

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

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

Part II

Country Case Studies

**Prepared for the Evaluation Office
UNICEF New York**

November 2001

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CASE STUDY 1: MYANMAR

1. Status of the Epidemic

The HIV/AIDS epidemic entered Myanmar relatively late, but since then it has spread rapidly. The Government's National AIDS Programme recently reported a total of 33,553 HIV positive cases (among blood donors and suspected hospital patients) and 4,598 AIDS patients (Ministry of Health, 2001). A total of 1,973 deaths were reported from hospitals in different parts of the nation. Most of the AIDS patients and HIV positive cases were in the age group 20 – 40 years of age, with a male to female ratio of six to one.

However, UNAIDS and WHO estimate that the number of people living with HIV was approximately 530,000 in 1999 (based on projection of sentinel surveillance data), and that a total of 86,000 people have died of AIDS between 1988 and 1998 (UNAIDS, 2001: UNAIDS and WHO, 1998). The discrepancy between the figures reported by the Government, and the figures presented by the international organisations, reflect the ambivalent stance of the Government in respect of the epidemic. The figures from UNAIDS and WHO suggest that Myanmar is one of the countries in Asia that is most severely affected by HIV/AIDS.

According to the international organisations, HIV/AIDS now appears in many socio-economic groups in the country and it is spread primarily through sexual transmission. The HIV prevalence rate among pregnant women has been found to be 2 percent (UNICEF, 2001, p 65). HIV/AIDS is considered well established in a country and spread through a cross section of its population when the rate of sero-prevalence for pregnant women reaches one per cent.

There is a range of direct and indirect factors contributing to the rapid growth of the HIV epidemic. These include a rather high incidence of injecting drug use and commercial sex work. There is also an increasing incidence of sexually transmitted diseases, which further aggravates the spread of HIV/AIDS. A number of factors contribute to the spread of the epidemic (UNAIDS, 1998), such as:

- (a) large numbers of mobile and transient populations;
- (b) limited condom supplies, use and acceptance;
- (c) limited laboratory capacities;
- (d) inadequacy of behavioural research;
- (e) delayed and poor health-seeking behaviour that increases STD/HIV risk; and
- (f) restricted access to people engaged in high-risk behaviour; etc.

UNAIDS (2001) is careful to note that the Government has not been slow to react to the epidemic. In fact, HIV screening began in 1985. After the first case was detected in 1988, a multisectoral National AIDS Committee was formed in 1989 and given the responsibility for formulating and guiding national AIDS policies. The Minister for Health chairs the National Committee, and other ministries are represented at Deputy Minister level. The Ministry of Health was given responsibility to administer HIV/AIDS prevention and control.

In 1990, a National AIDS Programme (NAP) was created and given its own administrative structure, staff and budget. This remains a temporary administrative arrangement and all professional staff are seconded from other assignments. Although the framework for a structured and institutionalised response is in place, the quantity and quality of activities have varied. The National AIDS Committee was dormant between 1995 and 1998, and presently meets about once a year. Government funding for the National AIDS Programme (NAP) is limited, and its activities are dependent on foreign support. The NAP manager is also head of the STD Control Programme for the Department of Health. In this capacity, he has managerial responsibility for 36 STD teams comprising over 370 staff working in 25 urban areas of the country. These STD teams form the primary front line of STD/HIV/AIDS care and prevention programmes of the government sector (UNAIDS and WHO, 2001, p:24).

While the Government has not been slow to react, the response has been constrained by high-level policy ambivalence, the limitations of a medical model perspective and by serious shortages of technical and financial resources. HIV/AIDS is a sensitive subject in Myanmar. It is associated with illicit or illegal sexual and drug-related behaviour, to the exclusion of other routes of transmission. This has led to HIV becoming understood or coded as “the virus of immorality” and the notion that HIV/AIDS is a marker of illicit or foreign influence retains credibility. This has created a paralysing policy ambivalence (UNAIDS and WHO, 2001, p:2). Nevertheless, AIDS is a disease of national concern, and it occupies third position after malaria and tuberculosis in priority diseases in the National Health Plan (1996 – 2001).

Furthermore, the response to the epidemic is severely constrained by the lack of resources. In a recent survey by UNAIDS, it was estimated that the total annual volume of resources put into HIV/AIDS work by the international organisations, bilateral funding agencies, NGOs, and all other actors, did not amount to more than some US\$1.5 million in the year 2000. The Ministry of Health allocated a total of 24 million Khyat (US\$45,000) to HIV/AIDS and STD activities in the budget for the year 2000/2001. It is obvious that these resources are totally inadequate in a situation with an estimated 530,000 HIV positive persons, large and unknown numbers of AIDS cases, and a continuing rapid rate of transmission of the disease.

2. The UNICEF Response

UNICEF’s response can be followed through three consecutive Country Programmes. During 1991 – 1995, the first steps were taken in the form of an allocation for innovative project activities. In the Country Programme 1996 – 2000, the HIV/AIDS activities were quite visible and stood for a significant share of total planned expenditures. In the Country Programme for 2001 - 2005, the activities of the previous programme are continued and strengthened. The total planned expenditure for HIV/AIDS activities in the 1990s are shown in Table 1 below. The UNICEF inputs for the next Country Programme (2001 – 2005) are shown in Table 2.

Table 1: Planned expenditure on HIV/AIDS projects, as expressed in Country Programme Master Plan of Operations 1991 - 2000.

Year	91	92	93	94	95	96	97	98	99	00
Budget*										
GR		20	25	15	25	190	190	140	140	140
Suppl.						250	250	200	180	180
Total		20	25	15	25	440	440	340	320	320

* Budget in US\$ thousands, GR is General Resources, Suppl. is supplementary funds.

Sources: Master plan of operations, 1991 – 1995, 1996 – 2000.

Note: the figures for 1991 to 1995 are those of the “Innovative project” divided by 5, as the HIV/AIDS projects were expected to be one of five project components.

As we can see, the plans indicated an ambition to experiment at a low, but steady level of funding during the first Country Programme, to expand rapidly during the second Country Programme, then to gradually diminish the funding in the last two years of the Programme. The third Country Programme showed a rising level of ambition, with allocations increasing by 25 per cent. However, the major part of the increase was expected to come from supplementary funds, whereas the first four years of the Programme showed a decrease in the allocation of regular resources to HIV/AIDS. These projects were thus more dependent on external goodwill, and the fund-raising capacities of the organisation.

However, the five-year plans are interesting to the extent that they show the intentions and levels of ambitions of the Organisation. It is not at all certain that real expenditures will correspond to the targets. In the following, we will briefly review how the plans developed and what actually happened in response to the HIV/AIDS challenge.

Table 2: Planned expenditure on HIV/AIDS projects, as expressed in Country Programme Master Plan of Operations 2001 - 2005.

Year	2001	2002	2003	2004	2005
General resources	113	92	115	116	150
Suppl. funds	303	305	305	305	305
Total	416	397	420	421	455

Source: Master plan of operations, 2001 - 2005. However, the amount of general resources is actually higher, as the MPO figure here does not include funding for SHAPE, Japan Grant Aid supplies for STD/PMCT projects, staff costs, Facts for Life training, Staff association activities, advocacy, etc

The Response in the 1991 - 1995 Country Programme Period

As the epidemic did not really become visible in Myanmar until late in the 1980s, it is not surprising that this first Country Programme Master Plan of Operations (CPMP) did not have much to say on the issue. The situation assessment in the Master Plan noted in one line that “*HIV infection deserves special mention because of its sudden sharp rise among intravenous drug users and other high risk groups*”. It is not, at this stage, connected to the health and welfare of women and children.

The total UNICEF resources for the period were UD\$25 million, out of which the health and nutrition projects accounted for US\$10 million (of the General Resources).

The health programme consisted of four projects: child survival, disparity reduction, innovative activities, and systems development. The innovative activities were the smallest, with total resources of US\$390,000.

The innovative activities, in turn, consisted of five different areas of intervention:

- (i) amalyse-rich food;
- (ii) iron-deficiency anaemia;
- (iii) credit programme;
- (iv) adolescent girls; and
- (v) prevention of HIV/AIDS.

The total funds for these five activities were US\$398,000, and in Table 1 above we interpreted it as if 20 per cent of the resources were allocated to the prevention of HIV/AIDS, throughout the period (although that was never indicated). As for the AIDS project, the CPMP stated:

“The activities on prevention of AIDS in Myanmar will be implemented through a three year plan assisted by WHO and UNDP. It will be directed towards studying and educating of high-risk groups, especially intravenous drug users and patients attending Sexually Transmitted Diseases Clinics. UNICEF will assist, subject to the availability of supplementary funds, in the formulation of a communication strategy for enhancing public awareness related to AIDS and in the development of appropriate communication material mainly to promote safe motherhood and better child care.”

The CPMP (also MPO, the terms are used synonymously) was a 142 page document and the above-mentioned sentences represented the total amount of text devoted to the HIV/AIDS issue. Consequently, one cannot say that HIV/AIDS played a major role in the formulation of the CPMP, but the quote does show that UNICEF intended to commence activities, subject to the availability of funds. We should remember that the CPMP was developed and formulated in 1989 and 1990, well before UNICEF’s Board developed any policy on HIV/AIDS.

The progress of the CPMP can be traced through the subsequent annual reports (ARs). The 1992 AR showed that HIV/AIDS had now become a major issue. Under the title “*Issues of particular concern to the UNICEF Executive Board*”, more than a full page of text was devoted to an analysis of the HIV/AIDS situation. The AR reported that UNICEF implemented a number of activities: “*workshops for health personnel and community leaders, production of health education materials, including a one hour video programme that will be broadcast on television and distributed to video parlours as soon as it is cleared by the Censor Board; sentinel surveillance; and the implementation of measures for ensuring safe blood transfusion services*” (AR 1992, p: 9).

This indicates a fast start of the activities under the “innovative projects” and a more significant response to the epidemic than outlined in the CPMP. However, the next AR (1993) did not mention HIV/AIDS at all in the analysis of the situation in the country, nor did it refer to the activities of the innovative project that were described in the previous AR. However, the information in the AR is deceptive, because 1993 was a very significant year in UNICEF’s response.

During the year, the Country Office (CO) was invited to take part in a workshop on communication strategies to reach youth, organised by the Technical Support Group (TSG). In response, the CO prepared a draft plan to bring to the workshop, and this in turn led to the development of the first major HIV/AIDS project, which became operational in 1994. Hence, 1993 was an important year when considerable staff resources went into project design. As there was no staff position for HIV/AIDS work, it was decided that a Programme Assistant would be upgraded to Assistant Programme Officer, to work on the HIV/AIDS project on a part-time basis (the other part of the duties being Women's Health).

The AR of 1994 reported that the new project on reproductive health for youth and women had started. Local NGOs and other UN agencies were involved, and the project was active in 15 townships, where it was expected to provide life-skills education to an estimated 2000 youths and young women, who in turn would serve as peer educators on HIV/AIDS prevention. Work on national communication strategies had continued with various surveys, and it was expected that prototype communication materials could be developed by mid-1995. There was a project analysis table covering three pages of text on the achievement of different targets. The project had a budget of US\$441,464, which was a major increase compared to the CPMP.

The 1995 AR reported on the project, both in the General Summary of programme activities (with four lines) and with a specific sheet describing the implementation of the project plan of action. While eight targets were achieved, five were only partially achieved, and one target was not achieved. The planned budget for the year was US\$425,000 but the estimated actual expenditures were only US\$277,000. The implementation structures were apparently not yet ready to absorb a project of this size. The major achievements were in the development of training materials, and in the first training of trainers. Other achievements lay in strengthening STD clinics, introducing STD care and counselling, and in assessment and evaluation of strengthening STD services.

The Response in the 1996 - 2000 Country Programme Period

Whereas the former CPMP took an unexpected direction as the HIV/AIDS activities were intensified and expanded, the next CPMP was able to build on the work done. The HIV/AIDS project was continued, and new elements were added. Several evaluations were conducted. There was not a similarly intensified response as in the period 1991 - 1995, but the HIV/AIDS activities continued to develop. The opportunities to respond to UNICEF's policy depend on many things, not least the co-operation with the national authorities.

In the previous CPMP, one of the most successful projects was the condom social marketing campaign. Even though the Government's National Health Plan for the 1996 – 2001 period declared AIDS to be the third most important disease to combat, there were a series of official denials of the HIV/AIDS prevalence from the top political leadership. A new Minister of Health was appointed, which meant an even tougher stance in denying the disease. Condom promotion was, for example, totally banned in 1997.

UNICEF's capacity to develop a programme under such adverse circumstances depends greatly on the human resources in the Country Office, and the support that these get from other parts of the Organisation. We have tried to assess the total volume of human resources mobilised for HIV/AIDS programming work. Apart from the posts that relate directly to HIV/AIDS, there are others who contribute: the Chief of the Health Section, the Programme Coordinator, the Head of Planning and Evaluation, and the Country Representative all spend some of their time on the issue. In addition, the Office had the opportunity to use consultants for project support – persons who at later stages were recruited to fixed term positions as Programme Officers. Table 3 below illustrates the human resources in the Country Office.

Table 3: Human resources used for the management of HIV/AIDS activities in the Country Office.

	93	94	95	96	97	98	99	00	01
Senior mgmt	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.3
Health Section PO and APO	0.5	0.5	1.0	1.0	2.0	2.0	2.0	1.0	3.0
Educa-tion Section	-	-	-	-	-	-	-	-	1.0
Consul-tants	-	-	-	0.25	0.25	0.75	0.75	1.0	0.2
Total	0.6	0.6	1.1	2.45	2.45	3.15	3.15	3.15	4.3

Source: Interviews on estimated time spent on HIV/AIDS activities, plus information on posts in the CO. In person-months worked during each year.

The CPMP referred to HIV/AIDS in several key sentences. It was mentioned at the outset in the analysis of the situation of women and children and the overall strategy had one specific goal about HIV/AIDS: *“to prevent transmission among young people and women of reproductive age through promotion of reproductive health”*. The CPMP stated that the project was expected to reduce the maternal mortality and child deaths caused by AIDS, and that it would reach the target groups of youth, women of reproductive age, primary school children and general population.

In the detailed programme description, eight pages elaborated the project: *“Prevention of HIV/AIDS through promotion of reproductive health”*. This represented some five per cent of the text of the CPMP. However, given the prominence of HIV/AIDS in the situation analysis, the actual message coming through the CPMP was that this was really an area of priority. The text covered background description, objectives, outputs, etc. This is not the place to review these in detail, but it may be worth noting that a specific indicator of success was mentioned:

“This project will be considered a success if MCH centres in the country provide STD management and education services; and all primary school children have access to supplementary reading materials on STDs and HIV/AIDS.”

As an indicator of success, this seems ill-considered as it did not relate to the overall focus of the programme, which was communication about responsible sexual behaviour to youth and women of reproductive age. However, there are actually no

indications that the indicator of success was used, either in the ARs or in the mid-term reviews. Even though the CPMP presented one HIV/AIDS project in its text, at the level of practical implementation there were several different projects. The main components of the activities 1996 - 2000 were:

- (a) Life-skills Training Programme, which was conducted in collaboration with the Myanmar Red Cross Society and the Myanmar Maternal and Child Welfare Association. The objective of the life-skills training was to encourage and promote informed decision making and care-seeking behaviour among youth and women. The training aimed to provide detailed and accurate information concerning sexuality, birth-spacing, sexually transmitted diseases, and HIV/AIDS, and to provide skills for youth and women to enable them to cope with their daily lives and become proponents of community mobilisation; and
- (b) SHAPE (School-based Healthy Living and HIV/AIDS Prevention Education) was designed to equip young people with the necessary knowledge and skills to promote healthy living and prevent transmission of HIV/AIDS through the active participation and involvement of teachers, students, school principals, education officials, parents and other community members. The project's objective was to develop the curriculum of SHAPE and introduce it in schools on a pilot-testing basis.

Whereas the above-mentioned activities were the main components of the larger HIV/AIDS project, there were also other activities. The social marketing of condoms continued, as did the efforts to develop an information strategy. A project to improve STD case management at STD clinics had started in the previous CP period, and continued through 1999. There were also contacts with other NGOs to develop training materials and co-operation with religious organisations, most notably Buddhist organisations.

Table 1 above showed the planned budgets for HIV/AIDS activities in the CPMP, but actual expenditures may look quite different. Table 4 below presents these from the first year that the project became operational, in 1994, through to the year 2000. As there were actually only small amounts of money available for HIV/AIDS in 1992 and 1993, the table illustrates UNICEF's response once the project had been formulated.

The figures must be interpreted with care. The project budget expenditures (planned and real) encompass both the UNICEF Regular Resources and Supplementary Funds (OR). But there could also be other activities occurring in Myanmar that are financed in other ways, for example from global or regional funds, or from another programme component. Whilst we tried to determine all possible expenditures, there is never any guarantee that we actually discovered everything.

Table 4: Actual and planned project expenditure for HIV/AIDS 1994 – 2000 (in USD thousands).

	94	95	96	97	98	99	00
HIV/AIDS project, budget	441	425	440	440	340	320	320
HIV/AIDS project, Expenditure	346	278	298	547	108	509	457
Expenditure as % of budget			24%	58%	27%	99%	161%
Rate of change in expenditure		- 20%	+ 7%	+ 83%	- 80%	+ 371%	- 8%

Source: 1994 and 1995 data are from annual reviews. 1996 – 1999 from CPMP and Programme/project implementation for year and expenditure (prepared by SST), Year 2000 data are from PROMS.

The figures indicate an intensified and expanded response to the HIV/AIDS epidemic. Even though UNICEF did not devote that much of its general resources to HIV/AIDS activities, the CO was successful in fundraising. Perhaps, therefore, it was a better strategic choice to let the HIV/AIDS activities be more dependent on supplementary funding since there is evidence that such funds could be raised. But the response is not only reflected in the absolute level of spending; it is also interesting to consider the relative share of the HIV/AIDS activities in the Office.

Table 5 below illustrates HIV/AIDS expenditure as a share of total programme expenditure for the period 1994 - 2000. The HIV/AIDS project, plus related activities share of the total, fluctuate wildly. On average, HIV/AIDS seem to account for around five per cent of total expenditures, though there was a high relative share of 17 per cent of resources in 1995, followed by a decline to around 4 per cent of resources at the end of the decade. The conclusion is thus less certain than it first appeared. Though the actual expenditures on HIV/AIDS do show an intensified and expanded response, the relative share of the expenditures does not point to the same conclusion. In relation to other activities, the HIV/AIDS activities were first assigned priority, but then other tasks assumed equal or higher priority.

Table 5: HIV/AIDS expenditure as a share of total programme expenditure between 1994 and 2000.

	94	95	96	97	98	99	00
HIV/AIDS expenditure	346	458	298	547	102	509	457
Total expenditure	3,154	2,720	7,113	7,621	6,656	12,193	12,650
HIV/AIDS as a share of total expenditure	11%	17%	4%	7%	2%	4%	4%
Rate of change in relative share of HIV/AIDS project		+ 6%	- 13%	+ 3%	- 5%	+ 2%	0

Source: 1994 and 1995 data are from annual reviews. 1996 – 1999 from CPMP and Programme/project implementation for year and expenditure (prepared by SST), Year 2000 data are from PROMS.

The Response in the 2001 - 2005 Country Programme Period

As the situation analysis above indicates, it is as relevant to operate HIV/AIDS projects in the subsequent Country Programmes as it was in the 1990s. To reduce the

transmission of HIV/AIDS and its impact on children, women and young people is actually stated as the third objective of the CP period (out of five such overriding objectives). Not only is HIV/AIDS activities expressed as a goal, it is actually one of five objectives by which the Organisation shall be held accountable for its activities in this programming period. The CPMP summarises UNICEF's operations:

“Within the framework of the UNAIDS strategic plan, UNICEF will focus on preventing HIV/AIDS by increasing access to relevant information and education for children, adolescent boys and girls, as well as reproductive health services, and by voluntary testing and counselling for pregnant women to reduce vertical transmission. UNICEF will collaborate with partners, including international and local NGOs, to build the capacity of health staff and communities by establishing youth friendly services, behavioural surveillance systems, and counselling and care services that target people with high-risk behaviour and vulnerability.”

This is mentioned as a part of the health and nutrition programme. A major change in comparison with previous CPs is that HIV/AIDS concerns are also raised in other programme areas. The Water, Environmental Sanitation and Hygiene Programme will also develop teaching materials in conjunction with the SHAPE project. The Advocacy, Information and Communication Programme will include HIV/AIDS issues in its different projects. Compared to the previous two CPMPs, this one makes HIV/AIDS a fully cross-sectoral concern.

The level of cross-sectoral co-ordination is also reflected in the management of the Office. In 2000, a cross-sectoral AIDS team was established. A core team consisting of ten members meets on a monthly basis. This team is supplemented by an expanded team, which is convened for special occasions. The workplan covers activities such as:

- (a) participation in the UNAIDS working groups and in-house information sharing;
- (b) identification of HIV/AIDS prevention and care activities along the border areas and plan for experience sharing with China and Thailand;
- (c) assessment of socio-economic impact of HIV/AIDS in Myanmar;
- (d) preparation of a UNICEF policy statement on HIV/AIDS prevention and care; and
- (e) in-house aids HIV/AIDS information, etc.,

The work plan also covers many specific and general activities. As Table 3 illustrated, the human resources available in the Office have increased. The first year of the CPMP saw a significant increase in the number of HIV/AIDS projects. But the funding situation is still one where supplementary funds must be raised, if the programme is to continue expanding. The situation is thus precarious. Even though the priority of HIV/AIDS prevention is clearly visible, not least in the overall statement of objectives, a small share of the General Resources are earmarked for HIV/AIDS, and the success of the projects will depend on the availability of supplementary funding.

3. Policy Implementation

The review of events during the 1990s and early 2000 seems to suggest that the UNICEF country office has been responsive to Headquarters policies. In fact, the response can be divided into three phases:

- (a) During the period 1992 -1996, there were several small-scale pilot activities in communication, social marketing of condoms, partnership with schools, and the National AIDS Programme. During this time, a larger project, designed as a regional project and financed through supplementary funds took shape.
- (b) During the period 1997 - 2000, the HIV/AIDS project was consolidated at a relatively high level of expenditure and visibility. There were several evaluations, and the core activities of life-skills training and SHAPE were taken to larger audiences, and incorporated into the national curriculum. New project activities were designed, for example in the field of PMTCT, while components that proved less successful were dropped.
- (c) Following 2001, the level of expenditures has increased again and the HIV/AIDS activities are becoming a cross-sectoral concern. There is also an increase in joint UN programming.

Recalling the main features of the UNICEF policy in respect of HIV/AIDS, it is not difficult to conclude that the operations in Myanmar have been in line with this policy.

First, the policy states that UNICEF should intensify and expand its support to HIV/AIDS prevention activities. In this respect, it is important to look both at the level of ambition, as reflected in the CPMP, and the actual expenditures. The allocations have increased from one CP to the next, throughout the period studied. However, the plans signify high initial levels of expenditure, to be followed by a phase-out of activities in the final two years of each programme cycle. In that sense, the planned response is not consistently expanded and intensified.

However, the reality has been different. Even though the level of expenditure fluctuated sharply, the overall pattern has been one of an intensified and expanded response – in real terms of programme resources. Furthermore, the level of expenditure has been higher than anticipated in the CPMP. UNICEF has successfully negotiated funds from a number of bilateral donors. The actual response has been more in line with policies than the response that is visible and documented in the CPMPs.

The challenge to intensify and expand the HIV/AIDS prevention activities has not only been met with increasing programme resources. An equally important aspect of the response has been the staff resources allocated for the purpose. While no more than six person-months of work were used for HIV/AIDS activities in 1992 and 1993, new posts have been created and currently there is an allocation of four person-years of work. While the Programme itself has increased from nil in 1991 to US\$1.5 million in 2001, the staff resources have increased from nil to the equivalent of four full-time posts.

Yet another indicator of the response lies in the relative share of the programme. HIV/AIDS prevention has a high profile as one of five indicators of success of the present Country Programme whereas it was not as visible in previous CPs. But the relative share of programme resources has actually declined, even though absolute levels increased. In 1996, HIV/AIDS prevention accounted for 17 per cent of all

programme expenditures, but the figures declined to around four per cent of expenditures at the end of the 1990s and 2000.

In sum, several indicators point to an intensified and expanded programme. Actual resources have increased, and the human resources in the office are better positioned to continue expanding the programme. Building up the staff resources show that these programme activities receive priority. However, in comparison to other programme areas, there seems to have been only a small shift of priorities. UNICEF does not allocate any major share of its General Resources for HIV/AIDS activities, which is strange given the prominent place that HIV/AIDS prevention takes in the goals of the present CP.

The second aspect of policy implementation concerns the priority areas. The actual level of resources devoted to HIV/AIDS prevention is one element of policy, yet another consists of the focus areas. The policy puts emphasis on youth, on communication, and on responsible sexual behaviour. The response in Myanmar has been in line with these priorities. The two major programme components (SHAPE and Life-skills training) focus exactly on these target groups, and they are concerned with the attitudes and behaviours that characterise responsible sexual behaviour. The third programme component, strengthening STD clinics, may look as if it is out of focus compared to these priorities. Whereas it is true that the component is not as clearly targeted on youth and communication as the other two components, it does reach youth as well, as many of the people who come to the clinics are found in the target group. The project also aims to make this particular part of the health system more responsive to the needs of those with STDs.

In the late 1990s the UNICEF Office introduced the idea of a PMTCT project. This was also in line with global policies. As we have seen above, UNICEF Headquarters started publishing in this field around 1997 and 1998, and in the Programme Approach document of 2000, this emerged as a priority area. In the Country Programme of 2001 - 2005, PMTCT is one of the prioritised areas for HIV/AIDS prevention.

The third aspect of policy concerns the approaches to project design, implementation, monitoring and evaluation. The policy documents clearly specify that UNICEF's approach should be participatory and community based. Again, the three country programmes have followed these directives. The Life-skills programme, in particular, has followed a community-based approach. The training has been designed and tested on pilot sites, trainers have been recruited and they, in turn, have trained trainers. Finally, the training is disseminated through peer groups. SHAPE also reflects a community-based approach to the introduction and development of a new curriculum, not least through the close co-operation between the project and different peer groups, such as parents' associations.

The fourth aspect of policy concerns cooperating partners. Three such partners are mentioned: NGOs, the business community and the UN system. The Myanmar Country Review (UNICEF, 1999) noted that UNICEF was a significant source of support for the introduction of several international NGOs to Myanmar. Among them were Population Services International (condom marketing), Medicin du Monde (STD prevention programme) and CARE/Myanmar for behavioural research. Other

significant partners were the Myanmar Red Cross, Myanmar Medical Association, Myanmar Maternal and Child Welfare Association, Save the Children, and several others.

But, if the policy intentions in respect of NGOs have been fulfilled, it is more questionable if other partners have been involved to the extent suggested by policies. We were unable to locate any significant activities in partnership with the business community. This may not be surprising. The business community in Myanmar is not as dynamic as in neighbouring countries. Considering the little information that is available about HIV/AIDS on the domestic scene, as well as the Government's policy ambivalence, it is unlikely that the business community could yet be an innovative and resourceful partner.

While the CPMP 1991 – 1995 stated that pilot activities in HIV/AIDS prevention should be undertaken with the support of WHO and UNDP, the actual project that was formulated in 1993 and 1994 was a UNICEF project. The UNAIDS review (2001) noted that, beginning in December 1993, UNICEF took an independent lead in the development of pilot service delivery programmes. However, following the establishment of UNAIDS in 1996, UNICEF has taken part in theme groups in Myanmar, and is also a partner in the Joint UN Plan of Action which was published in 2001.

The overall conclusion is thus that the response to HIV/AIDS prevention in Myanmar has many of the characteristics that would be expected according to UNICEF's global policy statements. The question we must now raise is “why?”. What were the mechanisms through which the policy intentions of the Organisation were communicated to the CO in Myanmar? Does the response in Myanmar depend on policies from headquarters and regional levels? Or would the response have been more or less the same, even if policies had not been formulated?

Directives, Orders and Instructions as Means of Policy Implementation

Neither in documentation nor from interviews have we found any evidence of “sticks” being used as policy instruments. There have not been any directives or orders from headquarters or regional levels to enforce any of the dimensions of the HIV/AIDS programme approach. It is noteworthy that:

- there were no instructions to earmark funds, either in absolute terms or in relative terms;
- there were no directives or orders in terms of priority areas, nor in respect of cooperating partners;
- there were no directives, orders or regulations in respect of staff development training, or directives for the competence base to be available in the office;
- there were no directives, order or regulations in respect of monitoring and evaluation of HIV/AIDS projects; and
- there were no directives, orders or regulations in respect of flexibility and change in respect of the HIV/AIDS prevention activities undertaken by the CO.

There is no doubt that the Country Representative, in collaboration with the national Government and other partners at the local level, had a considerable degree of

freedom in giving the Country Programme the profile deemed necessary to best respond to the needs of the children in the country.

However, apart from direct orders, instructions, regulations and directives, there could be other ways of enforcing policy. Presumably, the most forceful instrument lies in the process of formulating and approving a Country Programme. When a draft CP emerges, this is subject to a peer review, where the Regional Office plays an important role. As a first step, the sectoral advisers may comment on the emerging CP, as may the group of UNICEF Representatives from neighbouring countries. Thus, if a draft CP deviates strongly from organisational policies, this group could send the draft back with comments and questions that, in actual practice, may well amount to the same as orders and directives. Following the regional discussions, the CP has to be approved by Headquarters and the Board, and the same pressures may arise at that level.

It is difficult to trace many years later the debates surrounding an emerging CP. In addition, the first CP is of limited concern, as we would not expect any policy follow-up at that time. During the interviews we conducted, there was no information that suggested the CP 1996 – 2000 had aroused any critical queries at other levels in the Organisation. Nobody had any objections to the plans expressed in the CPMP.

It is particularly interesting to note that there were no objections either to the draft CP that emerged in 1999. However, during the interviews, we heard that the HIV/AIDS activities were cut back and assigned far lower priority and visibility than they presently have. The CP that emerged during the first 18 months of the design process did, in that sense, deviate strongly from the HIV/AIDS policy. Still, there is no evidence of any sticks being used. The arrival of a new Representative changed the situation, and in a very short period of time, the draft CP was changed into a document, which reflected the HIV/AIDS policies as does the present, CPMP. It is, of course, a futile speculation whether the Board would have endorsed the CP in the shape it had before the revision. Nevertheless, it is noteworthy that the process had been taken quite far, without any strong objections being voiced in the Organisation.

Provision of Funds as a Means of Policy Implementation

This category of policy instruments includes all enabling devices, whereby the higher levels of the Organisation can make other levels comply with organisational policies. In the literature, these are also called the economic policy instruments.

We did not find any evidence of these policy instruments being used. On the contrary, the funding situation appears to have been rather difficult. As we have seen, UNICEF has been reluctant to use its General Resources for the HIV/AIDS project. As Tables 2 and 3 indicate, 25 - 30 per cent of the planned expenditures were expected to be covered by General Resources.

It may be possible to argue for an indirect use of the policy instrument, in the form of enabling the CO to access the bilateral donors for funds. Most of the HIV/AIDS prevention activities in Myanmar are organised under the regional Mekong project, and this in turn is funded by the Netherlands, the Japan National Committees for UNICEF, AusAID, and the Rockefeller Foundation. Even though we have not been

able to fully document how and why these organisations were contacted, and how their support was negotiated, it seems a task the CO could hardly manage on its own. A certain amount of support from regional and Headquarter levels would have been necessary, and we may thus suggest that those levels in the Organisation did assist in finding the financial resources, even if they did not provide them.

Yet another source of influence in this respect can be found in the creation of posts in the Office. As we have seen, there are now several staff positions for HIV/AIDS activities. As far as we were able to determine, these were created on local initiative. But any creation of regular posts in the Office must be ratified by Headquarters. Hence we may also conclude that Headquarters supported the CO initiative with the help of this particular group of policy instruments.

The “carrot” is thus a policy instrument that has not been used directly to encourage the HIV/AIDS prevention activities of the CO. However, it is possible to deduce an indirect use of the policy instrument as other parts of the Organisation helped the CO locate external sources of funds, and enabled the Office to create regular staff posts for work in this field.

Encouragement, Verbal Support, Communications as a Means of Policy Implementation

If there is not much evidence of other policy instruments being used, there is much more policy influence coming from information, communication, training, etc. There were several key events from which it is possible to trace a direct impact on the activities of the Country Office.

The first occasion was in 1993, when the CO was invited to send a participant to a workshop conducted by the TSG. The CO responded to the invitation and as part of the preparation, the Officer in Charge had to work on a draft plan for an HIV/AIDS project. The subject was also to be directly in line with policy, namely, on communication for young people. The workshop was attended by participants from seven or eight countries, and this workshop was followed by another, some eight months later, which the Country Representative attended.

It was in response to the invitation to the workshop that the first draft of the HIV/AIDS project was prepared. During the workshop, it was refined and later elaborated upon with the insights gained during that and the subsequent workshop. Would there have been a project without the workshop? It is futile to speculate, because the propensity to attend and the ability to apply the lessons to develop a project were individual attributes. Maybe the same persons would have developed a similar HIV/AIDS project anyway, but if so, it would very likely have been at a later stage. We think it is quite safe to conclude that without this backstopping support/training from the TSG, it is unlikely that the HIV/AIDS project would have started as early as it did. It is also likely that a response built only in the local Office would have been smaller in scale, and perhaps less able to attract supplementary funds at that time.

The regional HIV/AIDS Advisor and his team have an important role to play. Perhaps the most important aspect of the work in the Regional Office lies in encouragement,

information sharing, and technical support. This can be directed at the management of the CP, but also at supporting the advocacy role of the CO. Myanmar is a difficult environment. We have briefly outlined the policy ambivalence that characterises the Government's response to the epidemic, and this is more thoroughly elaborated by UNAIDS (2001). The Regional Office has greatly facilitated the advocacy work by the CO, not least through the regional meetings. Delegations from Myanmar have thus been exposed to an international audience. They were criticised, encouraged and challenged by health policy-makers and administrators in the region, not only by the international organisations. They came to see how other countries acknowledged the epidemic and formulated their responses. We also heard that during presentations, the national position of the Myanmar delegates was facilitated by reference to the ongoing UNICEF project. Hence, the meetings also fostered a more comprehensive and active ownership from the administration.

The personal interest and inclination of the UNICEF Representative no doubt shapes much of the programme. However, that begs the question. How are the interests and the intentions of the Country Representatives formed? According to one of our interviews:

“The regional and global conferences for Representatives and senior management are important events. The organisers invite key policy makers from all spheres of life. Academicians deliver lectures on important subjects. All this has great importance for how we understand our task, and for what we want to do. The knowledge, visions and ideas we get make us more responsive to some project ideas than to others. I am sure we all try to apply what we learn during these meetings.”

It is not possible to trace impact from any particular conference, management retreat, or workshop. There are several, and the messages coming from them probably have different meaning for different people. The “sermons” delivered through these meetings thus have considerable weight as policy instruments.

Feedback Mechanisms

Monitoring and evaluation may also play an important role in the strategic development of projects/programmes. If the feedback in annual reports and evaluations indicate that the CP is out of phase with policy priorities, there would presumably be some form of action, possibly in the form of more forceful wielding of the policy instruments discussed above. We will first look at the monitoring systems, i.e. the annual reviews and mid-terms reviews of the CPMP.

Even though the HIV/AIDS project is a major share of the CP, and takes up a significant share of staff resources, it does not figure prominently in either annual reviews or in the mid-term review. It is only occasionally that the HIV/AIDS epidemic or the project is mentioned. Table 6, below, provides a summary of the level of reporting about the issue in annual reviews. However, when considering the ARs, we must remember that these are documents that must also be approved by the Government. Interviewees frequently mentioned that the texts submitted by the staff in the office, were removed, or significantly reduced, reflecting the official stance on the issue.

Table 6: Reflecting the HIV/AIDS activities in mid-term reviews and annual reviews.

	96	97	98	99	00
Mentioned in executive summary of achievements and constraints					
- HIV/AIDS in Myanmar	No	No	Yes	No	Yes
- HIV/AIDS project	Yes	Yes	Yes	No	Yes
Mentioned in analysis of women's and children's situation					
- HIV/AIDS in Myanmar	No	No	Yes	Yes	Yes
- HIV/AIDS project	Yes	No	No	No	No
Report on progress of the project					
- amount of text	1 page	2 sections	1 page	½ page	½ page
- share of text	10%	5%	1%	8%	5%
- includes lessons learnt	no	yes	yes	no	no
Specifically analysed in lessons learnt?	No	n.a*	No	n.a*	No

Note: n.a indicates that there was no such chapter in the Annual Review.

It is interesting to note that the HIV/AIDS project plays a far more significant role in the Country Programme, and in respect of office human resources, than the ARs and the mid-term review indicate. If the Board and other addressees relied only on this information, they would get the wrong picture of the policy response. However, it is important to see what the mid-term review actually reports on the HIV/AIDS project:

“During 1996 and 1997, the project registered several achievements. First, the training utilised materials developed to enhance the life-skills of youth and women of childbearing age. The training process encouraged and promoted informed decision-making, negotiation skills, care-seeking behaviour and compassion. It has reached 23,000 youth and 41,000 women in 36 and 65 townships, respectively. This innovative training, very much based on participatory methodologies, was implemented by the MMCWA and the MRCS through their central coordinators and core trainers, and their extended network.

In a joint undertaking by DOH and MMA, the delivery of STD services has been improved by providing STD drugs and necessary laboratory equipment to 35 public STD clinics, 27 MHC centres and 69 township hospitals. A total of 35 STD team leaders, 27 MCH officers, 1,080 basic health staff and 30 laboratory technicians received appropriate training. Another important achievement was the improved care given to STD clients by establishing the syndromic STD care and management for private health care providers. A total of 1,540 general practitioners in 27 townships participated in training courses conducted by the MMA. In addition, monitoring and evaluation component will be strengthened by providing MOH with reagents and laboratory materials for syphilis testing, as an important component of the STD sentinel surveillance system. Finally, preparation is underway to establish STD database information system.

With support from the Population Council and the Rockefeller Foundation, two participatory qualitative evaluations were conducted in 1997/98 to assess the “Life-skills” training provided to youth and women by the MRCS and MMCWA. Interestingly, results show that there was an improvement in youth and women's knowledge, attitudes and practices. Women were more knowledgeable about HIV/AIDS, birth spacing, reproductive health, care and counselling of HIV infected persons; changes leading to desirable attitudes and behaviour are noted and their training has apparently induced positive changes, improved their personal and family life, and a multiplier effect among friends and family members is evident. The life-skills training also proved to have positive influence on youth, both males and females. Youth have internalised “life-skills” concepts, increased their self-confidence and changed their attitudes positively, for example in terms of decision-making, care and counselling.

Finally, a noteworthy step is the development of the school-based “healthy life style’s” curriculum, which promotes information and skills for positive healthy living and components related to HIV/AIDS for standard 2 to standard 9. From December 1997 to May 1998, 71 core trainers, 1,080 zonal managers, and 33,531 primary, middle and high school teachers from 30 project townships were trained. The implementation of the curriculum will start during the 1998/99 school year. These townships are those where the non-formal education has been already imparted to youth and women, so school training will hopefully complement and consolidate the community-based activities.”

The mid-term review thus gives a picture of project components that are quite successful, and it does not point to any particularly difficult issues arising during the process of co-operation.

The mid-term review was preceded by two evaluations. Overall, there are not many evaluation studies. In total, we counted ten reviews and assessment reports and four donor reports. However, many of these are summaries of others, build on the others, or are not directly meant as an assessment of the Myanmar CP. In fact, there are only two substantive evaluation reports, i.e. reports that systematically gather and analyse data and reach conclusions about the project being studied. These were:

- (a) A participatory evaluation of the Life-skills Training Programme in Myanmar, by the Myanmar Red Cross and the MMCWA, 1997/98; and
- (b) Sexually Transmitted Disease Care in Myanmar, by the NAP, MMA and UNICEF, 1998.

Both studies are quite good. They document the projects' components in a comprehensive manner, provide an interesting analysis, and policy-relevant conclusions. They are both qualitative and quantitative in nature, the first having an emphasis on quantitative methods, and the second having an interesting and precise use of indicators to assess results.

Yet another very useful study was the Myanmar Country review of the Mekong Sub-Regional HIV/AIDS project, prepared by Owen Wrigley in 1999. This study takes the former reports to new levels of analysis and puts them in perspective. The author also reviews other project components, as well as aspects of project management. However, even if it is a highly interesting and very relevant study, it must be considered a meta-evaluation. It builds on previous evaluations and, in a sense, is a very well prepared desk study of them. The author does not collect any new data; he puts the old data to better use and integrates it with his own knowledge and understanding of the situation. The purpose was to contribute to the mid-term review and as such, it is a useful exercise. But there is little evidence in the documentation that these insights were actually used in the mid-term review. Programme development in 1999 would have been different if the recommendations in this report had been followed.

The remaining donor reports, situation analysis and assessments do not go beyond the above-mentioned documents. They repeat the information, at times they bring the quantitative data on numbers of villages and people reached up to date, but as for the crucial questions of behaviour impact and change, they have little to add. The evaluation for the mid-term review that was quoted above actually criticises the

approach (page 36): *“Monitoring and evaluation indicators ...have few qualitative measures....There are few attempts to qualitatively evaluate depth or significance of project activities. No behavioural research has been commissioned to date that would allow for qualitative inputs into both project management and design of new intervention strategies and activities.”*

The level of evaluation activities continues to be low, and there is also a considerable backlog. Studies that were completed several years ago were only made public in 2000 and 2001. The donor reports are comprehensive and interesting, but contain the same information as the above-mentioned two evaluations, and the synthesis report.

4. Policy Results

Even though there are few evaluations of the results, it is clearly apparent that the achievements are considerable. Large numbers of people, primarily among youth, but also in other groups, have been reached with information about HIV/AIDS. Training materials have been developed, teachers trained, etc. Several NGOs have developed innovative HIV/AIDS prevention programmes with UNICEF support. One major achievement is the introduction into the national school systems of a new curriculum, which will reach all children with information and knowledge on reproductive health. This short summary cannot do justice to all the achievements, but our objective is not to present results as such, merely to indicate whether the policy has had any results.

- **New and Innovative Programme Profile**

First, there is no doubt that the CPMP has changed considerably and that it has come to include many innovative activities around HIV/AIDS. The Life-skills training, the training for children in and out of school, theatre performances, broadcast messages, peer education, etc. are examples of innovative programmes.

Population Services International (one of the NGOs with which UNICEF collaborates) conducted formative research on condom social marketing in 1995. In 1996, UNICEF provided funding for a 10-month pilot project, which introduced a Myanmar brand name. This was a great success, and the sales were also supported by a number of innovative communication techniques such as traditional music and dance events, a rock concert for youth, football tournaments, and events during a pagoda full moon festival.

As we have seen above, the HIV/AIDS programme has actually expanded throughout the period 1992 - 2005. New partners have joined in the collaboration, and new approaches to communication have been tried and further developed. The present level of cross-sectoral work, which also includes closer co-operation with other UN agencies, shows that the HIV/AIDS activities continue to develop.

- **New Partnerships**

Some of the organisations that presently take part in the project, have been partners of UNICEF for a long time. These include, for example, the Myanmar Red Cross, the Myanmar Maternal and Child Welfare Association, and the Myanmar Medical Association. But, there are also a number of new organisations taking part in the

project, at least as far as the programme in Myanmar is concerned. Several international NGOs are now part of the work in Myanmar, such as Save the Children UK, Care International and Care Myanmar, PSI and Medicin du Monde.

During the last two years of the CP, a new programme component was initiated. Preparatory work for a future project in PMTCT was initiated in early 2000, but before that, UNICEF staff worked with the Department of Health to have the initiative endorsed. The consulting team presented its report in February 2000, and the project development continued. PMTCT is also designated as a specific UNICEF project in the Joint UN Plan of Action in response to HIV/AIDS.

- **Strengthened Partnerships**

The HIV/AIDS activities have expanded, and hence most of the partners have taken part in that expansion. This means that the level of co-operation is more intense. It is probably correct to infer that UNICEF funding provides quite an important share of total funding for the NGOs involved in the programme. Some of them are also funded by UNDP, UNAIDS and WHO, but the UNICEF funding is larger and more durable.

Money is the most significant building block for partnership, but not the only one. UNICEF inputs in terms of knowledge-sharing, technical support and communication, are also widely appreciated. Hence, if the projects come to an end from the NGO point of view, it is still likely that there will be a surviving partnership. One of the larger project components was implemented together with the Myanmar Medical Association. The results of the project were discouraging, and that component was discontinued. But the partnership continues, and there are close contacts between the UNICEF Office and that organisation.

- **Improved Communication and Coordination**

The HIV/AIDS project is part of the Health Section in the UNICEF Office, and it is also presented as one of the health projects in the CPMP. But as we have seen, it consists of many components, and one of the most significant is actually an education project. The Education section in the Office has managed this, hence there has been a cross-sectoral coordination between these two units throughout the 1990s.

However, a new step in cross-sectoral coordination was taken in 2000, when the CHAT group was formed. This was described above, and it gives a new weight to the coordination efforts. HIV/AIDS concerns will now be integrated in all major projects, where the issues are relevant.

- **Contribution to National Policies and Strategies**

The national policy response to HIV/AIDS has been ambivalent, and during several years the Government was very reluctant to approach the issue. However, there is a National AIDS Programme, and there is a rudimentary structure to cope with the epidemic in the Ministry of Health. The UNICEF project has very good collaboration with the operational staff of the Ministry and there can be no doubt that the HIV/AIDS project has played a major role in formulating the national response to the epidemic. The different advocacy activities have patently contributed to a better

understanding of the disease and of how it can be prevented. But it is a long and slow process, given the reluctance of the highest political leadership to recognise the full scale of the epidemic and the behavioural change that is a necessary step in coping with it.

- **Integration with National Plan**

The National Plan is general in nature, and still quite rudimentary. We have also seen that there are practically no funds available from the Government budget. Hence the question of integration with a National Plan is hypothetical. UNICEF's HIV/AIDS project budget is, in 2001, almost 30 times higher than the Government budget.

- **Replication and Scaling up of Pilot Programmes**

The project has, since its beginning in 1994, been characterised by a gradual scaling-up of activities. The different components were usually introduced in a small number of townships on a pilot scale, then refined and replicated on a larger scale, and in subsequent phases on an even larger scale. Some have become national activities, most notably the SHAPE programme, which is now part of the national curriculum.

- **Evidence of Programme Impact**

Impact is at present mainly documented through numbers of people who have been trained at different levels, in different areas. There are also a number of output indicators, as for example in training material produced, books disseminated, etc. One very popular project was the publication of 100 Questions and Answers about HIV/AIDS, which was actually banned from the media, but is available as an independent publication. There is a huge demand for that and similar forms of information.

There is very little information available on behaviour change. The bits and pieces of behavioural research which has been done, seems to indicate that there are still many myths about HIV/AIDS and STDs generally, as well as much risk-taking behaviour. The level of drug use is high in many areas, and all the risk factors that make Myanmar society vulnerable to the epidemic are still in evidence.

- **Changing Trends in Prevalence and Incidence**

The official figures on numbers of HIV positive and reported AIDS cases indicate that the rate of transmission is growing. WHO and UNAIDS have not revised their figures of the epidemic and there is no comprehensive surveillance data. However, there is nothing in the environmental situation to suggest that the rate of transmission is declining. 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 some US\$5 million. Whilst it is a substantial amount of money, it is obviously not enough to have an impact on an epidemic of this scale.

References

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1996

1997

1998 (Mid-term review: programme review and overview)

1999

2000

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IV Life-skills and SHAPE documents

SHAPE

SHAPE (Primary Level – Teachers' Manual)

SHAPE (Middle and High level – Teachers' Manual)

Reproductive Health & HIV/AIDS

V Donor reports

Donor report to Rockefeller Foundation

Japan National Committee (Consolidated report)

The Netherlands National Committee

The Japan Committee

VI National AIDS Programme Documents

Joint UN Plan of Action

Situation Assessment (with WHO)

CASE STUDY 2: THAILAND

1. Status of the Epidemic

Thailand's response to the HIV/AIDS epidemic has been celebrated as a great success. It has shown that the epidemic can be slowed down even in a country where commercial sex is common, and where the disease spread rapidly. Consequently, the Thai experience has been studied many times and there are a number of good reports available to describe what happened. The purpose of this section is to provide a background for the UNICEF activities. We will therefore draw on recent publications such as the World Bank (2000) and Karnpisit (2000).

AIDS had arrived in Thailand by 1984, but the initial policy response was muted. The prevailing view was that this was an epidemic brought from abroad that would be confined to a few individuals in high-risk groups, such as gay men and injecting drug users, and that it would not spread more widely. However, rising infection levels among sex workers launched subsequent waves of the epidemic in male clients, their wives and partners, and their children. In 1993, infection rates among 21-year-old army conscripts reached 4 per cent nationally.

In 1990-91, the Government launched a nation-wide campaign to reduce HIV transmission. The key elements of the programme were a massive public information campaign launched through the media, Government and NGOs and a programme to promote universal and consistent condom use in commercial sex. The response was led by a multi-sectoral National AIDS Prevention and Control Committee, chaired by the Prime Minister, which actively engaged NGOs and civil society. The results were dramatic. Fewer men went to brothels, condom use in brothels rose to more than 90 per cent, and infection rates among army conscripts dropped by half in only a few years.

The most recent data suggests that the annual number of new HIV infections peaked in the early 1990s and has declined by more than 80 per cent. Since 1993, an estimated 200,000 fewer people have been infected with HIV than would otherwise have been the case. The World Bank study concludes that this is an accomplishment that few other countries have been able to replicate. It is a result both of sound policy and the determination of the country.

Nevertheless, there is no room for complacency. Despite the success at lowering the new infections, HIV managed to gain a foothold in the population before policy was enacted and the consequences are apparent. Nearly 300,000 people have died of AIDS and 700,000 people are living with HIV/AIDS, the result of past infection rates and the long incubation period of HIV. Models suggest that in 2000, 55,000 people developed AIDS, and equally many would have died from it. Nearly one million people have been infected since the beginning of the epidemic and this number continues to grow, albeit at a slower rate.

The composition of new infections has changed. A decade ago, virtually all infections were among adults and more than 80 per cent were among sex workers and their clients. In contrast, of the estimated 29,000 people who became infected in 2000, 4,000 were children. About half of new adult infections were women infected by their

husbands or sex partners, a quarter were due to injecting drug use, and one in five occurred among sex workers and their clients. HIV prevalence is stable or rising among pregnant women in all regions. The prevalence of HIV in high-risk groups like sex workers, though reduced, is still high.

As those infected in the past fall ill, the demand for treatment is transforming the agenda of the national response. The demand for AIDS-related medical care – palliative care, prevention and treatment of opportunistic infections, anti-retroviral therapies, and end of life care – is rising. At the same time, the sustained response on prevention appears to be in jeopardy: Overall public expenditure on the national AIDS programme has declined by 28 per cent since 1997 and the prevention budget has declined by half. Prevention now accounts for only 8 per cent of the national AIDS programme budget.

The National Plan for Prevention and Alleviation of HIV/AIDS sets forth two key objectives – to prevent the spread of HIV in the general public and to reduce the impact of the epidemic on the population. The National Plan clearly states that success in overcoming the epidemic will require the joint effort of many partners in Government, the private sector, and civil society. Each partner brings a comparative advantage in addressing different aspects of the problem.

The World Bank report (2000) identified three priority activities that were expected to have the largest impact on the epidemic in the whole population. That short list was not meant to suggest that other activities should not be undertaken, but rather to draw attention to a smaller set of priority activities that would have the largest impact if undertaken immediately and in addition to ongoing efforts. These activities were subsequently supported by UNAIDS and were also presented as the Government priorities during the discussions we held in the country. The priority activities were:

- (a) a renewed effort to sustain condom use in commercial sex and to raise condom use, encourage safer sexual behaviour, and behaviour change among other groups at high risk and more widely in all relationships;
- (b) a major new initiative to prevent transmission by injecting drug use. HIV prevalence in this group is high and rising. A quarter of all new adult infections is due to injecting drug use. Left unchecked, the high infection rate among IDU will continue to be a reservoir for HIV transmission to the rest of the population; and
- (c) ensuring access for people with HIV/AIDS to cost-effective prevention and treatment of opportunistic infections. People with HIV/AIDS can fall seriously ill and die from curable infections that people with normal immune systems can resist or fight back. The most important of these is tuberculosis, but there are many others. Ensuring access to prevention and treatment of the major opportunistic infections is inexpensive, cost-effective, prevents life-threatening infections, will extend life and improve its quality, and will benefit in particular poor AIDS patients who otherwise might have gone untreated.

In responding to AIDS, Thailand clearly was able to draw on strong institutions and traditions that may not be present in other countries. These include:

- (i) an extensive network of STD services;
- (ii) strong and successful family planning programmes that had promoted condoms before the AIDS epidemic;
- (iii) a cadre of trained epidemiologists supported by the field epidemiology training programme; and,
- (iv) health infrastructure with qualified staff and a civil society with a tradition of volunteerism.

The rapidly expanding economy, with phenomenal growth rates up to 1997 inspired confidence in the administration and provided financial support for the response.

The lessons learned from Thailand show that:

- (i) effective action requires national leadership and political commitment at the highest levels;
- (ii) epidemiological surveillance is a critical tool for generating public awareness, political commitment and action;
- (iii) effective programs may “lead” policy to the right outcomes;
- (iv) NGOs can play a key role in ensuring non-discrimination and respect for human rights and in sustaining progressive policies of behaviour change;
- (v) a nation-wide programme that reduces transmission via commercial sex can have a potentially great impact on the course of the epidemic, even if enacted late; and
- (vi) good STD services are no insurance against an AIDS epidemic, but they were very important to the success of the 100 per cent condom programme (which exemplifies the potential success of multisectoral collaboration with a well-defined objective, support from the centre, and benchmarks for measuring success).

Finally, it is argued that the main contribution of the multi-sectoral approach at the national level in Thailand has been to raise the profile of the AIDS problem across society, to engage new participants in the policy dialogue and to set national priorities. This role in priority setting and consensus-building at a societal level is extremely important to the process of political mobilisation and may be the most important contribution of national-level multisectoral organisations.

2. The UNICEF Response

The period under review is covered by three UNICEF Country Programmes: 1989 – 1993, 1994 – 1998, and 1999 – 2003. Each Country Programme has its own distinctive features, and the UNICEF response can be characterised by its main features in each of the country programmes.

- In the first programme, we saw an escalated and intensified response. Starting from almost nil, significant new resources were devoted to HIV/AIDS prevention activities, and the CP featured many innovative programme components;
- During the second country programme the projects were consolidated, but the resources devoted to HIV/AIDS prevention increased significantly, in absolute and in relative terms. The projects had high visibility;

- In the third programme, the HIV/AIDS prevention has limited visibility, and the activities are spread as subcomponents in other programme areas. There is not any common cross-sectoral programming, and the staff resources in the Country Office have, until very recently, been a constraint (there has been no HIV/AIDS Programme Officer between 1997 and 2001).

In the following paragraphs we will look more closely at each of these programme periods. However, the information on the first programme is rather limited. In the review below, we thus focus on the 1994 – 1998 CP, but when describing the projects, we trace their background and lessons learned from the previous programme period.

The overall objectives stated in the 1994 – 1998 UNICEF HIV/AIDS programme were: to prevent HIV transmission among young people and women of child-bearing age and to promote appropriate models for care of children affected by AIDS. The CPMP had the following specific objectives:

- (a) to achieve 80 per cent coverage in implementation of life-skills educational activities that comprehend the AIDS topic in primary, secondary and vocational schools;
- (b) to increase knowledge and skills to face the risk of HIV infection in young people that do not attend school;
- (c) to strengthen the NGO involvement and capability in the response to AIDS; and
- (d) to test and disseminate appropriate models for care of children affected by AIDS and for hard-to-reach groups, such as hill-tribe populations and street children.

The HIV/AIDS programme was one of seven substantive programme areas, and it had high visibility in the CPMP. In the project description, a total of 28 pages were devoted to analysing the HIV/AIDS programme, and this also took a large share of the text in the introductory parts of the CPMP. As the CPMP was a document of 300 pages of text and tables, slightly more than 10 per cent of the volume dealt with HIV/AIDS. Table 1 below shows the planned expenditure for the HIV/AIDS projects, and relate this to the overall spending in the Office.

Overall, the HIV/AIDS programme accounted for around 17 per cent of total expenditure during the five years of the programme, but the HIV/AIDS programme took a much larger share of total expenditure towards the end of the programme period than it did in the initial years. The rate of increase of HIV/AIDS expenditure was very high - more than 50 per cent in three out of four years. The Table shows an interesting change in funding pattern; in the initial years, UNICEF's regular resources were the major source of funding, but towards the end of the CP, supplementary funds accounted for more than 90 per cent of programme expenditure.

Table 1: HIV/AIDS programme expenditure during 1994 – 1998 (in USD thousands)

	1994 (actual)	1995 (actual)	1996 (actual)	1997 (estimate)	1998 (planned)	Total
HIV/AIDS Programme						
General resources	199	198	300	104	94	895
Supplementary	23	258	184	772	1,304	2,541
Total	223	349	495	877	1,399	3,436
Rate of change		+ 56%	+ 41%	+ 77%	+ 62%	
HIV/AIDS Programme as a share of total Programme	6%	10%	17%	20%	24%	17%

Source: End of Cycle Review. Royal Thai Government and UNICEF Programme of Co-operation.(p.45)

The HIV/AIDS programme consisted of four projects (CPMP 1994 – 1998, p. 236 – 264). The first project was HIV/AIDS Education for Youth in School. The objectives were to help young people gain knowledge, skills and practices to deal with challenges of life and develop greater resistance to harmful and negative behaviour. The project was meant to reach youth in formal and non-formal education facilities as well as through peer education outreach for communities. The project intensified the efforts of previous UNICEF-assisted projects in municipal schools and teacher training colleges. The previous project built on two types of school-based intervention. The first reached all municipal schools and was implemented by the Department of Local Administration. It promoted positive life choices for school children and considered risk behaviour in the context of health and social values. The second intervention focused on an HIV/AIDS prevention campaign in teacher training colleges. Manuals and other materials were produced, and became part of the curriculum for teacher training.

The lessons learned from the 1989-1993 CP were summed up in three paragraphs: action research, flexibility in programming and extensive coverage. The first (research) means that there is no single best approach to obtaining changes in behaviour; the most effective approach must continually be sought and action research is an essential guiding tool. Consequently, it is also important to be able to modify the projects, and hence the programming must be flexible. The extensive coverage means that a nation-wide strategy could be formulated on the basis of the earlier project and all schoolteachers could be reached, thus having a greater impact.

The second project in the CPMP was HIV/AIDS Education for Out-of-School Youth. The project targeted youth working in large and medium-size factories and was meant to provide assistance for youth working in small business and in the informal sector, such as street vendors and garage attendants. The project emphasised communication strategies for women, using mass media and interpersonal channels.

The UNICEF-assisted project for factory workers began in 1991. This pilot project was implemented in 21 provinces and provided a workplace-based model which, by 1993, was used by a number of other agencies, including the Ministry of Labour and

Social Welfare. In 1991, UNICEF assisted with the production of the Karate Kids” posters and books on AIDS for young people, both in and out of school. In 1993, UNICEF provided funding to an urban-based project in Bangkok to promote accessible counselling and STD services for women and adolescents. This was implemented by two NGOs: the Thai Red Cross Society and the Population and Community Development Association.

The project for factory workers was also implemented by the Thai Red Cross and it was actually the first UNICEF-supported project that was not managed by the Ministry of Public Health. The lessons learned section in the CPMP says that *“The positive experience of collaboration with the Thai Red Cross and other NGOs led to a significant expansion of UNICEF – NGO collaboration”*.

The third project in the CPMP was called Community Support for HIV/AIDS. The main thrust of the project was to increase the implementation of NGO-assisted prevention and care activities and the monitoring of issues related to the rights of children and women. The CPMP explains the logic of the project in these words: *“Many NGOs are in close contact with communities. Moreover, the smaller size and administrative flexibility of NGOs means that they can respond faster to the needs of communities. However, lack of management experience and small size can also limit the capacity of NGOs and other community based organisations to contribute effectively to AIDS prevention and control.”*

This project also built on activities during the preceding CP. The project document refers to projects with substantial co-operation with NGOs, where the NGOs were either the main implementing agency or partners with government agencies. One UNICEF-assisted project, “Prevention among the Hill Tribe Population in Northern Thailand” formed partnerships among at least 12 other NGOs and Government agencies. The objective, as explained in the CPMP (p. 253) was to increase, by 1998, the technical and human resource capacity of NGOs to monitor and implement AIDS projects which supported the implementation of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women. It is also worth mentioning the specific objectives which were:

- (i) to establish, by mid 1994, a framework for monitoring NGO activities and by 1995, to be monitoring and reporting issues related to the rights of children and women. These included:
 - monitoring of health and welfare of AIDS orphans and of families affected by AIDS; and
 - monitoring changes in laws, which protect the rights of individuals;
- (ii) by the end of 1995, local NGOs and other community-based organisations would be trained in AIDS-related activities in all provinces. Ninety-five per cent of the target number (1,500) of NGOs would be trained; and
- (iii) by 1998, there would be an increase in the number of NGOs and other community-based organisations in all the provinces contributing to AIDS-related activities. It was expected that 50 per cent of NGOs and other community-based organisations in Thailand would be contributing to AIDS-

related activities. Provincial and district plans would indicate the involvement of community-based organisations and NGOs.

Though the general project objectives did not mention HIV/AIDS, it is clear from the detailed specification of objectives that this was the target. The capacities that would be built were to cope with the HIV/AIDS epidemic.

The fourth project under the HIV/AIDS programme was “Reaching the Unreached with HIV/AIDS Intervention”. The CPMP of 1994 noted that assessments of existing AIDS prevention and control efforts had revealed that the majority of hill tribe children, slum children, street children and those in the sex industry did not receive AIDS/STD interventions in spite of their high vulnerability to HIV infection and STDs. This project aimed to develop accessible and acceptable AIDS/STD interventions for these target groups.

There were no previous project activities with this focus, but the UNICEF-assisted efforts that started in 1989 for youth and women could draw the conclusion that there was a need to reach these particular groups. The CPMP mentioned that since the Government and NGO response to AIDS had increased enormously, it was time for UNICEF to focus on areas that had not yet been addressed.

In sum, the planned activities of the CPMP showed an intensified and expanded response to the epidemic. More precisely, the CP showed an intention to expand and intensify and to build on the lessons learned during the previous CP. This is an important distinction. The response did not start with the 1994-98 CP, it had started already in 1989 and developed through 1993. The later CP continued the efforts that were started several years before.

However, plans are one thing, actual implementation and expenditures another. The administrative framework around the programme came to differ substantially from the planned activities. The four projects were in fact merged into two: the first and second became a package of HIV/AIDS Education for children and youth in- and out-of-school; the third and fourth projects became one project on “Reaching the Unreached” through community-based efforts. The strong emphasis on NGO capacity building in the third project was never implemented. The nature of the objectives also changed for both projects.

The Mid-term review conducted in July 1996 recognised that the national response to the AIDS epidemic had continued to grow significantly since 1994. The AIDS budget for the fiscal year 1997 reached US\$60 million. In this context of very diversified, widespread and dynamic activities, the review recommended concentration of UNICEF co-operation in the Northern region, particularly in the Upper North, where the epidemic was seen in a more advanced phase. The aim of this recommendation was to be able to contribute better to AIDS risk reduction, especially in groups less covered by governmental services, as well as to draw lessons for AIDS prevention and care in other regions. Supplementary funds were made available by international donors for activities in this region. The mid-term review thus recommended a revision of the previously formed strategy for the CP, namely to have nation-wide projects (which had been one of the lessons learned from the 1989 – 1993 CP). We were not able to detect any debate around this strategic choice, since all decision makers in the Office were appointed subsequently.

The UNICEF Country Office is relatively small. As Thailand is a middle-income country, it does not get priority in the allocation of funds. The regular resources allocated to Thailand have been decreasing steadily, and it is also difficult to attract funds from bilateral agencies. However, UNICEF has been able to raise substantial amounts of funds in Thailand, but these can only be used for programme activities, not for staff. The amount of person-years devoted to HIV/AIDS work has thus been limited and has been a constraint for the development of the response, particularly since 1998. There used to be a Programme Officer with an HIV/AIDS specialisation, but since 1998 this post has been vacant. The programme work was shared between the Deputy Representative and other staff in the Office, and we would estimate that only some weeks, up to a month, could be spent on the programme annually. When there was a fully employed person, the CO would have been able to allocate some 13 to 15 months of work to the programme annually.

The new CPMP for 1999-2003 gave the HIV/AIDS programme a new twist; it was actually abandoned, and a new logic of structuring the CP took precedence. There are now four programme areas:

1. Child Protection and Development
2. Promotion of Child Rights and Disparity Reduction
3. Social Policy Analysis and Monitoring the Goals
4. Technical Co-operation among Developing Countries.

Each of these programmes consists of two to four projects, but none of these projects bear a title that would suggest it is an HIV/AIDS project. However, at the level of sub-projects, there are a number of activities that relate to HIV/AIDS, particularly under the first two programme areas. The consequence is that HIV/AIDS prevention is not visible in the overall structure of the CPMP.

One of the projects under the Child Protection and Development Programme is called "Integrated Family Development for Child Protection". It has a budget of US\$913,000. One of the four objectives is to "strengthen prevention of AIDS at the community level". One of the four sub-projects carries the same name as implied by that objective. But this sub-project, as well as HIV/AIDS related sub-projects under other projects, actually consists of a number of even smaller projects. Table 2 provides an inventory of the different activities, and also indicates the budget frames. As the table proves, it is not that difficult to get an overview of the HIV/AIDS activities, but the visibility and focus in this CP is quite different from that of the 1994 – 1998 CP.

Table 2: HIV/AIDS related activities during the CP 1999-2003

Activity	Funds available (US\$)	
	Regular resources	Supplementary funding
Training of Buddhist monks and nuns in using life-skills for protecting and caring for children affected by HIV/AIDS		10,400
Develop temple schools to be "Child Friendly Learning Environment" using the "Child Centred Teaching-Learning" approach		40,200
Development of HIV/AIDS intervention among vulnerable youth in Northern Thailand		16,850
Promoting of youth participation in HIV Prevention Programme in the Northeast Thailand		17,750
Seafarers project		28,000
Small grants projects and project administration		50,000
Project monitoring	5,000	
A "Child-friendly" Community Schools Approach for Promoting Psychosocial Development and Resilience in Children and Youth Affected by AIDS		15,000
Northern, Eastern NGOs provide protection and care for children affected by AIDS, AIDS orphans		40,000
Support to NGOs for prevention and care of HIV/AIDS in Bangkok		12,600
World Aids Day Activity		10,000
The Fifth International Conference on Home and Community Care for Persons Living with HIV/AIDS	8,000	
The 8 th National Seminar on AIDS		6,000
Tools for Life-skills Training for Youth		18,700
District-based AIDS orphans project in the 4 districts of the North		100,000
Assessment of district based AIDS orphans project	10,000	
PMCT: HIV/AIDS Counselling and Testing Region 3		34,700
PMCT Field testing Manual		5,600
PMCT Surveillance of children born to HIV infected mothers		35,800
PMCT Community based project		30,000
PMCT Training on Counselling and Testing		40,000
PMCT Evaluation Package	-	
PMCT National Evaluation	-	
PMCT Global Strategy of PMCT, Uganda	5,000	
Manual for Informed Decision making among pregnant women on the implications of HIV infection on children		26,800
Support documentation of best practices – Sanpatong HIV/AIDS	20,000	
Research on the medium and long-term impact of HIV/AIDS on children and child welfare		13,800

The table shows that the total expenditure on HIV/AIDS activities would be around US\$600,000 in 2001. In 1991 and 2000, the budget for HIV/AIDS activities was US\$693,000 and US\$333,000 respectively, and the actual expenditures were only slightly lower (US\$635,000 and US\$328,000 respectively). Compared to the 1994-1998 CP we thus see a significantly decreased response to the HIV/AIDS epidemic. The CO is back to the level of expenditure in 1995 and 1996. However, this picture may not tell the whole truth.

During interviews we were told that several other components in the current CP might contain activities that relate to HIV/AIDS. The development of child-friendly schools, for example, contains activities that also foster life-skills, which among other things

contribute to more responsible sexual behaviour. We are not in a position to assess how many other projects or programmes contribute to the HIV/AIDS objective of the CP. When looking at the CPMP, we cannot see much evidence that these concerns are raised at the formal level of setting objectives, identifying activities, and defining outputs. Here, HIV/AIDS figures on the earmarked sub-components, but not otherwise.

From our point of view, the design of the present CP raises a dilemma. However, we are not in a position to discuss whether the framework of projects and programmes provides a better response to the situation of children and women in Thailand. Obviously, the management of UNICEF at local, regional and headquarters levels have come to that conclusion, as well as the Thai Government as a collaborating partner. There can be no doubt that the present CP is less focused on HIV/AIDS than the previous CP; there are fewer activities, fewer cooperating partners, fewer objectives and less financial resources. The trend in the expenditure figures point to further decreases. The presence of a HIV/AIDS focal point in the CO indicates an intention to reverse that trend. It is worth noting that a special budget allocation from New York made it possible to recruit a person for this post.

3. Policy Implementation

The review of events during the 1990s and early 2000 seems to suggest that the UNICEF country office has implemented the kind of programme that is outlined in the policy documents, not least in the programme approach from 1992. In fact, the response can be divided into three phases:

- (a) during the period of 1989 - 1993, there were several small-scale pilot activities in communication, partnership with schools, working with minority groups, NGOs, factories and other work places;
- (b) during the period 1994 - 1998, two HIV/AIDS projects were consolidated at a relatively high level of expenditure and visibility; and
- (c) following 1999, the level of expenditures has decreased and the HIV/AIDS activities are not as visible in the CPMP. New projects (PMTCT), in line with policy development started in 1998, are now the major activity in HIV/AIDS prevention.

Recalling the main features of the UNICEF policy in respect of HIV/AIDS, it is not difficult to conclude that the operations in Thailand have been in line with the main thrust of these policies, if not necessarily with everything.

First, the policy states that UNICEF should intensify and expand its support to HIV/AIDS prevention activities. In this respect, it is important to look both at the level of intention, as reflected in the CPMP, and at the actual expenditures. The allocations increased from the 1989-1993 CP to the subsequent CP, but then declined again in the 1999-2003 CP. Hence, when the whole period is analysed, the intention cannot actually be characterised by an intensified and expanded programme.

But reality reveals a more complex picture. The four projects that formed the HIV/AIDS response in the 1994-1998 CP had budgets totalling US\$10.3 million in the Master Plan of Operations (CPMP) for the period, but the actual level of expenditure on the HIV/AIDS programme was estimated at US\$3.8 million in the mid-term review. It is likely that actual expenditures fell short of that, due to the economic crisis in East Asia which began in 1998. The programme that was implemented still expanded significantly compared to previous levels of expenditure, but it fell short of targets (reaching an estimated 30 per cent of expected volume during the 1994-1998 period). The level of expenditure has decreased since, though the fluctuations from one year to another is so high that a longer period of time is required to establish trends.

The challenge to intensify and expand the HIV/AIDS prevention activities has implications for staff resources that are used for the purpose. The Bangkok Country Office is small, and it is also affected by the close proximity of the EAPRO. In the period up to 1998, there was a HIV/AIDS focal point in the Office, meaning that there was a full time Programme Officer with a professional background in HIV/AIDS work. That post was discontinued in 1998, and it is thus not so surprising that the volume of expenditure and the general visibility of HIV/AIDS issues in the CP has declined. At the request of the CO, UNICEF Headquarters has approved funds for a new post in the CO, and since July 2001, there has been a full time Programme Officer devoted to HIV/AIDS issues

Yet another indicator of the response lies in the relative share of the programme allocated for HIV/AIDS activities. HIV/AIDS prevention does not have a high profile in the present CP, but was very visible in previous CPs. Nor are there overall objectives in the CP in respect of HIV/AIDS prevention. However, appearances are deceptive. The relative share of programme resources has actually gone up, even though absolute levels decreased. Due to the sharp decline in programme resources, the overall annual expenditure on the CP in Thailand does not appear to be more than around US\$1.6 million, and thus the annual expenditure on the HIV/AIDS projects may amount to as much as 30 per cent of the total.

In sum, several indicators point to an intensified and expanded programme during the larger part of the 1990s. But around 1998 the situation changed. Staff resources were cut back, funding become problematic, and the new CP design revealed priorities of a different nature. In spite of this, the relative importance of HIV/AIDS activities has increased, but that may be due more to the difficulties in funding other activities. The Thai CP relies on supplementary funds to a very high degree, and much of those funds are actually mobilised in Thailand. Furthermore, it may have been easier to mobilise funds for HIV/AIDS activities than for many other projects mentioned in the CPMP. In comparison, UNICEF does not allocate any major share of its General Resources for HIV/AIDS activities.

The second aspect of policy implementation concerns the priority areas. The policy puts emphasis on youth, on communication, and on responsible sexual behaviour. The response in Thailand has been in line with these priorities. The two major programme components (Youth in- and out-of-school, and Reaching the unreachable) focus exactly on these target groups, and they are concerned with the attitudes and behaviours that characterise responsible sexual behaviour. In the mid-1990s, UNICEF

funded a pilot PMTCT project, which was later expanded to become the major activity in HIV/AIDS prevention. This is also much in line with global policies. As we have seen above, UNICEF Headquarters started publishing in this field around 1997 and 1998, and in the Programme Approach document of 2000, this emerged as a priority area. Whereas this sphere of activities is not quite in line with the policy of 1992, it corresponds well to policies that developed in the mid and late 1990s.

The third aspect of policy concerns the approaches to project design, implementation, monitoring and evaluation. The policy documents clearly specify that UNICEF's approach should be participatory and community-based. In particular the third project of the 1994-1998 CP (which was subsequently merged with the fourth project) had community participation as a main theme, but the approach also figured in the other activities. In order to reach out-of-school youth, the operational strategy was *"increased participation of community groups, government agencies, business associations and workers' groups"* (CPMP, p. 246).

The fourth aspect of policy concerns cooperating partners. Three such partners are mentioned: NGOs, the business community and the UN system. In Thailand, UNICEF has worked actively with all three. The End of Cycle Review of the 1994-1998 CP noted that some 150 groups were reached during the period (p. 22). It is also clear from the project outlines of the CPMP of the 1994-1998 period that large numbers of NGOs were involved in the different activities. However, their involvement had already started in the previous CP. The management and staff of the CO in the early 1990s must be credited with having approached many new partners. It is even mentioned in the CPMP that this was innovative, as previously no projects had been implemented outside the administrative structure of the Ministry of Health. The tradition of working with new partners has been kept, and the two other CPs covered in this analysis also included extensive involvement with NGOs, and the business community

Due to the presence of many other UN agencies in Thailand, a high level of interaction is unavoidable. UNICEF has worked actively with UNAIDS, and was the focal point for UNAIDS in 1997. The end-of-cycle review noted that UNICEF gained support from various UN agencies to develop strong supporting mechanisms at regional and national levels (p. 22).

The overall conclusion is that the response to HIV/AIDS prevention in Thailand has several of the characteristics expected in accordance with global policy statements. The question we now have to raise is "why?" What were the mechanisms through which the policy intentions of the Organisation were communicated to the CO in Bangkok? Does the response in Thailand depend on policies from headquarters and regional levels? Or would the response have been more or less the same, even if policies had not been formulated? The latter is an interesting question, as the response in Thailand actually came before the policies. As we have seen, the programme in Thailand was largely shaped in the period from 1989 to 1991, before the Executive Board document of 1992 had been disseminated in the Organisation.

Directives, Orders and Instructions as Means of Policy Implementation

Neither in documentation, nor from interviews, have we found any evidence of “sticks” being used as policy instruments. There have not been any directives or orders from headquarters or regional levels to enforce any of the dimensions of the HIV/AIDS programme approach. It is noteworthy that:

- there were no instructions to earmark funds, either in absolute terms or in relative terms;
- there were no directives or orders in terms of priority areas, nor in respect of co-operating partners;
- there were no directives, orders or regulations in respect of staff development, training, or directives for the competence base to be available in the office;
- there were no directives, order or regulations in respect of monitoring and evaluation of HIV/AIDS projects; and
- there were no directives, orders or regulations in respect of flexibility and change in respect of the HIV/AIDS prevention activities undertaken by the CO.

There is no doubt that the Country Representatives, in collaboration with the national Government and other partners at the local level, had a considerable degree of freedom in giving the Country Programme the profile deemed necessary to best respond to the needs of the children in the country.

However, apart from direct orders, instructions, regulations and directives, there could be other ways of enforcing policy. Presumably the most forceful instrument lies in the process of formulating and approving a Country Programme. When a draft CP emerges, this is subject to a peer review, where the Regional Office plays an important role. As a first step, the sectoral advisers and the group of UNICEF Representatives from neighbouring countries may comment on the emerging CP. Thus, if a draft CP deviates strongly from organisational policies, this group could send the draft back with comments and questions that, in actual practice, may well amount to the same as orders and directives. Following the regional discussions, the CP has to be approved by Headquarters and the Board, and the same pressures may arise at that level.

It is difficult to trace, many years later, the debates around an emerging CP. In addition, the first CP is of limited concern, as we would not expect any policy follow-up at that time. During the interviews we conducted, there was no information that suggested the CP 1994 – 1998 had aroused any critical queries at other levels in the Organisation. Nobody had any objections to the plans expressed in the CPMP. The same applies to the 1999-2003 CP. The latter is, from our point of view, more surprising. As the visibility of HIV/AIDS activities has been reduced, there are no overall targets in this field, and very little General Resources earmarked for HIV/AIDS work, we would have expected some to have been expressed. As the CP was endorsed by the Board without comment, the conclusion must be that the UNICEF Board and management found that the programme reflected the policy concerns.

Provision of Funds as a Means of Policy Implementation

This category of policy instruments includes all enabling devices, whereby the higher levels of the Organisation can make other levels comply with organisational policies. In the literature, these are also called the economic policy instruments.

We have not found any evidence of these policy instruments being used. On the contrary, the funding situation appears to have been rather difficult. As we have seen, UNICEF has been reluctant to use its General Resources for HIV/AIDS projects.

According to the plans for the 1994-1998 CP, some 10 per cent of the total expenditures were expected to come from General Resources, and the balance provided from supplementary funds. In practice, the overall expenditures fell short of targets, but we have no information whether the balance between sources of funding changed. In the year 2001, we saw that around seven per cent of planned total expenditures were met from General Resources.

It may be possible to argue for an indirect use of the policy instrument, in the form of enabling the CO to access the bilateral donors for funds. The Regional Office may have assisted the CO locate and negotiate funds from international donor agencies. Although we have not been able to document fully how and why these organisations were contacted, and how their support was negotiated, support from regional and headquarter levels could have been forthcoming. We may thus suggest that those levels in the Organisation did assist in finding the financial resources, even if they did not provide them.

Yet another source of influence in this respect can be found in the creation of posts in the Office. When the HIV/AIDS focal point was withdrawn in 1998, this seems to have had implications for the HIV/AIDS activities. Headquarters influence thus had a negative effect on the growth and extent of the HIV/AIDS programme. Consequently, the decision to provide new funds for that post, and the subsequent recruitment, will have a correspondingly positive effect. In any case, this is clear evidence of the use of the "carrot" as a policy instrument.

Encouragement, Verbal Support and Communications as a Means of Policy Implementation

As the CO is part of the global system of communication, it gets all the messages coming from Headquarters and the Regional Office about the priority that should be given to HIV/AIDS prevention. However, we have not been able to make any explicit connections between these messages on the one hand, and the Thailand CP on the other. As we saw, the most significant policy development grew out of the experiences of implementing the 1989-1993 CP. As there have been several complete staff turnovers, there is no organisational memory in the Office that could trace the influences during this period.

The changes from the 1994-1998 CP to the 1999-2003 CP do not reflect any policy. Rather, they relate more to the funding situation in Thailand, the fact that Thailand is a medium income country with a high profile national AIDS programme and that Thailand is a country where external funding agencies have come to reconsider their priorities. If the encouragement and verbal support and other "sermons" in respect of HIV/AIDS had had an impact, the design of the CP would have been different.

The question can be asked to what extent this category of policy instruments was used in respect of Thailand? First, we noted that many of our interview respondents had a rather general understanding of UNICEF's HIV/AIDS policies. Neither the Executive Board document of 1992, nor the Programming Approach document of 2000 were well-known. It was actually not possible to locate the source of UNICEF policy, and hence the understanding of its content was vague. That the UNICEF policy is about youth, about PMTCT, is perhaps obvious.

Feedback Mechanisms

Monitoring and evaluation may also play an important role in the strategic development of projects/programmes. If the feedback in annual reports and evaluations indicate that the CP is out of phase with policy priorities, there would presumably be some form of action, possibly in the form of more forceful wielding of the policy instruments discussed above. During our visit to the CO, we reviewed the evaluation database for the period analysed, that is, from 1990 up to the present. The database listed the documents set out in Table 3 below.

Although they are listed as evaluations, some of the documents have the character of general reviews, future oriented studies, needs assessments and position papers. Our 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.

Table 3: Content analysis of evaluation database.

Year	Title	Purpose/contents
1991	AIDS and Children: Prospects for the Year 2000	To project the number of children affected by HIV/AIDS, to estimate effects on mortality rates, and orphaned children.
1994 *	Evaluation of HIV/AIDS prevention through health education and non-formal counselling in Thailand	Evaluation for rough picture of process and outcome activities
1994	Needs assessment and documentation of life-skills training and peer education experience in Thailand	To identify the needs, possibility and approaches for life-skill training in Thailand
1995	Provincial Health Survey	To measure the coverage of health services, to study health behaviour, and to monitor the health status of people
1995 *	Teaching life-skills for AIDS prevention with ONPEC teachers	To assess the impact of the programme, and to analyse obstacles to, and opportunities, for teachers training in this field
1996 *	HIV/AIDS prevention and care intervention among hill tribes: lessons learned and policy and programme implication	Analysis and interpretation of data from four mini-projects, and development of recommendations
1998 *	Evaluation of Recovery Programme of the Prevention and Occupational Development Centre	Assess impact and outcome of the recovery programme, analyse behaviour change, and recommend how programme can be strengthened and synthesise lessons learned

Source: UNICEF Intranet, evaluation database

Code: * an evaluation, according to the OECD/DAC terminology.

It is uncertain whether all the studies were undertaken. The database informed us that the 1998 evaluation was underway, but had no summary of findings, lessons learned or recommendations. Nor was there any budget. We therefore conclude that the evaluation never actually happened. A total of three evaluations were undertaken during this period. Should that be considered an adequate number?

As the CP in Thailand formulated an innovative response to the HIV/AIDS challenge very early, it would have been desirable to document the experience and to distil lessons learned. The evaluations mentioned above are not in a form that allow them to be widely shared and there is, indeed, no indication that they have been used that way. This is probably a missed opportunity for organisational learning.

The HIV/AIDS projects have relied on external funding. Perhaps the funding agencies satisfied themselves with site visits or other verbal information on the success and impact of the projects. These few evaluations cannot be enough to satisfy any controlling agencies about the impact of HIV/AIDS prevention. Accountability would thus appear to be rather low. Furthermore, the discussions held at mid-term reviews and end-of-cycle reviews would be informed by evaluations undertaken during the programme cycle. During the 1994-1998 cycle there were only two evaluations, and these only covered a small part of the activities.

The two evaluations undertaken during the 1994-1998 CP were both analysed. They were readily available in the CO. Both were solid pieces of evaluation work, based on sound strategies of data collection, comprehensive analysis and practical recommendations. The evaluation of "Prevention and Care among Hill Tribes" was based on participatory methods. Both evaluations were available in a basic format, straight from the evaluators' computers so to speak. No efforts had been made to publicise them for a wider audience, even though the content was quite interesting and of considerable relevance for others working with development of life-skills education, or community-based programmes of prevention and care.

But evaluation activities could be more extensive than we have captured so far. The evaluation database also includes Programme Review Sheets. There were three such sheets: 1994, 1996, and 1998. They were concerned with:

- (a) HIV/AIDS education for school youth
- (b) Health education for out of school youth project
- (c) HIV/AIDS Community support for the HIV/AIDS project

The sheets summarised decisions and recommendations. These were mainly concerned with expansion of activities, clarification of goals and objectives, the necessity of monitoring and evaluation, and the need for clear division of labour and distribution of roles among the actors. The sheets contained lists of agencies involved in the review - in one case it was a consultant only, whereas in the two other cases it was only UNICEF. As tools for learning and accountability, the review process - as documented here - is of limited value.

However, the CO database did not contain one of the most significant evaluations of the programme. Activities in northern Thailand, which constitute 40 per cent of the programme resources, are financed under the Mekong sub regional AIDS project.

This project was evaluated in 1998, and the analysis of that project was also summarised in specific donor reports to the bilateral funding agencies. Through this evaluation, the CO could be held accountable for a large share of its HIV/AIDS activities.

The Mid-term review had recommendations of a practical nature, but as we saw, there were no in-depth evaluations at the time that could feed into the review. The information was thus largely quantitative in nature, and dealt more with project delivery and outputs than with qualitative insights, outcomes and impact.

The end-of-cycle review had a good summary of the experiences through the 1990s. Many of the lessons learned could actually also be found in a rudimentary form in the previous CP. The report devoted nine pages (out of a total of 131 pages) to the HIV/AIDS programme, which does not quite reflect the significance of HIV/AIDS projects in the overall budget (17 per cent during the cycle). The review also suffered from the format, as nine pages is not much to present results, lessons learned, etc, from a programme, which was so diversified. Little of the excellent work done in the two evaluations mentioned earlier was brought forward in the end-of-cycle review, and there were probably many other insights and lessons learned that simply could not be reported in the review. In the next section, where we review the policy results, many of the findings are quoted from the end-of-cycle review.

4. Policy Results

It is beyond the scope of this report to make an independent and comprehensive analysis of results. We can only base our analysis on the evaluations and reviews that have been produced by UNICEF and its partners, that is, the monitoring and evaluation system that was reviewed above. We have chosen to call this analysis a review of policy results. However, that presumes a causal link between policies, activities and results. As we have noted above, the HIV/AIDS programme in Thailand cannot, in any credible way, be linked to policies. Rather, that link goes from Thailand to policies rather than the other way round (bottom-up, rather than top-down). Before we return to that question, let us see what the results were. The end of cycle review concludes that:

“HIV/AIDS has been a very successful programme due of course to a lot of support and attention given by the Government at the highest level, encouragement and recognition given to the work of NGOs and CBOs and decentralised decision making adopted effectively by Government.

Through the participation in the UNAIDS Programme activities, various networks and through national campaigns for fund raising activities, UNICEF has played a catalytic role in advocacy and awareness raising that goes along the projects specifically funded by the organisation. Following indicates the trends in HIV prevalence”

The report goes on to provide the statistics of HIV infection rates, indicators of sexual behaviour, etc that are directly related to a potential impact of the projects activities (though of course mostly affected by the Thai society’s response to the epidemic). The report summarises the Organisation and focus of the work: *“Since 1997 UNICEF co-operation has been organised in the two projects “HIV/AIDS education” and “to reach the unreached”. In reality the educational component has been the most*

important in activities included in both projects and has developed at the same time skills for prevention and care.”

- **New and Innovative Programme Profile**

The first UNICEF programmes had focused on youth and women in childbearing age. During the implementation of these projects, it was noted that there was a huge increase in Government and NGO activities in these fields (in the early 1990s). Consequently the programme responded by seizing opportunities where other programmes were not yet established. This included the projects for factory workers (i.e. under 18 years of age), street children, hill-tribe communities and children subject to sexual exploitation. The HIV/AIDS activities have also been integrated with projects around the concept of “child-friendly-schools”, which was new in the 1990s.

- **New Partnerships**

The projects in the first CP established links with several NGOs. One example was mentioned above, where the UNICEF-assisted project to prevent HIV/AIDS among the hill-tribes of northern Thailand formed partnerships with 12 NGOs. The CPMP mentions that there are over 300 NGOs, and many other community-based organisations such as workers’ associations and religious groups that could be enlisted in the fight against HIV infection. Not that UNICEF approached them all, but during the 1990s, there were new partnerships with many of them. That it was new, is reflected in the statement of the CPMP 1994-1998 (p. 251) that the co-operation with the Thai Red Cross, which started in 1991, was the first project implemented by an agency other than the Ministry of Health.

Although we have no overview of HIV/AIDS activities in other countries, the programme in Thailand seems to be one of the few that has successfully been working with the private sector. UNICEF works with the Thailand Business Coalition on AIDS. This network was established in 1993, and is a link between the private and public sectors. It aims to create AIDS-supportive work environments by providing HIV/AIDS education and prevention seminars and promoting the adoption of appropriate workplace policies.

- **Strengthened Partnerships**

UNICEF co-operation in the programme has been divided into many small local projects - there were more than 60 different project activities under the umbrella of the two main projects. This has been largely due to the strong role of NGOs as entities capable of ensuring flexibility, good quality and efficiency in working outside the boundaries of the existing established services. As a consequence, UNICEF is perceived as an important and valuable partner. During our visits, the interview respondents pointed particularly to UNICEF’s role in organising seminars and workshops, sharing information and bringing together different actors that would not meet otherwise. This role was more valued than monetary support or actual programme outcomes. During the late 1980s, UNICEF did not play this role, and would not have been appreciated to that extent by the NGO partners, and we must

conclude that the partnership with the NGO community has emerged and been significantly strengthened during the past 10 years.

- **Improved Communication and Coordination**

As we have seen, the Royal Thai Government has a large HIV/AIDS programme, and UNICEF's resources are small in comparison. There are large numbers of actors working with HIV/AIDS issues. It is beyond the scope of UNICEF, or any other organisation for that matter, to coordinate all. So, to what extent are activities coordinated, and what is UNICEF's contribution to the coordination process?

In theory, coordination 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 coordination among the UN agencies, but the major feature of that coordination is standardisation – each agency works according to its own niche in the international community. In that sense it adds little value, its primary contribution being to explain and make visible the logic of the division of labour between the UN agencies. On the other hand, for those who do not see the difference between agencies, this may bring a better understanding of their potential contribution.

UNICEF's programme has focused on communication. Its activities in schools and among communities have centred on communication, and so has its capacity building activities among the NGOs. However, communication is an activity that must be sustained by budgets, and the volume as well as quality of communications depends of the level of funding. The peak in communication was presumably reached in the period 1993 - 1997 and since then, activities have been less intense.

- **Contribution to National Policies and Strategies**

The Thai policy response to the HIV/AIDS epidemic has been significant. It is influenced by a variety of factors, not least the economic situation of the country. It evolves in interaction with the global research community. The advocacy of international organisations also has an impact, not least the World Bank, WHO and UNAIDS.

The present priority areas of the national strategy are not exactly UNICEF's priority areas. On the other hand, they are supplementary, and there is nothing in them that go against the policies of UNICEF. But at the same time, the strong emphasis on condom use and commercial sex, drug users, and opportunistic infection, are not quite UNICEF's priority categories of action.

UNICEF's work in the field of HIV/AIDS prevention and care 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 it 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 national curriculum.

- **Replication and Scaling up of Pilot Programmes**

One of the problems in working with small-scale projects in co-operation with NGOs is that it may be quite difficult to know whether and how activities are replicated and scaled-up. There can be no doubt that innovative NGOs imitate each other, and learn from each other. Successful modes of intervention are likely to be disseminated in these networks, but it is also likely that ideas, knowledge and models of intervention are transformed. There is no tradition of recording where ideas come from, nor of crediting those who may have started promoting a special kind of activity.

It is thus more likely that a project is replicated and changed by another organisation, than that it is scaled-up in the same organisation. Many of the NGOs seen here are really small, and their capacity to expand a successful programme is often quite limited. The extent to which UNICEF's programme in Thailand has led to scaling-up of pilot activities, is mainly seen in the projects undertaken together with the Ministry of Health, and the Ministry of Education (and possibly with NGOs as partners with the Ministries). The PMTCT is a prime example, but the education programmes also deserve mentioning.

- **Evidence of Programme Impact**

The experience of the programme in Thailand raises some key questions around evaluation. As we have seen, 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, led by its Government and, to some extent, supported by international organisations, has produced these results. The combined response has had an impact. 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 and 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.

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(See Table 3, page 37)

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CASE STUDY 3: UGANDA

1. Status of the Epidemic

Uganda is presented as both among the worst and most promising countries in terms of HIV/AIDS. On the one hand, a country with close to 1.5 million people infected with HIV/AIDS and on the other, a country where the rate of infection seems to have stabilised to around 30 per cent in 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 decline.¹

Further, self-reported data indicates an improvement in knowledge and avoidance of risk behaviour, especially in younger age groups. There also appears to be a substantial increase in the use of condoms by all age groups. An analysis of 300 studies provides relatively conclusive evidence that changes in behaviour are responsible for the reduction in incidence (UNICEF Uganda Annual Report 1999).

But prevalence rates remain still dangerously high and at the end of 1997, it was estimated that nearly one million people, or 9.5 per cent of the population between 15 and 49 years of age, were living with HIV/AIDS. The Government of Uganda (GOU) -UNICEF Task Force concluded recently that there is “*no credible evidence that the end of the epidemic is in sight* (Confronting the HIV/AIDS Epidemic, 1999).

In Uganda AIDS has surpassed malaria and other diseases as the leading cause of death among individuals 15-49 years of age. More than seven per cent of reported AIDS cases are children under 12 years of age. Poverty, HIV/AIDS and insecurity in Northern and Western Uganda has increased the number of orphans and children who need special protection. Government estimates of orphans (i.e. children who have lost one or both parents, increasingly from AIDS) in 1997 were 1.5 million while UNICEF's figure for 2000 is 2.7 million.

2. The UNICEF Response

The Government of Uganda responded early to the warnings and initial cases of HIV/AIDS. President Museveni became the first African leader to declare AIDS an economic and social catastrophe. Since the mid-1980s, UNICEF Uganda was one of the first international organisations to become involved in HIV/AIDS programmes. In the early phase, UNICEF programmes mainly concentrated on creation of awareness, understanding the epidemic, breaking the silence and fighting discrimination and stigmatisation.

¹ Questions have been raised whether the fall in number of HIV positive people really indicates that the epidemic is waning (Epstein, 2000). Incidence can remain high and even increase while prevalence rates are declining – if prevalence fell during the nineties mainly because many people infected during the war simply died of AIDS in the 1980's.

The 1990-1994 Country Programme

In the 1990-1994 Country Programme there were two major health education programmes known as “Safeguard Youth from AIDS” (SYFAIDS).

Some of the old and new programmes were:

- a) Health Education Network (HEN) from 1988 to support health education programmes in the Ministry of Health;
- b) School Health Education Project (SHEP) from 1987 to reach children in and outside the formal school system. HIV/AIDS became gradually a part of this project;
- c) Most Vulnerable Children Project supporting orphans and other vulnerable children in especially difficult circumstances;
- d) The People with AIDS project from 1991; and
- e) Support to NGOs for various types of information, education and communication activities.

The 1995-2000 Country Programme

Several important changes were introduced in the 1995 - 2000 CP. The first was a move away from the former vertical, sector-based approach towards a multi-sectoral way of organising the programme. The second was a shift of attention from national level to district level activities in line with the decentralisation of local government in the country. The third was the introduction of capacity building at all levels as an important strategy with both government and civil society partners.

The Country Programme consisted of four major components:

- **Health** – to address the physical development of children
- **Water and Environmental Sanitation** – to address the environmental risk and domestic workload faced by children and women
- **Basic Education, Child Care and Adolescent Development** – to address the psychosocial and cognitive development of children and adolescent
- **Coordination, Communication and Advocacy** – to promote an enabling environment for all the above

In order to promote positive family behaviour, the Country Programme supported four strategies as part of each of the four components:

- Building capacity at community level
- Improving skills of service providers
- Improving skills of resource managers and decision-makers
- Improving the policy environment

Basic Education, Child Care and Adolescent Development (BECCAD)

BECCAD was perceived as both a concept and a programme – focusing on the growing Ugandan child from birth to adolescence and on her changing psychosocial, emotional and cognitive needs. As a programme, it clustered strategies and activities in areas of basic education, childcare and protection and adolescent development.

a) Adolescent health and development

In the area of adolescent health and development, BECCAD focused, in the beginning, on the prevention of HIV/AIDS/STDs and reduction of mother to child HIV transmission. But the focus on adolescents opened up to include also young people's social and emotional needs, which eventually led to the adoption of a more broad-based approach to adolescent health and development.

(b) Communication/advocacy

This component (previously SYFA) targeted youth between the ages of 5 to 15 in the “window of hope”, where infection rates were still very low. This was primarily a communication initiative aimed at persuading young people to adopt no-risk or low-risk behaviour.

The activities covered:

- television and radio programmes;
- “Straight Talk” and “Young Talk”, monthly newsletters for younger adolescents;
- the “Philly Lutaaya Initiative” for people with HIV/AIDS; and
- at a later stage, the “Sara Communication Initiative” - a multimedia package focusing on issues affecting female adolescent in South and Eastern Africa, and first launched in Uganda in 1996. In Uganda, at least 45 NGOs, districts and schools use Sara materials in video shows, festivals and sensitisation.

(c) Promotion of life-skills for children in and outside schools

The first phase of the School Health Project concentrated on the provision of information – leading to an improvement in level of awareness and knowledge, but insignificant changes in behaviour. The original idea was to introduce health education as an examinable subject. However, this was not accepted and life-skills became, eventually, a non-examinable concern infused into other subjects at primary and later secondary level.

The in-school population was reached through revised curriculum, new materials and teaching methods. Out-of-school children were also reached with training in numeracy, literacy and life-skills. Training in incorporation of life-skills into primary and secondary schools reached nearly universal coverage of teacher tutors (Annual Report, 1998). Seventy-five per cent of all Primary Teacher Colleges responsible for pre-service training of primary school teachers, 100 per cent of National Teacher Colleges responsible for training secondary school teachers and faculty of the National Institute for Teacher Education and the National Curriculum Development Centre benefited from the programme.

But evaluations found that knowledge and new practices hardly reached the classrooms. Initially, life-skills were supposed to be a part of health sciences, but teachers did not adopt and follow the life-skills messages. The life-skills initiative has

recently been revitalised and a more focused approach is underway in which psychosocial life-skills becomes part of the Health Science curriculum.

(d) Youth Friendly Health Services

What was called “Adolescent-Friendly Health Services” (AFHS), was introduced in five districts under the 1995-2000 Country Programme. The services included provision of information on sexuality, growth and development, reproductive health services, counselling and linkages to life-skills education.

(e) Communication and Advocacy

The CCA (Coordination, Communication and Advocacy) Programme had a special responsibility to support advocacy efforts across the country. The promotion of, for instance, Sara as a role model and the use of Sara materials have been promoted through this programme.

Mid-Term Review of UNICEF Country Programme (1997)

A comprehensive Mid-Term Review (1997) demonstrated the following three successes:

- a) a successful transition from a project to a programme approach. Emphasis had been placed on strengthening underlying service delivery systems and on integrating activities within and across sectors;
- b) greater emphasis on capacity building and empowerment approaches; and
- c) establishment of management structures that enhanced government ownership and multi-sectoral team decision-making.

The three most difficult problems were found to be:

- a) the need for a better balance between process and outcomes – to demonstrate that processes lead to concrete, positive outcomes for women and children;
- b) the need for better coordination across the country programme – to integrate the collection of programme specific activities; and
- c) demands for further decentralisation while the technical and financial capacity at district level were found weaker than expected.

In 1998, it was acknowledged that the decentralised, multi-sectoral and participatory programming was far from straightforward and also too ambitious in some areas (Annual Report, 2000). It was recommended that the programme be focused on a set of attainable activities at district level, while comprehensive district activities were eliminated.

In terms of HIV/AIDS, it was also acknowledged that basic knowledge of causes, modes of transmission and consequences was not the major problem, but that changes in behaviour had not matched this knowledge. Hence, a need was identified to revise and adjust the knowledge transfusion model, which was implied in the

communication and information strategy, and to focus more directly on change in behaviour.

GOU-UNICEF Task Force

In 1999, the GOU-UNICEF Task Force was established to identify gaps in knowledge and action in the area of HIV/AIDS and to revitalise the national response. The Task Force, recognising the signs of complacency setting in due to Uganda's status as a success story, outlined the priority actions and strategies to bring HIV/AIDS back onto the political agenda, with greater emphasis on district-specific responses (Confronting the HIV/AIDS Epidemic).

The 2001-2005 Country Programme

In the new Country Programme, HIV/AIDS is presented as "a priority among priorities" and the promotion of human rights serves as the fundamental basis to enhance the quality of development programming. This is said to imply that *"the focus of programme planning and implementation is on identifying individuals or groups responsible for meeting children's rights. The rights based approach also seeks to reinforce duty-bearers' ability to fulfil children's rights and right-holders' ability to claim and uphold their rights. The ultimate objective is to motivate individuals at all levels of society to become active partners in the development process"* (Annual Report, 2000). The programme consists of the following components:

- HIV/AIDS: Rights to Self-Protection
- Maternal Well-being: Early Childhood Development and Rights
- Community-Based Malaria Prevention and Control
- Child-Friendly Basic Education and Learning
- Rights of Children in Armed Conflicts

The programme seeks to advocate an approach whereby health, education and development are seen as rights to be realised and not only as needs to be met. The new programme addresses the following challenges:

- more emphasis on adolescent and community participation in programme design and implementation;
- designing comprehensive approaches that effectively cause sustained behaviour change or development of positive behaviour;
- reaching children in the classroom with life-skills education and a wider spread of high quality out-of-school life-skills practices;
- accessibility for adolescents to youth friendly health services; and
- improved partnership and collaboration with other donor funded programmes in order to harmonise approaches and strategies in districts.

3. Policy Implementation

- **Priorities are Country-Driven**

Priorities and programmes have primarily been shaped from below – based on needs and opportunities as they have emerged in the country – and not on a global policy or comprehensive analysis and plans for HIV/AIDS. We have not been able to trace the concrete events and processes that influenced the selection of individual programmes, but they are all in line with UNICEF general priorities and, to a large extent, a result of initiatives taken by a group of strong UNICEF Country Representatives during the 1990s, UNICEF Programme Officers and their partners.

- **An Incremental and Additive Policy Process**

UNICEF has consistently supported some programme priorities from the beginning (youth, school health, communication, NGOs, etc.) The policy development process has been incremental with no dramatic changes from one year to the next. Even the changes introduced by the 1995-2000 Country Programme did not change programme priorities as such, but more strategies for implementation (decentralisation, more integrated approaches, more emphasis on capacity building, etc.).

The process was also additive in the sense that new priorities were included in the Country Programme without excluding others. There has been a shift in allocation of resources, but few cuts.

- **A Rich Programme Flora**

The additive and incremental processes, in combination with a broad global policy, have allowed UNICEF to spread its resources to a large number of programmes, activities and partners. Since we have not been able to analyse expenditure, it is difficult to assess to what extent UNICEF has spread its resources too thinly, but plans and reports provide a picture of a rich and varied programme flora. With increasing budgets, UNICEF will often tend to include new programmes and priorities since they are all based on needs, but such an approach presents a challenge for UNICEF's technical and managerial capacity.

It is interesting to ask why certain priorities are not included in the UNICEF programme. For example, AIDS orphans have received weak attention. The reason given was the lack of a global policy on orphans. We are not arguing that UNICEF Uganda should have provided more support to AIDS orphans. Orphans could have been excluded because of resource constraints or because other organisations provided such support. Needs are endless and most programmes can be justified in their own right. What UNICEF would have needed was not only a policy for what to support, but also criteria for excluding new projects.

- **Weak Involvement of Headquarters and the Regional Office**

The Country Office is of the opinion that both Headquarters and the Regional Office have played a marginal role in developing HIV/AIDS priorities and programmes and in providing technical support to those programmes. Current Programme Officers are

not aware of, and consequently have not read, the global UNICEF HIV/AIDS policy. They believe that the policy development process has followed more of a bottom-up direction, i.e. lessons learned from programmes in Uganda become part of global processes and return later to Uganda as UNICEF policy.

The perception of independence is to some extent exaggerated. There is a strong element of self-discipline in UNICEF. Representatives will most often not overstep the invisible border of accepted corporate policy, even if it is not written down. Most Representatives will, for instance, keep a low profile in contentious areas like condom distribution, abortion, sexual abuse of school children by teachers, etc. There are certain things UNICEF stays away from and areas in which a low profile is found useful.

On the other hand, most priorities and programmes are also in line with global policies – partly because those policies are broad, developed as a result of lessons learned at country level and because UNICEF staff are exposed to the same information, ideas and messages around the world. They read the same reports, hear about the same successes and internalise the same common wisdom about what programmes are supposed to work.

The importance of the formal planning and review mechanisms in UNICEF should also not be underestimated in shaping Country Programme priorities. Both Headquarters and the Regional Office take active part in the discussion and approval of draft Programme Plans of Operations and are also involved in annual and mid-term reviews of programmes. The Regional Office in Nairobi has also formulated a clear strategy for HIV/AIDS.

- **The Policy Environment is Rich and Flexible**

The UNICEF Country Office perceives the policy environment around HIV/AIDS as broad and flexible. It is relatively simple for a CO to fund any sensible programme, except for the few contentious areas mentioned above. No interest is expressed for a more strict global policy in the future.

- **New Policies are Supported with Sermons and Resources, not Directives**

We did not find any evidence of new policies and priorities introduced by using “sticks” – directives and rules from above - leading the Country Programme in specific directions. On the other hand, some “carrots” have been available, for example, additional financial resources for a programme priority such as HIV/AIDS. There are more “sermons” – written and verbal communication - conveyed in meetings and reports affecting the process of setting priorities.

- **Missing or Weak Participation**

UNICEF promotes participatory planning at all levels. On the other hand, Government partners often have limited capacity to take active part in long and complex planning processes.

Country plans are a result of broad consultative processes, but the Plan of Operations and other project documents are often produced primarily for UNICEF and their donors. They tend to be dominated by complex terminology, not reflecting participatory processes or promoting user friendliness. The rights-based approach in the new CP is interesting, but the analytical framework is complex and the new terminology looks impressive, but to some extent difficult to operationalise.

Groups weakly represented in the planning process were said to be children, women and young people. It is complicated to involve direct beneficiaries in planning, but it is a challenge for UNICEF.

- **Few Organisational Learning Mechanisms**

In the early 1990s, Uganda was a so-called “*strategic programming country*” for UNICEF globally in the area of HIV/AIDS and it became an active member of the Technical Support Group (TSG) process in the Youth Health and Development Group.

The TSG Evaluation (Organisational Learning, 1999) referred to the following positive outcomes of the TSG process for Uganda:

- the meetings were useful in broadening the approach to HIV/AIDS programming;
- the process influenced the decision to include adolescents as a target group;
- TSG encouraged countries to take programmes to scale; and
- the technical support and technical discussions in meetings were useful.

The TSG Initiative was thus an example of an organisational learning mechanism facilitated by UNICEF Headquarters. Through a participatory process, new messages and programme ideas were fed into Country Programmes and technical partners provided short or long-term inputs in relevant areas.

However, TSG came to an end in the mid-1990s and nothing replaced what had been found useful. The Regional Office is said to have played a marginal technical role in the area of HIV/AIDS but few relevant networks exist. Technical inputs have been provided by individual consultants or institutions invited directly by the Country Office. It should, however, be mentioned that the Regional Office in Nairobi has more recently formulated a set of clear regional targets for HIV/AIDS which will be monitored continuously.

In the area of rights-based programming UNICEF Headquarters and the Regional Office have provided important inputs. Other levels of UNICEF must have heavily influenced the analytical framework in the Plan of Operations and the new terminology in the area of rights.

4. Policy Results

- **Expansion of the Approach**

The global HIV/AIDS policy document from 1992 stated firmly that UNICEF should expand and intensify its response to HIV/AIDS by investing more resources and

broadening its interventions to fight the epidemic. What happened in Uganda during the 1990s in terms of scaling-up the response?

Uganda was one of the first countries where UNICEF funded HIV/AIDS programmes beginning in mid-1980. The previous chapter on UNICEF's response during the 1990s shows a clear and broad commitment supported by both regular and extra-budgetary resources. HIV/AIDS became an important part of the 1990-94 Country Programme, had an even broader position in BECCAD (1995-2000 Country Programme) and in the 2000-2005 Programme, HIV/AIDS has become "a priority among priorities". There is little doubt that UNICEF expanded and intensified its response during the last ten years

The only problem is that UNICEF Uganda has no financial data to verify and quantify the absolute growth in HIV/AIDS spending through the 1990s and to show the relative expenditure on HIV/AIDS compared to other programme priorities. The financial reporting system does not capture data from activities integrated in broader programmes, a weakness explained in more detail in the main report.

The conclusion that UNICEF's HIV/AIDS response was scaled-up during the 1990s is therefore, strictly speaking, based on informed estimation. Without a baseline and solid information on intended and actual resource allocation, UNICEF has no mechanism and basis for setting and changing priorities. In order to move direction, you need to know where you are coming from. More and better data is said to be available in the new Country Programme period.

The HIV/AIDS Task Force in Uganda (Confronting the HIV/AIDS Epidemic 1999) reported that UNICEF had contributed US\$35 million to HIV/AIDS between 1986 and 1998, making UNICEF the second largest donor after USAID to HIV/AIDS activities in the country up until 1998. The absolute figures are only estimates, but the trends and relative importance of UNICEF as a donor is said to be correct.

Source of Funds	Amount US\$
WHO (GPA) (86-95)	14.5 Mill
UNAIDS (96-98)	3.0 Mill
UNDP (87-98)	15.5 Mill
UNICEF (86-98)	35.0 Mill
World Bank (90-98)	30.0 Mill
EU (88-98)	8.5 Mill
USAID ((88-98)	46.0 Mill
DFID (90-98)	16.0 Mill
GTZ (91-98)	1.0 Mill
Italian Co-operation (94-98)	4.0 Mill

In the new Country Programme (2001-2005), the HIV/AIDS component absorbs 22 per cent of regular resources (US\$5.766 million) and 24 per cent (24.561 million) of total resources. This probably represents a major increase in absolute and relative investment in HIV/AIDS compared to previous Programmes.

• Major Achievements and Innovations

The previous chapter provided an overview of UNICEF-assisted HIV/AIDS programmes during the decade. What were the major achievements and to what extent were some of the programmes and approaches new and innovative in the Ugandan context? We also seek to identify examples of initiatives, which were replicated and/or taken to national scale.

The assessment is limited to stated achievements, meaning that we have not been able to verify their validity and our information is based primarily on UNICEF's own documents. However, key findings were discussed with, and to a large extent supported, by other informants in Uganda.

(a) Contributing to declining trends in HIV/AIDS prevalence.

The most important achievement is that HIV/AIDS infection rates declined in Uganda during the 1990s, particularly among young people. It is impossible to attribute such achievements directly to UNICEF and/or measure the relative importance of individual programmes. On the other hand, it is not unreasonable to argue that since most of the programmes have been implemented, some on a large scale, that UNICEF has, in all probability, made a positive contribution to the declining trends.

(b) Placed HIV/AIDS and adolescent development on the agenda.

UNICEF Uganda played an important role in the early 1990s in focusing attention on young people and HIV/AIDS, in addition to children and women. UNICEF provided support to the formulation of policies for adolescent health and prevention of HIV/AIDS among young people in the previous two Country Programmes, a priority that was also followed-up in the new Country Programme (with a strong component on prevention of HIV infections among young people and teenage pregnancy). The focus on young people has changed over time and other priorities have been introduced, but UNICEF has not lost its original concern for adolescents, even if the increasing number of new priorities has, to some extent, changed the original youth focus.

(c) Promoted a broad multi-sectoral and decentralised approach to HIV/AIDS prevention.

During 1995-2000, the GOU-UNICEF Country Programme went through a number of changes. The first was a move away from the previous vertical, sector-based approach towards a multi-sectoral way of organising the programme. Secondly, in keeping with the decentralisation and restructuring of local government in Uganda, attention and programmes shifted from national to district level. In the new Country Programme, 80 per cent of the resources will be spent in districts, while some strategic national programmes are maintained to support the district focus.

(d) Introduced and supported psychosocial life-skills education in and outside the formal school system.

UNICEF was involved from the mid-1980s in the School Health Education Programme and played an important role, first in including HIV/AIDS in the curriculum and later, in introducing life-skills education in the country. This was an innovation in the Ugandan school system. Despite weaknesses in strategies and implementation of the life-skills approach, a new concept was introduced with much stronger links between information and potential behavioural change.

Life-skills education in Uganda is also an example of UNICEF taking a programme to national scale. The original ambition was national coverage and almost all teachers

were retrained. The programme did not successfully reach the classroom and intentions were diluted along the way, but it became, nonetheless, a national programme.

(e) Supported a broad range of information, education and communication (IEC) activities for young people, particularly girls.

IEC has been important for UNICEF from the start, but changes have been introduced over time and some of the initiatives have had clear innovative qualities (e.g. Straight Talk, Sara Communication Initiative). Some of the achievements were:

- providing technical and financial support to more than 25 NGOs, youth groups and religious groups;
- support to new communication initiatives targeted at young people, like “Straight Talk”, new radio programmes, etc.; and
- adoption and use of the Sara Communication Initiative to promote concerns relating to the adolescent girl.

Several of the ideas and programmes were replicated from other programmes which were part of regional initiatives and taken to national scale through radio, newspapers and NGOs.

(f) Introduced and supported Adolescent Friendly Health Services.

This programme was launched in five districts under the last Country Programme. It has remained relatively small and not scaled-up in the same way as the life-skills programme. Important new ideas were introduced, but it is difficult to assess its impact and significance from available documents.

(g) Prevention of Mother to Child Transmission (MCTC).

UNICEF became involved in supporting the prevention of HIV through MTCT, a component of the new Country Programme. This is partly a new initiative. What is new is also exciting and consequently receives more attention than more established programmes. UNICEF Uganda has, for instance, a Programme Officer working only on MTCT, while the other HIV/AIDS priorities do not have the same level of technical staff support.

(h) Voluntary Counseling and Testing (VCT) – an emerging priority.

Although not supported under the previous programmes, VCT has emerged as an important aspect in the new Country Programme.

(i) HIV/AIDS placed in a human-rights perspective.

In the new Country Programme, HIV/AIDS is defined “*as a result of a human-rights crisis in Uganda*” – focusing in particular on the non-fulfilment of rights for girls and women (gender inequality). This is a recent development and it is too early to assess its significance.

- **Strengthening of New Partnerships**

Accompanying the process of decentralisation, there has been a proliferation of civil society organisations in Uganda, from community to national level. At an early stage UNICEF involved such organisations in several of the programmes, as an important complement to having only Government as a partner. The private sector has so far played an insignificant role as a partner for UNICEF.

The BECCAD programme is said to have built partnerships with over 52 NGOs since it began. In 1999, UNICEF Uganda paid special attention to improving the scope and quality of its collaboration with civil society by undertaking a major NGO assessment.

UNICEF's collaboration with Save the Children Alliance members is presented as a model for future NGO collaboration. UNICEF also approached a new set of partners in human rights and the programme against elimination of child labour (Annual Report, 1999).

NGOs in Uganda provide useful support to a broad range of HIV/AIDS programmes, but it is a problem that most are small – and unable and unwilling to scale-up or mushroom – leading to a relatively fragmented response from the NGO sector.

UNICEF's link to technical partners seems weaker. Consultants and university departments are used to carry out specific studies and assignments requiring special skills, but there are no permanent partnership arrangements with technical institutions. UNICEF is a donor and is perceived by its partners primarily as a donor with relatively weak in-house technical capacity, partly because of the broad range of areas it is working in and the heavy administrative burdens placed on its personnel.

There are currently four positions in the HIV/AIDS cluster in the UNICEF Country Office. Some have a relevant HIV/AIDS technical background, but UNICEF staff are, or become, generalists. UNICEF thus depends in principle on strong technical networks of individuals and institutions in order to do quality work. Since the technical back-stopping is not easily available from other levels of UNICEF (Headquarters and Regional Office), the Country Office needs a stronger and more institutionalised technical support system. The global and regional technical partnerships established through the Technical Support Group process (TSG) during the first part of the 1990s were not maintained and no mechanisms replaced the TSG. Some technical support is provided from other UN agencies, but on an ad-hoc project basis.

- **Contribution to Improved Coordination and Communication**

In this section we are discussing communication and coordination between international donors and Uganda and between the Government and donors, mainly in the area of HIV/AIDS.

Although the UN reform process had a slow start in Uganda, several improvements have been introduced over the last two years (Annual Report, 2000). The Resident Coordinator convenes a regular monthly meeting of UN Heads of Agencies, including

the World Bank and the IMF. This is the main forum for information sharing and harmonised decision-making in the UN system (Annual Report, 1998).

There is a monthly meeting of the Social Sector Donor Group chaired by the World Bank and co-chaired by UNICEF and USAID. The meeting brings together most of the UN agencies as well as the major bilateral and multilateral donors to Uganda's social and financial sectors and Government representatives from the Ministries of Local Government, Public Service and Planning and Economic Development.

Much of the formulation of the Poverty Eradication Plan (PEAP) in 1996 was referred to as participatory, involving NGOs and academic institutions and extra efforts were made to include the concerns and voices of the poor. In this plan, HIV/AIDS was accorded the same status as other priority development areas.

The 1999 Annual Report stated that UNICEF played a major role in the completion of the first Uganda Common Country Assessment (CCO), having been chosen by all UN agencies to lead the process. Key policy areas were identified and by 1999, ten Theme Groups were commissioned to assess the status of development rights in each policy area.

The CDF process was in its early phase in 1999 and the Government is said to be pursuing the CDF concept actively.

The ongoing Sector-Wide Approaches (SWAPs) and Sectoral Investment Plans (SIPs), especially in health and education, are going to influence all aspects of the Government response to HIV/AIDS. The 2001-2005 Country Programme is part of the SWAPs and SIPs, but UNICEF does not fund the common basket. UNICEF, in collaboration with other partners, was instrumental in having issues affecting the health and welfare of children and women included in the "minimum essential health care package" and as priority interventions in the sector programmes.

UNAIDS

There is an Expanded Theme Group on HIV/AIDS in Uganda chaired by the UNICEF Representative. Members of the group are UNICEF, UNDP, UNFPA, UNESCO, WHO, World Bank, SIDA, USAID, DFID, EU, UNHCR, other bilateral agencies, the National AIDS Commission, Ministry of Health and organisations of persons living with AIDS. The Group is said to have worked effectively from mid-1999, meaning that meetings were regular. There is also a Technical Working Group with almost the same members as the Theme Group.

A strong opinion seems to prevail that the Expanded Theme Group has not yet become the forum it was meant to be. Agendas are often over-crowded with information sharing while common issues for more proactive action and coordination among participants are scarce. Most members still attend and the UNICEF Representative provides a high profile leadership, but some of the co-sponsors are small players in the area of HIV/AIDS or are passive, disinterested members.

The Expanded Theme Group is also large. The extent to which such a group is the most effective way to reach consensus and act on common issues is open to question.

Furthermore, there is a blurred distinction between the Expanded Theme Group and the Technical Working Group(s). With the Expanded Theme Group, the UN agencies lack their own forum to improve UN coordination. A UN System Integrated Work Plan has, for instance, not been prepared this year.

There has been a heavy turnover of CPAs in UNAIDS and the current CPA is relatively new. However, she has established herself well technically and vis-à-vis other partners. The CPA is, however, only one person. Some co-sponsors claim that UNAIDS has been driven too much by a central agenda which is not based on national priorities. However, those allegations are not well substantiated. There is no evidence of “mission creep” i.e. that UNAIDS has assumed executive or implementing roles and thus competing with other co-sponsors.

The most acute challenge for UNAIDS is to explain and show its potential and actual added value, since it is not a programme with financial or technical resources and it is unable to move further or faster than the co-sponsors permit. UNICEF has taken active part in establishing UNAIDS in Uganda. Whether UNICEF has changed as a result of UNAIDS is difficult to judge. There might have been a change in the level of co-operation with co-sponsors, but not at the programme level. UNICEF has, to some extent, made use of PAF funds from UNAIDS, but those are small and perceived as relatively insignificant.

We are not in a position to judge the extent to which UNAIDS has, generally, contributed to a more coordinated UN and/or country response to HIV/AIDS. It has probably made a positive contribution, but it has not had a very distinctive impact to date.

- **Support to National Capacity Building**

- (a) Provided support to national coordination and policy formulation**

In the early 1990s, the Ministry of Health established the AIDS Control Programme to coordinate the national response to HIV/AIDS. From the beginning of the decade the Government saw HIV/AIDS not just as a medical phenomenon, but also as a national developmental challenge. In order to stimulate and coordinate interventions from various sectors, the Government established the Uganda AIDS Commission in 1992.

A National Strategic Framework was formulated for HIV/AIDS Activities (1998-2002). A new and revised strategic plan has been prepared for the period 2000/1-2005/6 based on the assumption that HIV/AIDS is a concern for more than the health sector. Strategic plans on HIV/AIDS are also in the process of being formulated for all key Ministries.

UNICEF initially provided technical, moral and financial support to establish the National AIDS Commission, e.g. offices, staff and transport. UNICEF has also been involved in several national policy development initiatives, including the development of the national youth policy, drafting of the adolescent health policy and preparation of a strategy document on young people and HIV/AIDS.

UNICEF, UNFPA and WHO have provided support to Government efforts to coordinate all interventions in the area of adolescent development. The three UN agencies have also participated in the formulation of the National Adolescent Reproductive Health Strategic Framework.

(b) Contributed to capacity building at all levels

Capacity building was one of the pillars in the BECCAD programme, targeting capacity at various levels of society and experimenting with a cross-sectoral programme as part of the capacity building strategy. A current review of the capacity building process (Assessing the Capacity Building Process in Uganda, 2001) is positive about the relevance and importance of the multi-level capacity building approach followed, but it has little to say about outcomes and impact of UNICEF initiatives.

In other reports, it is mentioned that UNICEF underestimated the lack of financial and technical resources at district level and consequently became too ambitious in its efforts to change and strengthen knowledge, attitudes and skills.

• Evidence of Results and Impact

A major weakness in UNICEF's response to HIV/AIDS from the start has been the lack of documented data and information about results and impact. UNICEF has been guided by all the right intentions, approaches, strategies and programmes, but it has not been able to provide systematic evidence on results. Most likely there have been results, but no systematic monitoring and evaluation system has been in place to measure and document changes, and whether results are reasonable compared to investments.

From a practical and methodological point of view, it is difficult to measure immediate outcomes and the long-term impact of most UNICEF programmes, which is not a good excuse for not trying. Information about results is necessary for accountability, but also in the continuous search for improved and more effective interventions.

Some evaluations are carried out, some of them with rather critical and negative findings about results. An evaluation of, for instance, the comprehensive school-based AIDS education project in Masaka came to the conclusion that the programme had little effect: seven out of nine variables showed no significant increase in score after interventions (Evaluation of Masaka AIDS Education programme). The major reason was incomplete implementation of the project and not the programme approach as such.

A main conclusion is, therefore, that UNICEF has continuously been doing more in the area of HIV/AIDS i.e. more funds for a broader range of programmes. Whether UNICEF is doing those programmes better (from a qualitative point of view) and to what extent they lead to the expected results are open questions.

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CASE STUDY 4: ZIMBABWE

1. Status of the Epidemic

Zimbabwe has gone through a dramatic deterioration in its social, political and economic situation. UNICEF's Annual Report 2000 talks about a country going "from crises to crises". Such a situation has increased the level of vulnerability of children and women. Government capacity is diminishing as available resources decline, while retrenchment and HIV/AIDS reduce the civil service base. The country's macroeconomic instability and political situation have forced donors to suspend or reduce investments. This has affected the funding of UNICEF's country programme, which has depended heavily on support from bilateral agencies. In brief, the country is in a situation where the external environment, to a large extent, confines what can be achieved generally and, specifically, in the area of HIV/AIDS.

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, affecting an estimated 25 per cent of adults between 15 and 49 years of age, and over 10 per cent of the entire population (E/ICEF/ 1999/P/L/Add.1).

The most vulnerable children were found to be out-of-school youth, children of illiterate parents, neglected and abused children, and girls without adequate parental support. Almost six times as many girls as boys have AIDS in the 15-19 year old age group, and almost twice as many in the 20 to 29 year old age group. By the year 2005, approximately 910,000 children are expected to have lost one or both parents to AIDS.

There has been a 40 per cent decline in real capita allocations to the health sector between 1990 and 1997, while the drug fund has declined by 67 per cent. There has been a sharp reversal in the reduction of infant mortality (IMR) seen in the 1980s. Most of this deterioration is due directly or indirectly to HIV/AIDS. With 30 per cent of pregnant women HIV positive, about 9 per cent of new-borns now carry the virus. By 2005, it is estimated that HIV/AIDS will account for 60 per cent of all child deaths.

The National AIDS Control Programme (NACP) was established as a Division in the Ministry of Health in 1987. A new National AIDS Council (NAC) was set up the same year to provide a multi-sectoral response to the epidemic. The first Council was dissolved in April and a new Council put in place, answerable to the Ministry of Health and not to a higher-level body in Government. The Council has branches in each province and financial resources will be channelled from the NAC to provinces and districts.

The Government of Zimbabwe has launched a National AIDS Policy and introduced an AIDS Levy to complement resource mobilisation towards the fight against HIV/AIDS. The AIDS Levy is unique in the sense that nationals pay into this fund strictly for the purpose of financing HIV/AIDS activities. The NAC is given the responsibility for managing the funds.

The new Council has not yet constituted itself, but it is said to have lost some of its credibility among international donors. Despite the fact that an increasing number of

donors have HIV/AIDS as a priority, most have stopped funding Government programmes and increased their support to NGOs, but with a short-term perspective and a wait-and-see attitude. The time does not seem conducive for long-term donor commitments with close partnerships between Government, international donors and civil society.

At the moment, there are nearly 250 NGOs working in the area of HIV/AIDS in Zimbabwe, providing a significant contribution to the prevention and care of HIV/AIDS cases, ranging from highest quality to scattered inputs. The restructured Zimbabwe AIDS Network (ZAN) has registered about 150 NGOs. The new AIDS Council has mechanisms for funding local NGOs, but not national organisations. This is perceived as a constraint by those organisations, which have so far filled huge gaps in Government provision of services.

2. UNICEF Response to HIV/AIDS

The First Stage

In April 1991, the Zimbabwean delegation to the UNICEF Executive Board requested the Organisation to get involved in AIDS work in Zimbabwe. This was based on a document called "Information, Education and Communication of AIDS Prevention in Zimbabwe". This was initially a two year pilot project (1992-94) to create greater awareness of HIV/AIDS and STDs, through formal and non-formal education, prevention of HIV and care for people with AIDS. The project was later extended to cover a five-year period.

A new head of UNICEF's Harare Office was appointed in August 1991 and she vigorously promoted the initiative. Once programme activities began in January 1992, UNICEF Harare began successful fundraising among donors.

Country Programme 1992-1996

In the Country Programme Recommendation (E/ICEF/1991/P/L.5) for 1992 –1996, it was acknowledged that HIV/AIDS *"threatens to erode previous gains in the reduction of morbidity and mortality"*. The new Programme was to focus on health and nutrition, water supply and sanitation, support to women and basic education, with most support going to national programmes.

The HIV/AIDS programme in Zimbabwe was eventually made up of the following seven projects:

Projects:	Brief description:
1. In-school Youth project (from 1992)	• AIDS education for youth in primary schools
2. Community Information Project (from 1992)	• AIDS awareness at community level (relying on NGOs, churches and community based health and extension workers). Institutional capacity building activities of supporting organisations.
3. Out-of-school Youth Project (from 1993-94).	• AIDS awareness of youth out-of-school. Popular radio channels, peer education networks, sporting and cultural activities, mobile film vans, etc.
4. High-risk Group Project (from 1993-94).	• AIDS awareness, peer education, condom promotion for commercial sex workers.
5. Community based Care of Orphans project (from 1993-94)	• Development of strategies and viable approaches for community and family based care for orphans.
6. Support to National Coordination Project	• Support to NACP and other national coordinating bodies.
7. Operational Research Project	• Socio-behavioural research on various aspects of HIV/AIDS – emphasising practical application for programme development.

In contrast to Uganda, where AIDS activities were integrated in ongoing activities, UNICEF Zimbabwe had a separate HIV/AIDS programme during most of the 1990s which was specifically concerned with the prevention and control of HIV/AIDS. There was also an HIV/AIDS Unit responsible for all projects (Review of UNICEF Support, 1995).

The principal target for the *in-school youth project* was school-going youth and their teachers. It was started for two reasons: HIV infection rates among in-school youth were still low and the education system had good coverage in Zimbabwe with almost all children attending primary schools. The project emphasised a broad-based approach, encompassing not only factual information, but also issues of relationships, life-skills, human growth and development and health. This became the largest project among the seven- absorbing the major share of the budget.

Community information focused on supporting and utilising existing community level organisations, e.g. NGOs, village community workers, extension workers, etc. for AIDS awareness work.

The *out-of school-youth project* tried to reach different categories of youth and used many channels for communication – non-formal education programmes, radio, mobile cinema and community drama.

The high-risk group project introduced peer education among commercial sex-workers in cities and growth points around Zimbabwe and was technically supported by the University of Harare.

In the *Community Care of Orphans project*, support was given to develop a national policy and testing of different approaches to care for orphans.

National coordination provided support to the national coordinating body (NACP) in the area of IEC.

Operational research aimed at developing cost-effective methods and approaches for IEC interventions. Monitoring, analysis, evaluation and documentation were also important functions of operational research.

1995-2000 Country Programme

In the Country Programme Recommendation for 1995 - 2000(E/ICEF/1994/P/L.8), it was stated that 7.5 per cent of the population were infected and that AIDS had become the primary cause of death among adults and children from one to four years of age. Prevention and control of HIV/AIDS was expected to absorb about 25 per cent of the total country frame. The initiative to reach all *youth in-school* should continue. Tertiary-level institutions, including teacher-training colleges, would be an important target group for further development of the life-skills approach.

Activities to reach *out-of-school youth* would also continue, using popular radio channels, peer educator networks, sports and cultural organisations. Assistance would be provided to NGO networks, especially churches, the first source of information for rural women. UNICEF was to provide material, logistical and technical support to help strengthen national coordination, especially the National AIDS Coordination Programme (NACP) in the Ministry of Health.

Mid-Term Review 1997

A Mid-Term Review was organised in the first half of 1997. The continuously rising HIV/AIDS rate indicated that, despite the large volume of information provided and the high level of awareness achieved, changes in behaviour did not follow.

Project evaluations had demonstrated that modest positive behaviour change occurred where interventions went beyond the provision of information and built skills and provided support and services for community-level action. Hence, there was a need to move beyond an information diffusion model and aim at promoting adoption of healthy sexual behaviour. It was also necessary to streamline and prioritise strategic interventions more effectively.

It was also recommended that synergies between programmes be increased by merging CEDC (Children in Especially Difficult Circumstances) and the AIDS prevention programmes.

The HIV/AIDS Programme also showed that the epidemic could not be fought within the framework of a single programme or strategy; actions against it had to be included in all interventions through a more integrated approach (Reaching the Grassroots, 1995). The process of mainstreaming the issue became a key concern for UNICEF Zimbabwe.

A challenge also remained in linking schools with family and community life in improving openness about HIV/AIDS. Evaluations had shown that community-based

approaches had a greater impact and were more effective than top-down national initiatives. The key success factors were said to be the consultation with and involvement of community leaders and families in programme design and evaluation.

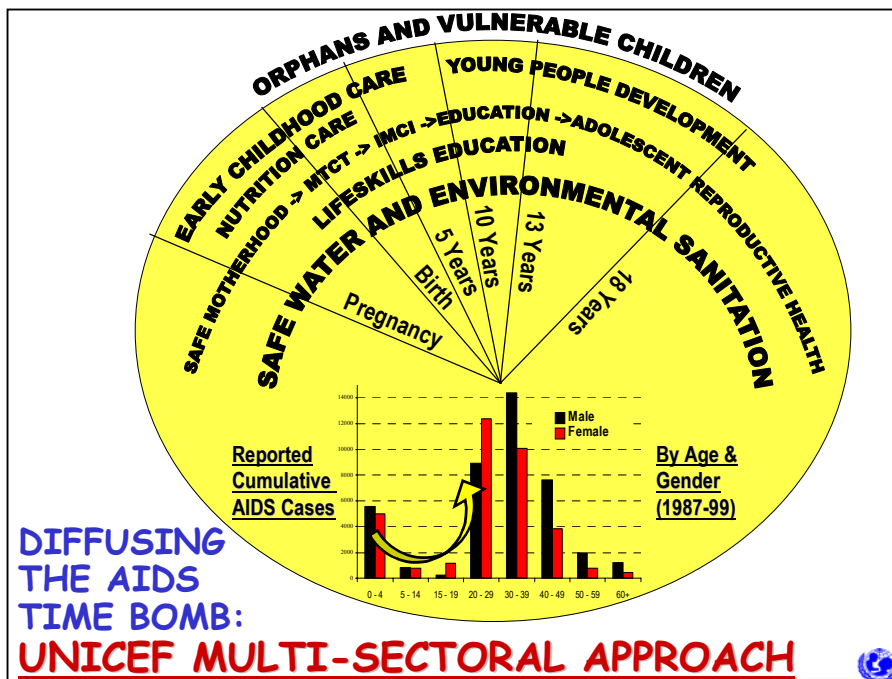
2000-2004 Country Programme

Since the 1997 Mid-Term Review, the Country Programme also began to adopt a rights-based framework. Programme experience had illustrated that the defence of children's rights must begin at the household, and that interventions should focus more on community capacity development, social mobilisation and communication strategies in order to assist duty-bearers in meeting their obligation to children.

The new Country Programme will focus on HIV/AIDS as the single most important factor affecting the survival and development of children in Zimbabwe (Master Plan of Operations 2000-2004). The overall strategy is to support key actors with obligations towards the child (duty-bearers) in their efforts to prevent HIV/AIDS and to realise children's rights. There will also be a strong advocacy effort in all programmes with community capacity development and social mobilisation as key crosscutting strategies. The country programme structure is comprised of three complementary components focusing on:

- (a) health, nutrition and environment;
- (b) child learning and life-skills; and
- (c) rights planning and advocacy.

The new Country Programme for UNICEF Harare is not vertical, but presented as multi-dimensional to deal with the multi-dimensional character of the HIV/AIDS problem. The CP seeks to address HIV/AIDS Prevention as a key concern in all programme sectors, from water and sanitation, to education, health and social sector planning so as to ensure a multi-sectoral attack on the epidemic. The multi-sectoral character of the current/new CP is presented in the figure immediately below.



HIV/AIDS represents an overall priority in the new CP, but are commitment and activities less visible in the programme structure and, in practice, less important? Has mainstreaming created less clarity and direction for UNICEF HIV/AIDS work? When it is everywhere, is it then nowhere? Do the new strategies lead to more and better results? Answers to such questions are debatable and there is unfortunately not much empirical evidence to compare alternative strategies. When UNICEF presented its new CP to Government partners, it was met with some resistance, because UNICEF had committed the entire CP to the fight against HIV/AIDS. Other partners felt that UNICEF had lost some of its direction for HIV/AIDS activities.

There is a tension between mainstreaming HIV/AIDS into all projects and clustering HIV/AIDS activities into separate programmes. The UNICEF Country Office seems to have perceived the choice as an either-or, while a strategic choice could also be placed on a continuum from partial to complete mainstreaming. At any rate, mainstreaming is not a goal in itself, but has to prove its effectiveness through rigorous evaluation.

Policy Implementation

- **Clarity, Mainstreaming and Momentum**

UNICEF Zimbabwe was an early starter in the area of HIV/AIDS and contributed to the formulation of UNICEF global policies, particularly in life-skills education. In all country programme presentations throughout the last decade, policies and programmes have been clear and consistent and well in line with UNICEF's global policies. The programme has also maintained a strong focus on youth.

With the Mid-Term Review in 1997 the "vertical programme structure" was criticised and more and better integration of HIV/AIDS in all programmes was called for. The early HIV/AIDS Programme had a strong and visible UNICEF profile with its own

management structure and ample financial resources. This was most likely out of balance with the rest of the Country Programme and with marginal communication between the various sectors (Organisational learning, p. 134).

But the HIV/AIDS programme established itself early, created a lot of enthusiasm and gained a momentum within the Organisation. It produced impressive achievements in terms of activities and outputs. Mainstreaming may lead to a more integrated and effective approach in the end, but in the meantime HIV/AIDS initiatives lose their visibility (which is, to some extent, the purpose) and, perhaps, momentum. From a practical and psychological point of view, integration always has a cost added to it. HIV/AIDS is given a top priority in the new Country Programme at the overall policy level, but for an external reviewer of the Plan of Operations, it is difficult to see the specific targets in UNICEF's new approach to HIV/AIDS.

It will require a more in-depth review to find out the extent to which the new Country Programme has lost, or just changed, its approach to HIV/AIDS. Fewer resources are available and spent on HIV/AIDS. Previous activities were heavily supply oriented and expensive (books, equipment, etc.), while the new approaches have a stronger software profile.

A rights-based approach clearly demands a strong advocacy, communication and social mobilisation capacity in the Office. The provision of basic social services for orphaned and vulnerable children and adolescents is becoming more imperative in a country with over half a million orphans and over 70 per cent of the population living in poverty. These are some of the strategic and existential dilemmas for an organisation like UNICEF.

- **Tacit HIV/AIDS Policy**

The global policy document is not known in the Country Office, but no-one is of the opinion that UNICEF does not have a policy on HIV/AIDS. The regional five-point strategy is referred to as policy. UNICEF policy on HIV/AIDS is, to a large extent, implied; it appears as a tacit policy everybody is aware of and has internalised over the years.

- **Direct - Indirect or Long-Term Impact**

With the new Country Programme it would be useful to clarify what should be considered and included as AIDS prevention. Different interventions may have direct preventive effects, indirect effects, and long-term effects. Girls' education and school construction are long-term interventions with a potential long-term preventive effect on HIV/AIDS, but should it be classified as HIV/AIDS investments? And what is an appropriate balance between direct and more indirect interventions?

- **Technical Support Initiatives**

Zimbabwe was chosen as a "flagship country" for UNICEF in the early 1990s. The idea was to ask those countries to place emphasis on testing and developing approaches and methodologies for AIDS prevention and care, and to document

experiences for potential use by other countries. Zimbabwe also became part of the global TSG process as a member of the group on School-Based Interventions.

As a follow up to the TSG process, UNICEF ESARO established a regional HIV/AIDS network to address and discuss common issues. The fourth Eastern and Southern Africa regional HIV/AIDS Network meeting took place in October 1996 in Malawi (“Reaching the Hard-to-Reach Youth” 1996). The meeting discussed four important regional programme approaches:

- Programmes for children affected by AIDS, including AIDS orphans
- Effective and comprehensive communication strategy development
- Life-skills education for youth
- Access to youth friendly health services

The “Fifth HIV/AIDS Network Meeting” in 1997 focused on “Youth-Friendly Health and Counselling Services”. This was the last meeting of the Network. There is a draft concept paper called “A Multi-Country Initiative to prevent HIV Infection and Increase Choices for Young People in Southern Africa” which promoted stronger regional approaches to HIV/AIDS with reference to the International Partnership Against AIDS in Africa (IPAA). The proposal suggested that “*a network of UNICEF offices in nine countries in Southern Africa can capitalise on individual country’s efforts by building upon another’s successes, and by sharing resources, capacities and materials*”. The concept has, as far as we know, not been operationalised.

• **Few and Weak Inputs from UNICEF Headquarters and the Regional Office**

Except for the networking referred to above, UNICEF Headquarters and the Regional Office played few and minor roles vis-à-vis the Country Office. Most of the extra funding came from bilateral donors and not General Resources. The Country Programme had its own internal dynamics. The profile of the Regional Office changed in the late 1990s with the appointment of a new Regional Director.

At the ESAR-RMT meeting of November 1998, a commitment was made to establish HIV/AIDS as a “priority among priorities” within the East and Southern Africa Region. It was agreed that for UNICEF to respond fully to this priority, it must focus its organisational attention and resources on a limited number of interventions which, if taken to scale, could make a difference in reducing the growth of the epidemic, and provide support to those affected.

It was acknowledged that the response from UNICEF so far had been limited and fragmented and far from commensurate with the size of the problem.

UNICEF placed its scaled-up response within the context of the new International Partnership Against AIDS in Africa (IPAA)². UNICEF’s role within this partnership

² The International Partnership Against AIDS in Africa is a strategy adopted by a coalition of actors (African governments, United Nations, donors, the private sector and NGOs) for more effective achievement of the overall HIV/AIDS goals. *The Framework for Action* constitutes the basis for this Partnership. In December 1999, the Secretary General assembled for the first time representatives from all the five constituencies who negotiated and approved this document.

should be to promote a sense of urgency and an appreciation of the need for a larger scale for the response.

A regional Task Force recommended further that UNICEF should work closely with UNAIDS co-sponsors within the region to develop a set of goals and targets for IPAA in the region. An action plan was also prepared to develop skills and equip UNICEF staff as HIV/AIDS advocates, to ensure that Country programmes were adjusted and staffing capacity strengthened with new posts such as Regional HIV/AIDS Adviser and HIV/AIDS Communication Adviser, etc. (Report of the ESAR HIV/AIDS Task Force March 1999).

4. Policy Results

- **Expansion of the Response**

We have tried to collect and systematise information about UNICEF Zimbabwe's budgets and expenditure on HIV/AIDS during the last decade. Figures are not easily available, but the following Tables illustrate important trends.

Table 1: Expenditure on HIV/AIDS as part of total expenditure for UNICEF (US \$ mill.)

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total Country budget	5.954	5.980	4.100	5.153	5.950	4.200	4.800	6.200	6.481
HIV/AIDS Expenditure	1.537	1.377		1.331	1.310	0.685	1.417	1.682	1.233
% of total	26%	23%		26%	22%	16%	30%	27%	19%

Another useful table is the financial commitments for the period 1995-2000.

Table 2: Country Programme budget 1995-2000 (US \$ mill)

Sectors	Budget	% of total
Health	13.5	27%
Education	7.5	15%
Water & Sanitation	9.6	19%
AIDS Prevention	12.39	25%
Social Policy Development	2.91	6%
Women's programmes	0.48	1%
Children in Diff. Circumstances	1.5	3%
Social mobilisation	0.84	1%
Programme support	1.65	3%
Total	50.4	100%
General Resources	8.4	17%
Special Resources	42	83%

The two tables illustrate important issues and trends:

- Between 1992 and 1996 UNICEF spent approximately US\$1.3 - 1.5 million annually on HIV/AIDS and the in-school life-skills project absorbed most of the

resources, followed by the IEC project. The total figures are most likely higher since there are HIV/AIDS-relevant activities in the other sectors as well.

- UNICEF was one of the first and most important international donors to HIV/AIDS in the first half of the 1990s.
- For several years HIV/AIDS absorbed around 25 per cent of the total country frame and was the largest programme together with health. The HIV/AIDS Programme represented a major involvement and commitment from UNICEF.
- Of the total country frame, less than 20 per cent of the funds came from UNICEF's General Resources and the largest share (80 per cent) came from bilateral donors as a result of successful fundraising by the Country Office.
- Allocations to HIV/AIDS remained stable until 1997 when there was a drop in expenditure from one year (1996) to the next (1997). With the mainstreaming and integration of HIV/AIDS in all programmes that followed the Mid-Term Review, reported expenditure on HIV/AIDS fell. We do not have sufficient information to explain the considerable variation in expenditure for the years between 1997 and 2000.
- In the period 1992-1996, the HIV/AIDS programme provided significant financial support for the production of learning materials and other equipment. The move towards a more "software approach" was less capital intensive and explains part of declining expenditures.
- From 1998, UNICEF Zimbabwe does not report expenditure on HIV/AIDS in Annual Reports since activities are either subsumed under broader categories or components of other programmes. There is also an argument about what activities should be included under HIV/AIDS prevention – only HIV/AIDS directly relevant activities or also programmes with a more indirect long-term impact on HIV/AIDS, like girls education, construction of schools, etc.
- UNICEF has gradually lost most of its bilateral support and the total Country Programme has been reduced to a much smaller programme.
- AusAID was the major donor to the IEC programme. Funding came to an end in 2000³. The Government of Netherlands has provided most of the funds to the in-school life-skills programme.
- UNICEF has decided to continue the life-skills programme while discontinuing the IEC component since the "old" approach was not effective. The latter argument may be true, but there is not much more documented evidence of effective impact in the life-skills programme. However, there is a willing donor for this project.

³ AusAID refers to changing global priorities as the reason and not UNICEF and/or programme performance.

- The new 2000-2004 Country Programme has no specific budget for HIV/AIDS.

It is difficult to draw any overall conclusion, but if we focus on financial commitment and expenditure only, HIV/AIDS became, early on, a top priority for UNICEF in Zimbabwe. About one quarter of the total country frame was allocated to HIV/AIDS between 1992 and 1997. The response did not expand, but remained at a high level throughout the period. It then appears as that the response was scaled-down in terms of financial expenditure from 1997 onwards. Another question is the extent to which UNICEF, in practice, has scaled-up its response in the area of HIV/AIDS with more effective mainstreaming and less costly strategies.

- **Major Achievements and Constraints**

- (a) From the early 1990s, UNICEF became one of the most important international donors in the area of HIV/AIDS in Zimbabwe, together with WHO and GPA.
- (b) UNICEF has played a significant role in creating awareness about HIV/AIDS as a threatening problem among government and political leaders, and even more among civil society organisations and people at district and community level. UNICEF advocacy work has resulted in greater participation and involvement by Governors in HIV/AIDS interventions as illustrated in the adoption of the HIV/AIDS policy in 1998 and the introduction of the HIV/AIDS levy in 1999).
- (c) UNICEF has contributed to raising the level of knowledge about HIV/AIDS in the country.
- (d) UNICEF has been the most important organisation in assisting the Government in introducing and institutionalising AIDS and life-skills-education in primary, secondary and tertiary curricula.

A Review of the AIDS Action Programme for Schools (J.O' Donoghue) noted a number of important achievements: AIDS education has been made compulsory in primary and secondary schools and in tertiary colleges. *"In less than four years, high quality materials have been produced and introduced into over 6000 schools where the prescribed curriculum is now being taught. All national, regional and district Education Officers and about one teacher per school, as well as 5000 teacher trainees, have received training through the programme. An effective research and monitoring component has been built up and the Programme's managers have demonstrated a readiness to assess their problems and make corrections as needed.... The AIDS Action Programme has helped bring the HIV/AIDS problem in Zimbabwe out into the open for discussion"*.

It is much more difficult to assess to what extent the in-school project has successfully achieved its objectives. Have the life-skills messages reached the classrooms and contributed effectively to change young people's knowledge, attitudes and eventually sexual behaviour? Evidence of documented results is meagre, and not systematically documented. Impacts are often described in statements like: *"The Young People Development and AIDS Project saw achievements resulting from activities relating to the direct capacity building of*

young people, as well as the development of a safer and more supportive environment for them”.

An Impact evaluation of HIV/AIDS Education in Tertiary Colleges carried out in 1998 found a low increase in knowledge about HIV/AIDS. Students' attitudes towards people living with AIDS had not improved, but they were more confident discussing issues about gender and sexual behaviour.

A baseline study of Grade 7 pupils in primary school in Matabeleland South and Mashonaland East was carried out in 1993 – before the National Action Programme for Schools started (“What Grade 7 Pupils know and think about AIDS”). The study provided interesting information about knowledge levels and was meant to be repeated later in order to measure change over time and the potential impact of programme interventions. A similar follow-up study was not carried out. In other cases pre- and post surveys are undertaken, but impact assessment are methodologically and practically difficult. What is missing is an overall, broader assessment taking into account not only individual studies, but also data from a broad sample of schools.

Life-skills education is a noble concept, but there is scepticism and uncertainty regarding the quality and ultimate results of ten years efforts in Zimbabwe. Continuation of this project should depend on a solid assessment of achievements and lessons learned so far.

- (e) New and innovative to approaches to Information, Education and Communication (IEC) at all levels.

The overall aim of the IEC project was to promote behaviour change within communities, using three different channels: community based educators, mass media and print media. More than twenty publications were developed and a broad range of training courses organised.

Several evaluations found most of the material to be of high quality, relevant and useful, but had little to say about impact. An undated evaluation of the film “Facts about AIDS” was undertaken and it found that *“people in the rural areas liked the film. Many said they found it educative and also interesting. From this evaluation it was clear that film as a way of communicating messages was very effective ... and it is also very cost-effective because many people see the film”*. There was no serious effort to try and measure behavioural change or other impacts.

An evaluation of the “Pilot AIDS Drama Project” was commissioned in 1994. Activities for out-of-school youth were combined with research. The study did not find conclusive evidence about impact, but noted that *“the drama succeeded well in stimulating people to think about their own behaviour patterns and those of their community. A few youth stated that they had changed their behaviour since seeing the play. It can be concluded that the play was successful in personalising AIDS in the lives of the youth to some extent”* (Evaluation of a Pilot AIDS Drama Project, 1994).

Despite their achievements, weaknesses were later found to be:

- little or no follow up of the training conducted;
- insufficient coordination within UNICEF;
- too many workshop running at a fast pace; and
- the difficulty for community workers to adopt participatory learning methods.

Major lessons learned were:

- materials developed are only as good as their distribution plan;
- more local languages should be used, target groups should decide use of language;
- the target audience should be more involved in the production process; and
- materials have focused too much on information sharing (Reaching the Grassroots, 1995).

(f) Innovative approach to peer education among commercial sex workers.

An evaluation of the Chitungwiza HIV/AIDS Peer Education Project was carried out recently for the Town Council (Munodawafa, 2000). The report found that *“the project reached a wide cross-section of the community in the area. Commercial sex workers reached more adult men and young females with information compared to young males and elderly women. The project seems not to have reached other commercial sex workers. A major weakness according to the general public was that it focused more on condom distribution and ignored life-skills development, such as decision making, negotiation and assertiveness”*.

The report concluded that the approach was innovative and interesting, but *“there was no evidence to suggest that the project had an effect on commercial sex workers themselves or the commercial sex workers industry for which it was intended”*. A more in-depth study is suggested to analyse the utility of commercial sex workers as HIV/AIDS educators.

(g) New alliances were built with civil society organisations.

The support to civil society organisations envisaged that a network of NGOs, churches, women’s groups and workers’ committees would be effective intermediaries *“to reach communities with AIDS information and promote behavioural change”*. Zimbabwe AIDS Network (ZAN) represented an inroad to such organisations and UNICEF decided to concentrate its efforts on strengthening NGOs through ZAN (Reaching the Grassroots 1995).

Training material and manuals were prepared for NGOs and found to be of high quality and relevance. However, the materials were seen as UNICEF products and not sufficiently “owned” by NGOs themselves. Management training courses were also organised for NGOs, focusing more on individual staff development than organisational dynamics. ZAN was also given support for conferences, a Directory and newsletter.

A Report on the Community Information Project (Reaching the Grassroots, 1995) concluded that UNICEF's strategy of working through national NGO networks had not been effective. The capacity of the networking bodies proved to be

stumbling blocks, with dubious effects for smaller NGOs and beneficiaries. *"NGOs are generally thought of as the best inroad to rural communities at grass roots levels. However, this was not found to be the case for many of the NGOs working on AIDS-related programmes who tended to be more urban based"*.

The report also concluded that it was easier to work with individual churches than church networks. The nature of church teaching was also different from UNICEF, particularly on the issue of promoting condoms.

When it was found that the capacity of NGOs to reach rural communities was limited, UNICEF considered alternative strategies by focusing on community-based workers in the Government system. No evaluation has been undertaken of this project. Several constraints were identified and the impact limited, and at best, individualised.

(h) Significant efforts in operational research and evaluations.

The HIV/AIDS Unit had its own operational research component. A large number of baseline studies and evaluations of individual projects were carried out, particularly in the first half of the decade when a Project Officer was responsible for planning and organising such studies. As of December 1994, 36 different reports had been produced (IEC for AIDS Prevention in Zimbabwe, 1995). It is unusual for a UNICEF Country Programme to have such an active evaluation programme. The two reports about "Flashback and Hindsight" for life-skills education and information, education and communication provide good summaries and lessons learned from the two projects.

In the new Country Programme (2000-2004), KABP (Knowledge, Attitudes, Behaviour and Practices) surveys were carried out with the purpose of gaining knowledge, monitoring trends, measuring impact and feeding back results to user groups in order to raise awareness and identify potential interventions (KABP Baseline Survey on Health, Education, Hygiene, Water and Sanitation, 2000). Data on mother-to child-transmission was also collected and assessed. It is too early to assess the usefulness and effects of those efforts.

(i) Avoiding controversial issues

Sex education in schools became a controversy as a result of some parts of the life-skills training. Churches insisted that UNICEF should change the "language" in books for 7th grade, particularly all reference to the use of condoms. The Catholic Church even threatened to produce their own books. UNICEF responded in a diplomatic manner and changed the contentious paragraphs, arguing that too much was at stake for the life-skills project as a whole. For some, this was seen as a lack of principles from UNICEF, whereas others considered it a pragmatic approach. In any case, it illustrates that condoms and sex education were, and are, contentious issues.

- **Strengthening New Partnerships**

UNICEF built and strengthened a broad range of partnerships during the 1990s with local and international organisations, parliamentarians and Government at central and local level.

In 1997, the first steps towards strengthening and streamlining UNICEF's relationship with the media was reported (Annual Report, 1997). Collaboration with NGOs has already been discussed. UNICEF also forged relationships with NGOs to undertake joint advocacy on children's issues. There are no formal and/or institutionalised partnerships with technical institutions in Zimbabwe.

Potential partnerships with the private sector remain relatively untapped (Annual Report, 1997). In the 2000 Annual Report, it is mentioned that the private sector assisted in the production of the Community Newspaper Group, highlighting activities on child rights, sexual abuse and community counselling.

- **Contributing to Improved Coordination and Communication**

In response to the UN Secretary-General's reform programme, 19 pilot countries, including Zimbabwe, were selected for the preparation of the United Nations Development Assistance Framework (UNDAF), in order to achieve greater integration of UN activities at country level. The formulation of UNDAF was to be preceded by a Common Country Assessment (CCA). The 1997 UNICEF Annual Report stated that the CCA and UNDAF ("Looking forward together") developed by all 18 UN agencies in Zimbabwe in 1997 -1998 *"represented an opportunity and challenge, allowing a wider scope of analysis and conceptual development, but at the cost of lengthier processes with diverse planning, operational and funding arrangements"*.

UNDAF identified four strategic objectives for coordinated UN system activities in Zimbabwe:

- Human rights and Governance
- Equity and Poverty Reduction
- Economy and Employment
- Population and Basic Social Services.

In addition, Information, Education and Communication for HIV/AIDS Prevention are presented as a common activity. HIV/AIDS was acknowledged as a national problem in the UNDAF document, but not given any prominent position (one page out of 61 pages).

A new CCA is under preparation and will be finalised in late 2001. The process of developing a revised UNDAF should start soon. On the other hand, it is not a conducive climate in Zimbabwe at present for discussing long-term development strategies and joint programmes. UNDP has also been occupied by other concerns such as land reform.

The 1999 UN Annual Retreat reviewed the progress made by UNCT and referred to limited clarity in the role of the Theme Groups, weak participation and commitment

to common activities. The Theme Group on HIV/AIDS is said to be the most effective group. In the Annual Report from the UN Resident Coordinator (Meeting the Challenges, 1999), it is admitted that HIV/AIDS was not given adequate attention at the time of the UNDAF's drafting. This will be changed in the new document.

1999 also saw the formulation of the first United Nations Strategic Framework on HIV/AIDS in Zimbabwe 1991-2001.

The Government, assisted by the UN, finalised the National Strategic Framework on HIV/AIDS/STDs. The framework identifies priority strategies and policies needed to reduce the spread of HIV and to respond to the impact over the coming years.

The UN has also developed a Joint Project, HIV/AIDS District Response Initiative, mobilising US\$ 1 million to initially support ten districts. The UN Foundation (UNF) will provide an additional US\$ 3.5 million for supporting ten more districts.

UNAIDS

A UN Theme Group on HIV/AIDS was first established in 1997. The UNAIDS Programme Development Committee (PDC) and the UNAIDS Steering Committee were collapsed into the same Thematic Group. WHO became the leader of the group after UNDP leadership for two years. The principle of rotation is retained and UNICEF has now taken over as Chair of the Group.

The first three to four years were difficult for UNAIDS. Each co-sponsor considered themselves as independent and motivation and interest for "being coordinated" by anyone was weak or non-existent. There was little "glue" or incentives for coordination and joint action. UNICEF had been a major player among UN agencies in the area of HIV/AIDS while WHO had performed a different role through GPA, according to their more technical and health-specific mandate. Initially, UNICEF was of the view that they had to give more than they would benefit from within a co-sponsored programme such as UNAIDS.

A more collaborative spirit has gradually emerged. UNICEF now takes active part in the Expanded Theme Group. The current Country Programme Adviser (CPA) for UNAIDS is well known and respected and plays an important role in bringing different actors together.

The 1997 Annual Report from UNICEF admits that the Theme Group is still mainly used for information sharing, and that it seems to be wanting in terms of strategic and analytical depth. The assessment of the Expanded Theme Group is mixed. Some bilateral donors feel that "nothing happens" in the meetings, meaning that they mainly meet to share information. UNICEF finds the meeting useful, but admits that the group has not yet found its form.

In addition to the District Response Initiative funded from UNF, UNAIDS is coordinating a national programme focusing on youth. There are no strong views on this programme, but it is argued that UNAIDS has taken on a coordinating and implementing role that should belong to one of the co-sponsors and not UNAIDS.

- **Support to National Capacity Building**

With support from UNICEF, the NACP Medium Term Plan 3 was finalised in 1999, within the framework of the overall national strategic planning process. UNICEF has also provided direct support to NACP and increased their capacity in IEC.

The NGO programme had a strong capacity building component and the major programmes have been planned with and implemented, with a relatively high UNICEF profile, through Government ministries.

For example in the area of life-skills education and IEC, UNICEF was a major player, particularly in the early 1990s. The capacity in partner institutions was often weak and UNICEF tried to compensate by direct involvement in order to speed up implementation processes. At that time, UNICEF had no clear strategy and practice of building and using capacity within partner institutions. An evaluation of the life-skills project in 1997 showed that the Ministry of Education had not been in the driving seat for the project and recommended that a Secretariat within the Ministry should be established. Such a Unit was in place from 2000, but there is so far no budget line in the Ministry for life-skills education.

- **Evidence of Results and Impact**

The dilemma for UNICEF is to explain and bridge the gap between persistent higher levels of HIV/AIDS prevalence in the country on the one hand and some useful and effective interventions on the other. The cynical comment is that UNICEF may have contributed to win some small battles, but has lost the war.

In a report to AusAID, UNICEF seeks to address this dilemma:

"Major achievements were made in the area of community mobilisation and empowerment through the High Risk Behavioural Groups Project. A National Policy was developed and debated at community, district, provincial and national levels, with a final version launched 1 December 1999 by the State President. A Draft Youth Policy paper is in the process of review after national consultation.

It is important to point out that the impact of the UNICEF assisted HIV/AIDS Prevention Project was not as a result of the direct actions of the UNICEF support alone. It is certainly clear that the catalytic and facilitating role played by UNICEF did make substantial difference in assisting the Government, NGOs and communities at large to effectively and jointly search for sustainable short and long-term solutions to halt the AIDS epidemic. As such, the objectives set for AusAID funded project components were attained, even though it cannot be possibly maintained that the long-term goal was achieved, given the current increasing statistics on HIV/AIDS infection rates in the country".

Here UNICEF is not accountable for achieving long-term goals, only short-term outcomes, which are important elements for making an ultimate impact. UNICEF may also have played a role in reducing the severity of the problem. In other words, the situation could have been even worse if UNICEF had not been there.

The immediate problem is that such arguments are only speculative. Despite efforts to make research and monitoring and evaluation central to programming in the last Country Programme, mechanisms for monitoring implementation and impact were inadequate (UNICEF Master Plan of Operation, 2000-2004). Useful evaluations were

carried out of individual projects, but there were few broader studies of outcomes and impact.

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