressing key questions developed, such as:
 - How have policy statements been introduced at regional and country levels? (e.g. focus on different programme approaches such as Adolescent Friendly Health Services which have been introduced at the Executive Board level and follow the development through the system).
 - What are the best practices at country level we can learn from in improving the quality and scale of programmes for young people living in societies affected by HIV/AIDS, which should be reflected in UNICEF policy and programme documents? What are best practices that facilitate good linkages?
 - If there is a gap in the linkage between the various levels from HQ to the Country programming, where is the barrier? Are the reasons operational, technical, or resource- related?
 - Has the introduction of guidelines/policies at regional and country levels translated into changed programmes for young people and HIV/AIDS in terms of quality and quantity of programmes, including policy and partnership?
 - To what extent are policies developed based on identified programme needs at country-level?
 - Were the mechanisms for technical support to country programs reoriented and improved to a degree that UNICEF facilitated technical/programme support with respect to HIV/AIDS in young people to countries?
 - What is the contribution of UNICEF to national needs assessment, strategy formulation and integrating planning at national level; how could it be improved?
 - Has UNICEF succeeded in expanding the number of emphasis countries every 12 to 18 months, as suggested in the 1992 UNICEF Executive Directive (E/ICEF/1992/L.11)?
 - Is there evidence for improved/ accelerated programming for young people at country level? If so, what have been contributing factors?
3. Prepare guidelines for the key informant interviews, which are to be used as a tool for the interviews with key UNICEF staff and partners in country offices. The guidelines should inform participating team members in the Evaluation Office of the suggested survey approach and include critical interview questions. The guidelines should further outline how to take advantage of the planned Regional meetings to formulate HIV/AIDS strategies and elaborate questions for group discussions at those meetings.
4. Analyse the interviews at regional and country level and document the findings in a draft report.
5. Synthesis of the two established reports (desk review report and analysis of the interviews) into one final document which should address key questions outlined above, identify strengths and weaknesses, and make recommendations to UNICEF for future development of policies and programmes with respect to HIV/AIDS in young people, enabling the organisation to respond more efficiently to the epidemic.

Outputs

1. Framework of the “vertical linkages” between organisational levels
2. Desk review report
3. Guidelines for the key informant interviews, regional meeting discussions, overview of the survey and outline of the questions to be addressed
4. Report on the findings of the interviews with key informants and of the information obtained from regional meetings
5. Final report, which shall synthesise the findings of the two established reports

Use

The report will be made available to three main groups of users:

1. UNICEF staff involved in producing relevant materials of UNICEF for the End-Decade Review
2. The Programme Committee Board of UNAIDS for incorporation into the institutional review process
3. Staff of the Health Section that is involved in monitoring the achievement of programme priorities and the preparation of the HIV/AIDS Strategic Plan for input in the Medium-Term Strategic Plan.

Annex 2: References

- Clarke, John (1991), "Making a Difference? NGOs and Development in a Changing World", Earthscan, London.
- DFID (2000), "Working in Partnership with The United Nations Children's Fund (UNICEF): Institutional Strategy Paper.
- Fullan, M. (1991), "The New Meaning of Educational Change", Cassel, London.
- Gachuhi, Debbie (1999), "The Impact of HIV/AIDS on Education Systems in the Eastern and Southern Africa Region and the Response of the Education System to HIV/AIDS: Life-Skills Programmes", UNICEF ESARO.
- Johnston, T. et al. (1999), "Ukweli. Kenyan Adolescent Reproductive Health: Implications for Schooling", Population Communication, Nairobi.
- Nduati, R. And Kiai, W. (1997) Communicating with Adolescents about AIDS. Experience from Southern and Eastern Africa. IDRC.
- O'Donoghue, Joan (1995), "Zimbabwe's Action Programme for Schools: Flashback and Hindsight", UNICEF Harare.
- Reinisch, Annette (2001), "UNICEF's Response to HIV/AIDS in Young People", Evaluation Division, UNICEF NY.
- Reinisch, Annette (2000), "Evolution of UNICEF's Response to HIV/AIDS in Young People", Evaluation Division, UNICEF NY.
- Russon, Craig (2000), "Evaluation of the Sara Communication Initiative", UNICEF ESARO.
- UNAIDS (2001), "UN System Strategic Plan for HIV/AIDS – 2001 to 2005".
- UNAIDS (2001), "UNAIDS Unified Budget and Workplan".
- UNAIDS (2001), "Summary of UN System Organization Plans", PCB (11)/01.3, May.
- UNDP (1995), HIV/AIDS The Global Connection.
- WHO (undated), "Global Programme on AIDS. Final Report with Emphasis on 1994-1995 Biennium".
- WHO and KIT (1991), AIDS prevention through Health Promotion: Facing Sensitive Issues
- Vedung, E. et al (editors) (1998), "Carrots, Sticks and Sermons. Policy Instruments and Their Evaluation", Transaction Publishers; New Brunswick
- World Bank (1999), "Confronting AIDS; Public Priorities in a Global Epidemic", Oxford University Press.

Relevant UNICEF documents

- | | |
|------------------|---|
| CF/AI/1998-002 | UNICEF Guidelines for UNAIDS Collaboration. |
| E/ICEF/1992/L.11 | UNICEF Programme Approach to the prevention of the human immunodeficiency virus/acquired immunodeficiency syndrome. |
| E/ICEF/1993 | Progress Report on UNICEF programme activities in the prevention of HIV and in reducing the impact of AIDS on families and communities. |
| I/ICEF/ 1993/2 | Report of the Executive Director |
| E/ICEF/1994/3 | Medium-term plan for the period 1994-1997. |
| E/ICEF/1994/L.14 | UNICEF support to the proposed United Nations Joint and co-sponsored programme on HIV/AIDS. |
| E/ICEF/1994/L.15 | ECOSOC, HIV/AIDS programme |
| E/ICEF/1995 | Health Strategy for UNICEF. |

E/ICEF/1995/16	UNICEF Strategies in Basic Education
E/ICEF/1996	UNICEF's policy on children in need of special protection measures.
E/ICEF/1998	Review of the Impact of HIV/AIDS on women and children.
CF/AI/1998 – 002;	Programme Directives, Notebook on Programming for Young People's Health and Development
CF/AI/1988-002;	Administrative Instructions, UNICEF Guidelines for UNAIDS Collaboration
E/ICEF/2000	Emerging issues for children in the 21 st Century.

Santos Pais, Marta (1999), "A Human Rights Conceptual Framework for UNICEF", Innocente Essays No.9, UNICEF.

UNICEF (1990), "Children and AIDS. An Impending Calamity", UNICEF New York.

UNICEF, "Global Girl's Education Programme" (not dated)

UNICEF, (2000), "Girl's Education: A Framework for Action".

UNICEF (1991) "AIDS and Orphans in Africa".

UNICEF (1993), "Young People in Action (Report from the VIII th International Conference on AIDS in Africa", Marrakech.

UNICEF, Action for Children Affected by AIDS – Programme Profile and Lessons Learned

UNICEF (1993), "Report of the Technical Support Group Meeting", June and October 1993; Mass Communication and Mobilisation for Youth Health and Development.

UNICEF (1994), "Action for Children Affected by AIDS".

UNICEF (1995), "Children and Families Affected by HIV/AIDS".

UNICEF (1995), "Report of the meeting: UNICEF Approaches to Children and Families Affected by HIV/AIDS".

UNICEF (1995), "Report of the meeting: UNICEF Approaches to Youth and Women's Health

UNICEF biennial report on HIV/AIDS prevention and care, 1993 – 1994.

UNICEF; AIDS: The Second Decade – A Focus on Women and Youth.

UNICEF (1997), "Youth Health - for a Change. UNICEF Notebook on Programming for Young People's Health and Development.

UNICEF Statement to the World Conference of Ministers Responsible for Youth; Lisbon 1998.

UNICEF (1998), "Key Programme Reference Material, UNICEF's Role within UNAIDS Programme".

UNICEF (1998), "Programme and Policy Briefs; Young People's Health and Development".

UNICEF (2000), "Programme Approaches to HIV/AIDS".

UNICEF Annual Reports 1990 – 2000

UNICEF Progress of Nations (1995 – 2000)

Annex 3: People Met

Myanmar

Bertrand Mendis, UNICEF Country Representative
 Aye Aye Mon, Assistant Project Officer (HIV/AIDS)
 Myo Zin Nyunt, Project Officer (HIV/AIDS)
 Ryoko Yokoyama, UNICEF intern
 Robert Jenkins, Head, Planning and Evaluation Unit
 Dr. Ye Mon Myint, Assistant Project Officer (UNICEF:HIV/AIDS)
 Dr. Tin Mak Aung, Education Officer (UNICEF: Education)

Ms. Nennifer Ashton, Country Program Adviser (UNAIDS)

NGOs

Dr. Kyaw Win, President of Myanmar Red Cross
 Dr. Win Win Aye, Project Co-ordinator
 Dr. Kyu Kyu Swe, President of Myanmar Maternal and Child Welfare Association (MMCWA)
 Dr. Nu Aye Khin, Joint Secretary (MMCWA)
 Dr. David J. Valentine, Deputy Country Representative, (PSI)
 Dr. Myo Lwin, Medical Co-ordinator (HIV/AIDS & STD Prevention Programme: MDM)
 Ms. Saba Khan, Programme Officer (Population Council)
 Dr. Iwan, Area Co-ordinator, Eastern Shan State & Kayin State, (World vision)
 Dr. Sid Naing, Medical Coordinator (CARE international, Australia)

Organisations visited

Ministry of Health, National Aids Programmed
 Myanmar Medical Association
 Myanmar Red Cross Society
 Myanmar Maternal and Child Welfare Association
 Population Services International
 Medicin du Monde
 Save the Children Myanmar
 Population Council
 World Vision
 Care International Myanmar

Thailand

Gamini Abeysekera, UNICEF Country Representative
 Fida Shah, UNICEF Deputy Country Representative
 Somsak Boonyawiroj, Programme Officer, Planning and Evaluation
 Scott Bamber, Project Officer (HIV/AIDS)
 Nitsamai Rantsaeva, Programme Officer,
 Robert Bennoun, EAPRO, Regional Adviser HIV/AIDS
 Gregory Carl, EAPRO, Programme Officer
 Prudence Borthwick, EAPRO, Programme Officer
 Thazin Oo, EAPRO, Programme Officer

Organisations visited

Ministry of Public Health
 Ministry of Education
 National Economic and Social Development Board
 UNAIDS
 CARE Thailand
 Raks Thai Foundation
 Siam-Care

Uganda

Acou Sam Ogojoi, Senior Probation Officer, Commissioner, Ministry of Gender, Labour and Social Development.
 Elise Ayers, HIV/AIDS Advisor, USAID.
 Emmanuel Kusemererwa, Principal Education Officer, Ministry of Education.
 Jan Olav Baaroy, Emergency & Conflict Resolution Officer, UNICEF.
 Jantine Jacobi, Country Programme Adviser, UNAIDS.
 Kari Egge, Senior Programme Co-ordinator, UNICEF.
 Noreen Susan Oketcho, Desk Officer School Health, Ministry of Education & Sports.
 Paul K. Kato, AIDS Care Education and Training (ACET).
 Pelucu Ntambirweki, Executive Director, Uganda Women's Effort to Save orphans (UWESO).
 Prof. Rwomushana, Uganda AIDS Commission
 Rose Tiridri, Principal Health Educationist, Ministry of Health.
 Samuel Enginyu, Senior Health Educationist, Ministry of Health.
 Tim M. Rwabuhemba, Project Office HIV/AIDS, UNICEF
 Uma Agula Francis, Principal Education Officer, Ministry of Education.
 Wabwire Nathan, Senior Youth Officer, Commissioner, Ministry of Gender, Labour and Social Development.
 Willie Iwoe-Otim, Asst. Commissioner, Ministry of Gender, Labour and Social Development.

Zimbabwe

Bongiwe Moyo, Program Officer, AusAID, Australian High Commission
 Davison Munodawafa, D&J Health & Education Promotion Services.
 Eunice Pfende, Programme Officer, Netherlands Embassy
 Fabio Sabatino, Programme Officer, UNICEF
 Farai Mugweni, Executive Secretary, SANASO
 Felicite Hatendi, Project Officer, UNICEF
 Heather Wall, Senior Development Adviser, CIDA Program Support Unit
 J. van Hussen, Head of Development Co-operation, Netherlands Embassy
 Kate Muhambi, Director, Zimbabwe AIDS Network (ZAN)
 Lillian Chikara, Programme Officer, Netherlands Embassy
 Lindy Francis, The Centre
 Margareth Mehlomakhulu, Project Officer, UNICEF
 Nomasomi N.Mpoffu, Social and Gender Analyst, UNDP
 Sunanda Ray, Director, SAFAIDS
 Tsitsi Dangarembizi, Project Officer, UNICEF

UNICEF New York

Annette Reinisch

Ian McLloyd

Jean Quesnel

Joseph Foumbi

Mark Connolly

Nicola Bull

Nicolette Moodie

Roeland Monasch

Other UN Organisations

Bertil Lundblad, UNAIDS

Elhadj Sy, UNAIDS

Jim Sherry, UNAIDS

Jane Fergusson, WHO