

**EVALUATION
WORKING PAPER**

FIGHTING HIV/AIDS: A STRATEGIC REVIEW

MATTHEW HODGE

JUNE 2004

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY



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A STRATEGIC REVIEW**

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**Evaluation Office
UNICEF New York
June 2004**

Fighting HIV/AIDS: A Strategic Review

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UNICEF

3 UN Plaza, NY, NY 10017

June 2004

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ABBREVIATIONS AND ACRONYMS

ADAP	Adolescent Development and Participation
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral (drugs)
BMS	Breastmilk Substitutes
CCM	Country Coordination Mechanism
CFU	Caring For Us
CO	Country Office (UNICEF)
CPA	Country Programme Adviser (UNAIDS)
CRIS	Country Response Information System (UNAIDS)
CS	Caesarean Section
DPP	Division of Policy & Planning (UNICEF)
ECOSOC	Economic & Social Council of the United Nations
EOR	Emergency Other Resources
GMT	Global Management Team (UNICEF)
HIV	Human Immunodeficiency Virus
HQ	Headquarters (UNICEF)
IATT	Interagency Task Team
M&E	Monitoring and Evaluation
MERG	Monitoring & Evaluation Reference Group (UNAIDS)
MOU	Memorandum of Understanding
MTSP	Medium-Term Strategic Plan
NGO	Non-governmental Organization
NY	UNICEF New York Headquarters
OP	Organizational Priority
OVC	Orphans and Vulnerable Children
PAF	Programme Acceleration Fund
PCB	Programme Coordinating Board (UNAIDS)
PCSM	Programme Communication and Social Mobilization
PD	Programme Division
PLHA	Persons Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
RO	Regional Office
ROR	Regular Other Resources
UBW	Unified Budget and Workplan
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDG	United Nations Development Group
UNICEF	United Nations Children's Fund
UNGASS	United Nations General Assembly Special Session
UN-ISP	United Nations Country Team Implementation Support Plan
UNTWG	United Nations Thematic Working Group
VCT	Voluntary Counselling & Testing
WCBA	Women of Child-Bearing Age

FOREWORD

This review is an effort to strike a middle ground between a formal evaluation of UNICEF efforts under the MTSP HIV/AIDS priority and an internally focused self-reflection exercise. This strategic review is intended to deliver on the direction from the Executive Board regarding a thematic evaluation of the organizational priority of fighting HIV/AIDS. It is based primarily on review of UNICEF documents and interviews with UNICEF Headquarters and Supply Division staff working on HIV/AIDS. Broader strategic questions are generally not addressed as this would require a more resource-intensive effort and seems premature at this point in the MTSP's lifecycle.

The review draws on UNICEF's own documents and the input of primarily New York-based staff members. As many of the elements essential to following through on the priority that the MTSP assigns to HIV/AIDS imply a leadership or direction from Headquarters, this New York emphasis emerged as a pragmatic compromise. As a result, some of the innovation and energy invested in countries may have gone unnoted, and assessments of crosscutting themes, including gender, participation and humanitarian emergencies as they pertain to HIV/AIDS would require further work. Future evaluations or efforts to address some of the questions emerging from this review would certainly benefit from stakeholder input across the organization.

This report was prepared by Matthew Hodge under contract to the Evaluation Office. We are grateful to the UNICEF and UNAIDS staff who gave freely of their time in interviews and informal discussions.

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EXECUTIVE SUMMARY

HIV infection has evolved from a novel infectious disease into perhaps the single greatest obstacle to development and the realization of the rights of children in much of the world. Despite some progress in prevention and tearing down stigma and fear, numbers of new infections continue to rise in much of the world. Young people aged 15-24 face the highest risks of infection. 'Highly affected' or high prevalence countries are primarily in sub-Saharan Africa. However, understanding the impact of HIV/AIDS requires acknowledging that the world does not face a single pandemic but faces different patterns of infection in different countries and regions.

In June 2002, the UNICEF Executive Board directed the Evaluation Office to complete a series of thematic evaluations over the lifecycle of the 2002-2005 MTSP. This strategic review is intended to deliver on the direction from the Executive Board regarding a thematic evaluation of the organizational priority of fighting HIV/AIDS. It is based primarily on review of UNICEF documents and interviews with UNICEF Headquarters and Supply Division staff working on HIV/AIDS. This work does not explicitly assess progress towards the targets but rather examines UNICEF's progress to date in implementing the organizational features and mechanisms commensurate with translating the priority accorded to fighting HIV/AIDS into programme excellence

Globally, an estimated 40 million people were living with HIV/AIDS at the end of 2003, of whom as many as 70% are living in Sub-Saharan Africa. In addition, an estimated 3 million people died of HIV/AIDS during 2003, of whom as many as 80% were living in sub-Saharan Africa. The context in which UNICEF is implementing its MTSP priority — Fighting HIV/AIDS — is thus one of increasing numbers of people at risk of infection, increasing numbers of people living with HIV or AIDS and increasing numbers affected by HIV/AIDS. To date, UNICEF's MTSP has prompted action focused in four areas: young people, parent-to-child transmission, care and support, and orphans and vulnerable children.

UNICEF does not work alone and a key forum for partnership is UNAIDS. Recently the subject of a five-year evaluation, UNAIDS has a multifaceted relationship with UNICEF, that is likely to deepen as the challenge of intensified support for highly affected countries continues to grow.

Within UNICEF, the MTSP priority accorded to HIV/AIDS has engendered innovative management structures. This innovation has, in turn, highlighted the need for intensified managerial effort to ensure adequate resource mobilization, results-driven resource allocation, attention to alignment of financial, managerial and accountability mechanisms across all levels of the organization to ensure focus on effective interventions delivered at scale to children, young people and their families, and the significant capacity development needed for UNICEF staff to make a forceful impact in the fight against HIV/AIDS.

1. INTRODUCTION

In the 20-odd years since AIDS was first described, HIV infection has evolved from a novel infectious disease into perhaps the single greatest obstacle to development and the realization of the rights of children in much of the world. Despite some progress in prevention and tearing down stigma and fear, numbers of new infections continue to rise in much of the world. Young people aged 15-24 face the highest risks of infection.

It has become commonplace to speak of 'highly affected' or 'high prevalence' countries, primarily in sub-Saharan Africa. However, understanding the impact of HIV/AIDS requires acknowledging that the world does not face a single pandemic, rather it faces different patterns of infection in different countries and regions. Put another way, small increases in HIV prevalence in large population countries and regions translate into potentially tens of millions of people dying of AIDS in the coming decades.

At its June 2002 session, the UNICEF Executive Board received the document 'Report on the Evaluation Function in the Context of the Medium-Term Strategic Plan' (E/ICEF/2002/10). This was submitted in follow-up to Executive Board decision 2001/23 identifying this report and subsequent deliberation as part of the programme of work for 2002. The Report included a timetable of major thematic evaluations during the period of the 2002-2005 MTSP. First among these, for the period 2002-2003, is HIV/AIDS.

This strategic review is intended to deliver on the direction from the Executive Board on a thematic evaluation of the organizational priority of fighting HIV/AIDS. It is based primarily on review of UNICEF documents and interviews with UNICEF staff working on HIV/AIDS and related issues in UNICEF Headquarters and Supply Division. As a result, this work likely under-represents the views of staff in RO and CO. In addition, resource and time constraints meant that no field visits to UNICEF-supported activities were conducted.

The paper begins with an overview of current data on HIV/AIDS in the world, identifying several global themes likely to shape effective responses over the medium term. Subsequent sections provide more detailed information on the three areas with targets under UNICEF's MTSP: young people, parent-to-child transmission, and orphans and vulnerable children.

These are followed by an analysis of the recent five-year evaluation of UNAIDS and UNAIDS' response to that evaluation. The final section of the report draws on internal interviews and documentation to examine UNICEF's progress to date in implementing the organizational features and mechanisms commensurate with translating the priority accorded to fighting HIV/AIDS into programme excellence. This is followed by a summary of UNICEF's key achievements in the area of HIV/AIDS for 2003, prepared by the HIV Unit at UNICEF HQ. Annex I provides a detailed summary of the UNAIDS evaluation findings and UNAIDS' responses.

2. GLOBAL THEMES

2.1. HIV/AIDS by the Numbers

Data gathered and analyzed by UNAIDS provide glaring evidence of HIV/AIDS as a global health problem. According to data published in the December, 2003 AIDS Epidemic Update,¹ an estimated 40 million people were living with HIV/AIDS at the end of 2003, of whom as many as 70% are living in Sub-Saharan Africa. In addition, an estimated 3 million people died of HIV/AIDS during 2003, of whom as many as 80% were living in sub-Saharan Africa.

As grave as the consequences of HIV/AIDS are and will be for many African countries and families, infection rates are now rising rapidly in countries of Eastern Europe and Central Asia. In addition, even low prevalence rates, (the proportion of the population living with HIV/AIDS) in Asian countries with large populations could add tens of millions of people to the estimates for the mid-years of this decade.²

Initially, prevalence and incidence both rise together as HIV spreads within a community or country. As death rates rise, usually several years after the first arrival of HIV, prevalence will fall, unless incidence (i.e. new infections) is maintained at a high level. Effective HIV prevention efforts such as 100% condom use can decrease incidence rates. Widespread access to antiretroviral drugs (ARV) and HIV testing can appear to increase prevalence, since people living with HIV can live longer with ARV treatment. Unfortunately, while incidence would provide the most accurate indicator of progress in preventing HIV/AIDS, collecting valid incidence data can be very difficult, even in well-resourced settings.

In addition to assessing incidence and prevalence, distinguishing among modes of transmission is critical, since effective prevention means targeting HIV transmission. The relative importance of modes of transmission also changes over time. For example, in Thailand during the early 1990s, males frequenting commercial sex workers had high rates of HIV incidence. The success of the 100% condom campaign meant that some new infections due to heterosexual intercourse were prevented, but also meant that injection drug use came to account for an increasing proportion of a smaller number of new infections.

For UNICEF, overall prevalence is an important determinant of the impact of HIV/AIDS on children and young people. As prevalence rises among women of child-bearing age, the number of children infected at birth or through breastfeeding will increase. Similarly, as increasing numbers of adults die from HIV/AIDS, children are at increased risk of being orphaned. Finally, overall prevalence data include data from young people. Where overall prevalence is high or rising, numbers of young people becoming infected with HIV and living with HIV/AIDS are also rising.

¹ UNAIDS. Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003. UNAIDS: Geneva, 2003.

² Epidemiologists characterize an illness by its prevalence and incidence. Prevalence describes the proportion of a population with the particular condition, (e.g. living with HIV/AIDS) at a particular point in time. Incidence describes the proportion of a population who develop a health condition, (e.g. become infected with HIV), in a given period of time.

2.2. Moving Beyond Numbers: Themes Relevant to UNICEF Action in the Global Context

To provide a global context for UNICEF's MTSP action to fight HIV/AIDS, the following sections each examine a thematic area that contributes to the rapidly changing context within which UNICEF and its partners seek to assist those infected with and affected by HIV/AIDS.

Global Advocacy

Advocacy around HIV/AIDS takes many forms but, in 2004, the overall impact of these efforts is a world vastly different from that of the 1990s. No longer can national governments deny the existence of HIV/AIDS within their borders without drawing forth a high profile, increasingly evidence-based response to the contrary. National government leadership has been identified as a critical input to effective action against HIV/AIDS and while much progress remains to be made, most governments have developed or are developing action plans. Without such plans, co-ordinated comprehensive national responses are near impossible and the risk of small-scale duplicative haphazard efforts increased.

A vital component of effective HIV/AIDS advocacy has been the growing involvement of people living with HIV/AIDS (PLHA). As advocacy has shifted from an external pressure on governments to an internally-arising grassroots effort, this participation contributes both to achieving the advocacy goals and to linking identifiable human faces to the stories of HIV's impact on individuals, households, and communities.

Advocacy contributes to but does not translate into victory in the fight against HIV/AIDS. Advocacy's success in reducing fear and inciting action by governments has highlighted the need for more specific national and subnational analysis to inform effective action. While there are key generic steps that all countries are encouraged to take (e.g. protecting blood transfusion systems from donations infected with communicable diseases), an effective national plan requires an accurate national diagnosis of — the characteristics of people living with HIV infection, of groups at highest risk of infection and transmission, and of effective methods of equipping people with the information, skills and commodities they need to protect themselves.

In 2004, while much remains to be done to reduce stigma and discrimination, the successes of the last decade of advocacy must be used as a foundation for country-specific, evidence-based plans rather than generic prescriptions of action untied to the persons and places among whom and where HIV transmission occurs. This move from primarily global advocacy to more specific national and subnational efforts will likely require an increasingly extensive partnership between global, intergovernmental advocacy efforts and these more specific efforts, ideally implemented in coordination with and supported by ongoing global advocacy by the likes of UNAIDS and UNICEF.

From Health or Development to Health and Development

When HIV infection was first identified, it was described in medical terms – a retrovirus infecting a human cell population, the CD4 cells, leading to the death of the infected human over a period of months to years. Yet medicine, even in the world's most resource-rich countries, had little to offer that was effective in prolonging the duration or improving the quality of life for infected individuals.

Partly in response, much of the analysis of the impact of HIV/AIDS went beyond medical science alone – ranging from the role of legal sanctions against particular behaviours that appeared to facilitate transmission to an analysis that, by the latter half of the 1990s, situated HIV infection as a consequence of and continuing threat to economic and social development.

Considering the situation in 2004 – millions infected, no cure, difficult treatments available to a fraction of those who could benefit, and no sign of an effective human vaccine – it should be no surprise that HIV is increasingly described as a development issue and not merely a health issue. This broadening of perspective can bear fruit in mobilizing an effective intersectoral response to HIV and highlighting the importance of broad social mobilization and behavioural change in preventing HIV infection. At the level of specific interventions that require leadership by a traditional sector (e.g. school-based life skills training for adolescents, health services for PLHA), it remains to be seen how the broadening of perspective will intensify result achievement.

For UNICEF, health or development was at the centre of the organization's most recent evaluation of its HIV/AIDS efforts, entitled 'Carrots, Sticks, & Sermons'.³ Completed in November 2001, it noted with approval the shift from conceptualizing HIV/AIDS as a health issue to a development issue. In 1998, ARV treatment cost upwards of US\$10000 per person per year, yet by 2003, that had fallen over 95% to \$US2-300 per year. The development perspective is essential, but conceptualized as a victory over health rather than a synthesis with health, it offers precious little to children orphaned by AIDS whose parents could still be alive, to teachers and nurses unable to work due to illness and dying before midlife, or to the 40 million people living with HIV/AIDS whose daily struggle is focused on meeting their basic needs for food, water, shelter, and freedom from pain and suffering.

Looking ahead, however, the challenge is not to delineate further the limitations of a solely health perspective on HIV/AIDS but to focus clearly on 'health and development'. Several changing features of the landscape highlight the importance of moving on from dichotomy to synthesis. First, available medical treatments, particularly pharmaceuticals including antiretroviral drugs (ARV), can prolong the life of PLHA and improve the quality of that life. Second, the prices of those pharmaceuticals have fallen dramatically which highlights the third key factor: even if drugs were free of charge and 100% effective, many of those who could benefit would still go without due to weak health systems and overwhelmed services in the countries where the vast majority of infected people live. Without both creative approaches to health service delivery and a vision that sees the health of people, including PLHA, as a necessary input to development, progress in the fight against HIV/AIDS will remain a rare luxury good instead of the global public good it could and should be.

Finally, the 'crisis' wrought by HIV/AIDS shows no sign of quick resolution, meaning that even as infections are successfully prevented and PLHA live longer, many people will continue to be affected by HIV/AIDS. The health of individuals merits attention given their intrinsic rights to health. Moreover, particularly in places heavily affected by HIV/AIDS, effective action on health and development is essential if social services and civic functioning are to weather HIV/AIDS' impact.

³ Kruse S-E, Forss-Andante K. An Evaluation of UNICEF's Policy Response to HIV/AIDS in the Nineties: The Use of Carrots, Sticks and Sermons. Prepared for the Evaluation Office, UNICEF NY. November, 2001.

Prevention, Treatment and Support

Mirroring the health or development debate, effective action against HIV/AIDS can seem to be an 'either/or' choice between allocating resources to prevention and resources to treatment. This tension, with decades-long roots in public health, also parallels the health/development issue in that recent events have highlighted the need for synthesis. The world and particularly people infected with and affected by HIV/AIDS need both prevention and treatment.

For prevention, progress has been hampered by the essentially private nature of the two behaviours that determine risk of infection for most people: sexual practice and injection drug use. As infection rates climb, the ongoing discomfort of governments and individuals in equipping young people with the information, skills and commodities they need to protect themselves represents perhaps the greatest failure of will in the fight against HIV/AIDS. ABC: Abstain, Be monogamous, and use Condoms has been the foundation of prevention efforts since the earliest days of HIV infection, but the knowledge necessary to understand why this behavioural and social norm change is vital to survival has yet to reach many young people in the high prevalence areas.⁴

Moreover, the case for prevention is not weakened by drawing attention to and allocating resources to treatment. Treatment for PLHA encompasses three areas of action: simple interventions to prevent HIV progression and opportunistic infections, antiretroviral drug treatment, and support and assistance to ensure that the lives of PLHA, however long they may be, are marked by dignity rather than discrimination. Advocacy to lower drug prices by over 90% was a necessary but, alone, insufficient step to treatment access, for if there is no distribution system for medicines, no food to take with the pills, and no choice but to face stigma and discrimination in order to access treatment, drug prices become vanishingly relevant.

In the current context, improving treatment access itself also contributes to prevention and breaking down stigma. Consider efforts by international organizations, (including UNICEF), and others to promote voluntary counselling and testing (VCT) for HIV; if a positive test result can be learned confidentially and enable a person to access treatment and support resources, the incentive to test is far greater than that generated by an exhortatory billboard alone. The greater the proportion of people who know whether they are infected or not, the greater is the proportion who are equipped to protect themselves and others. In addition, when this knowledge becomes a social norm, (i.e. increasing numbers of people in a community have been tested), the supposition that 'everyone is infected, there is nothing to be done' becomes harder to sustain. As conceptually attractive as this logic is, most people in highly affected countries not only have never been tested, but do not even know where to go for testing. The challenge of VCT, as with every other individualized intervention, is delivery at scale.

On an encouraging note, the 'prevention versus treatment' debate seems to be fading in light of both broad recognition of the immense need for both and the growing appreciation of the synergy between them. Ensuring adequate resources to deliver effective interventions to all who can benefit or who are at risk must receive intense focus to capture this synergy fully.

⁴ UNICEF. Young People and HIV/AIDS Opportunity in Crisis. UNICEF: New York, 2002.

Conclusion: Global Themes

Given the evidence of HIV/AIDS growing toll, both in terms of people infected and living with HIV/AIDS and those affected by the death and illness of family members, parents and other duty-bearers, there is simply no doubt that persistent, intensified action is needed and will probably continue to be needed for several decades.

As daunting as global estimates may seem, effective action to prevent, treat, and mitigate HIV/AIDS must rely increasingly on accurate national and subnational data about determinants of infection risk, behaviour and outcomes. This strategic information is also essential to advocacy and to moving from the general diagnosis of a 'crisis' to sustained setting-specific efforts to respond to a crisis that is not going away. Furthermore, rooting action in the experience of individuals as people at risk, people infected with HIV, and people affected not only gives voice to intended beneficiaries but it is also vital to maintaining a focus on results that matter for people.

As HIV has moved from a rare biological curiosity to a public health issue and to a threat to the economic and social fibre of societies, the importance of integrating that past into action for the present and planning for the future cannot be underestimated. HIV/AIDS is both a health and a development issue that requires intervention to prevent infection, to provide care to those living with HIV/AIDS and to mitigate its impacts. Effective programmatic intervention will also require meaningful participation of intended beneficiaries and up-to-date technical knowledge, translated into programmatic guidance and regularly monitored and evaluated to assess impact.

Finally, the sheer scale of the work to be done in fighting HIV/AIDS heralds a shift from projects and pilots to at-scale delivery of effective interventions. The next section looks more closely at the priority areas of action identified for UNICEF in the 2002-2005 MTSP and in all areas, much is known about what is effective. It would be particularly unfortunate if the massive scale of the urgently-needed response to HIV/AIDS becomes acceptable cover for dozens more well-intentioned micro- and pilot-scale projects subject only to qualitative evaluation and failing to embody what is already known about how HIV spreads, the factors determining vulnerability and the interventions that effectively prevent infection, improve health and mitigate impact.

3. UNICEF'S MTSP PRIORITY: FIGHTING HIV/AIDS

3.1. Introduction

UNICEF's 2002-2005 MTSP⁵ identifies 'fighting HIV/AIDS' as one of five organizational priorities. UNICEF's strategy for this MTSP priority lists four 'priority areas for action': prevent HIV infection among people aged 10-24, prevent parent-to-child transmission, provide care for children and parents living with HIV/AIDS & ensure protection, care and support for orphans and for children in families made vulnerable by HIV/AIDS. Targets are stated for all but the third of these four.

The MTSP approved by the UNICEF Board is ambitious in scope, directing UNICEF to tackle four distinct areas of action on HIV/AIDS. Each of these has a corresponding workplan at HQ. From a global perspective, the countries where such actions are responding to the greatest immediate need are those of sub-Saharan Africa. The HIV/AIDS Strategy recognizes this in part by proposing minimum actions for countries with HIV prevalence less than 1% that differ from those proposed for countries with prevalence greater than 1%.

Concrete globally agreed goals and targets for fighting HIV/AIDS are found in the Declaration of the 2001 UNGASS on HIV/AIDS,⁶ and reinforced for UNICEF in the Declaration of the 2002 UNGASS on Children.⁷ Within the HIV/AIDS Strategy document,⁸ UNICEF's own targets are described primarily in aspirational and process terms rather than in quantifiable targets for outcomes experienced by people infected with or affected by HIV. Links between UNICEF's 2002-2005 targets and the global and national goals may be more evident in operations documents guiding country programmes of cooperation than is the case in materials available in HQ.

Priority Area	UNICEF 2002-2005 Global Target
Preventing HIV infection among young people	By 2005 national policies and strategies will have been approved and action plans will be under implementation to reduce the risk and vulnerability of young people to HIV infection in countries with emerging, concentrated, and generalized epidemics
Preventing parent-to-child transmission of HIV infection	By 2005, national policies, strategies, and action plans will be under implementation to prevent mother-to-child transmission of HIV in all countries affected by HIV/AIDS
Providing care for children and parents living with HIV and AIDS	
Ensure protection, care and support for orphans and children in families made vulnerable by HIV/AIDS	By 2005, all countries affected by HIV/AIDS will have developed and implemented national policies, strategies and action plans to ensure protection and care for children orphaned or made vulnerable by HIV/AIDS

⁵ UNICEF Executive Board. Medium-term strategic plan for the period 2002-2005. E/ICEF/2001/13. November 7, 2001.

⁶ United Nations General Assembly. Declaration of Commitment on HIV/AIDS. June 25-27, 2001.

⁷ United Nations General Assembly. S-27/2. A world fit for children. A/RES/S-27/2. October 11, 2002.

⁸ UNICEF. Fighting HIV/AIDS Strategies for Success 2002-2005. UNICEF: New York, 2003.

3.2. Preventing HIV infection among young people

The MTSP text clearly prioritizes this area of action, stating:

“82. The prevention of HIV infection among young people, by reducing their vulnerability and risk to HIV infection, will form the core of the UNICEF global response to the HIV/AIDS pandemic and will be a priority in all regions.”⁹

Conceptually, realizing young people’s rights in an era of HIV/AIDS means ensuring they are equipped with the knowledge and skills they need to protect themselves. If sexually active, they also need access to commodities and health services. And finally, young people do not exist in a vacuum - surveys in South Africa report that as many as 50% of young women report that their first sexual intercourse involved coercion or rape, highlighting the limits of knowledge and skills if the enabling environment does not both protect young people and facilitate action by young people to protect themselves.

UNICEF’s own analysis, embodied in the Programme Working Note intended to provide technical guidance for UNICEF activities, is useful as an introduction to the challenges and comprehensiveness of the needed response:

Young people all over the world are at risk. Efforts to prevent HIV infection need to start before adolescents become sexually active to support adolescents to postpone first sex, and to ensure that when they do have sex, that they follow safer sexual practices. In countries where Injecting Drug Use (IDU) is a significant mode of HIV transmission, there should be an emphasis on reducing incidence of IDU and supporting harm reduction measures. Moreover, interventions need to take into account the heterogeneity of young people and of the pandemic itself.

In South Asia and sub-Saharan Africa, 62% of 15- to 24-year-olds living with HIV/AIDS are female (UNAIDS/UNICEF 2000). In East Asia and the Pacific, 51% of youth living with HIV/AIDS are male. In Latin America and Caribbean, trends are shifting with adolescents increasingly at risk (UNICEF/UNAIDS/WHO 2002). The CEE/CIS region, which has some of the highest global STI and IDU rates, has the fastest growing HIV epidemic. IDU often begins during the adolescent years and the proportion of young people injecting drugs appears to be rising in many countries (UNICEF 2001).

Differing patterns of HIV transmission mean that the world is facing a series of different HIV/AIDS epidemics. Many countries are facing generalised epidemics with HIV prevalence over 1% and virtually all groups affected. In other countries, concentrated epidemics are occurring among specific groups (e.g. injecting drug users and commercial sex workers). In these countries, over 5% of members of a high-risk group and less than 1% of the general population is infected. Finally, a third group of countries have low or emerging epidemics, characterised by the combination of low prevalence (the proportion of young people who are infected with HIV) but facing the possibility of increasing incidence (the number of new infections per year).

Despite two decades of effort, many young people are alarmingly uninformed about HIV. Almost half of 15- to 19-year-old girls in sub-Saharan Africa do not know that a healthy looking person can have HIV/AIDS. The same is true for 66% of girls in Cambodia and 80% of girls in Nepal. In rural Kenya, only 15% of girls 15-19 can name two or more ways to protect themselves from HIV/AIDS. Over 40% of 15- to 19-year-olds in Guinea-Bissau have never heard of HIV/AIDS. Nearly two-thirds of 15- to 19-year-old girls in Haiti, (prevalence 10%) and close to half the girls in Togo (prevalence 7%) do not see themselves at risk of HIV/AIDS¹⁰. Only 1% of 15- to 19-year-old girls and none of the boys in Cameroon reported using a condom during last intercourse, yet over 60% of teenage girls in Yaoundé report being sexually active.¹¹

⁹UNICEF Executive Board. Medium-term strategic plan for the period 2002-2005. E/ICEF/2001/13. November 7, 2001.

¹⁰ Data from Progress of Nations 2000 and secondary analysis of DHS reports 1994-1999 conducted by UNICEF New York

¹¹ Programme Working Note. UNICEF Intranet under ‘HIV/AIDS Top 10’.

At the global level, UNICEF has been a leader in the identification and implementation of global level indicators on HIV/AIDS and young people for the Millennium Development Goals (MDG) and UNGASS follow-up efforts. In addition, in 2002, UNICEF, WHO and UNAIDS jointly released a document entitled 'Young People & HIV/AIDS: Opportunity in Crisis' which summarizes available information on the knowledge of young people and estimates of HIV prevalence among young people and numbers of young PLHA. An updated version of this is under preparation for release at the XV International AIDS Conference in July 2004.

Given the broad scope of activities that UNICEF supports in its pursuit of the goal of preventing infection among young people, an emerging priority is linking the national policies and strategies that UNICEF has chosen as its MTSP targets to outcomes that matter for young people. Ensuring that verifiable information is available to assess progress in realizing these linkages for increasing numbers of young people in increasing numbers of countries, and that it is gathered with the meaningful participation of young people would be an important UNICEF contribution.

The scope for improvement on existing information systems is significant. For example, based on UNICEF CO Annual Reports for 2002, 80 countries were reported to have 'established policies, strategies and action plans to prevent HIV infection among young people'.¹⁴ One of the core elements of such plans, identified by UNICEF and others is school-based life skills education, equipping young people with knowledge and skills to take steps to reduce their risk of HIV infection. Using reported data on the UNGASS Follow-up through July 15, 2003, only 16 of these 80 countries where UNICEF identifies an established action plan reported any information on proportion of schools whose teachers had been trained in life skills education.¹⁵ Put another way, no information was available for 80% of countries where a plan is stated to exist. Among the 16 that did report, the proportion of schools with trained teachers ranged from 0 to 100%.

While nominal responsibility for data collection for this indicator lies with UNESCO and thus outside the scope of direct UNICEF action, UNGASS follow-up indicators of knowledge and condom use, for which UNICEF has direct accountability, were similarly sparse. Sixteen of 80 countries with plans provided information on young people's knowledge levels¹⁶ and 17 of 80 provided information on young people's condom use at last sexual intercourse with a non-regular partner.¹⁷

Given UNICEF's leadership role in assisting countries with the establishment of policies, strategies and plans of action to prevent HIV infection among young people, this paucity of information about what is happening in countries may be hampering the translation of these plans into changes in outcomes experienced by young people. At a minimum, UNICEF assistance to countries to monitor progress on these core globally-agreed indicators could be a valuable contribution not only to global efforts but also to UNICEF's efforts in countries.

¹⁴ Fighting HIV/AIDS Progress Analysis and Achievements in 2002; UNICEF Programme Division, June 2003.

¹⁵ UNAIDS. Follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS. Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003. September, 2003. Annex 3.

¹⁶ Ibid. Annexes 8, 9 & 10

¹⁷ Ibid. Annex 11.

3.3. Parent-to-Child Transmission of HIV Infection

The MTSP refers to preventing 'parent-to-child' transmission (PPTCT) while many of UNICEF's partners, including WHO,¹⁸ and some of UNICEF's publications^{19,20} refer to preventing 'mother-to-child transmission' (PMTCT). Some UNICEF staff are of the view that the use of 'parent-to-child' avoids blaming mothers for HIV transmission. Others feel this largely symbolic semantic shift undermines clarity about the activities supported by UNICEF. In this review, mother-to-child transmission (MTCT) is used to refer to activities where intervention is directed solely at women. Parent-to-child transmission (PTCT) is used to describe interventions directed to both males and females.

From an epidemiologic perspective, transmission of HIV from fathers to their children can occur only through unscreened blood transfusion or sexual intercourse. Transmission of HIV from mothers to their children can also occur through unscreened blood transfusions. However, HIV can be transmitted from mothers to their children in utero, during labour and delivery, or through breast milk. WHO estimates that, in the absence of intervention, the risk of HIV transmission during pregnancy and delivery is 15-30% and a further 10-20% during breastfeeding.¹⁶

In resource-rich settings, most if not all women are provided confidential testing (VCT) for HIV and if positive, ARVs, delivery by caesarean section, and breastmilk substitutes (BMS). In the absence of these three interventions, between 25 and 50% of children born to HIV-infected mothers will be infected. The variation in transmission rates is, in part, a function of the duration of breastfeeding and, in part, of whether breastfeeding is exclusive or mixed, in addition to the viral load of the mother, and aspects of delivery care.²¹ Without ARV treatment, most infected children will die before age 5. In resource-poor settings, intervention has focused on VCT, short-course ARV and infant feeding counselling.

Globally, UNICEF and its UN partner agencies have adopted a four-prong PMTCT strategy:

1. Prevent HIV infection among women of child-bearing age
2. Prevent unwanted pregnancy among HIV-infected women
3. Reduce transmission from HIV-infected women to their infants
4. Care and support, including treatment, for women living with HIV/AIDS and their children

UNICEF staff note that the bulk of the organization's efforts to date have focused on 'prong 3', delivering VCT, ARV and infant feeding counselling to women through antenatal care settings. Donor interest and the opportunity to implement an effective, individualized intervention appear to have contributed substantially to this focus, as UNICEF played a leadership role in the development of pilot sites for delivering these interventions. In addition, UNICEF Supply Division has provided procurement services under contract to a Columbia University-managed project called 'MTCT-Plus', intended to demonstrate the feasibility of prong 4 by providing ARV treatment to women and their partners and children identified through PMTCT efforts.

¹⁸ <http://www.who.int/reproductive-health/rtis/MTCT/index.htm>

¹⁹ Mother-to-Child Transmission of HIV. A UNICEF Fact Sheet. 2002.

²⁰ Infant Feeding and Mother-to-Child Transmission of HIV Technical Guidance Note. CF/PD/PRO/02-03.

²¹ Per-month risks of transmission are reasonably constant. Thus, a child breastfed for 24 months has a higher risk of HIV transmission than one breastfed for 6 months. Mixed feeding appears to increase the per-month risk of transmission, particularly at ages less than 6 months.

Prong 3 also presents significant delivery challenges. Successful delivery of the PMTCT intervention in the prepartum phase alone requires counselling of a pregnant woman, provision of VCT and, for women found to be HIV-infected, provision of ARV at the time and dose required for effect. If a PMTCT effort reaches 80% success at each step (counselling, testing, ARV provision), overall programme performance is still only slightly over 50% ($80\% \times 80\% \times 80\% = 51.2\%$).

In November 2002, UNICEF released the report of an external evaluation of pilot sites completed by the Population Council. The report included the following estimates of coverage for each step:

	Reported Coverage Level
Counselling	25% - over 90%
Testing	64% - 83%
ARV Provision	40% - 60%

Using these data from actual PMTCT sites, programme effectiveness as calculated above would range from 6.4% to 50%. In several countries, initial expansion in the number of sites led to decreases in counselling coverage as capacity needed to be developed. With the move to 'scaling up', data on programme performance are reported to be less complete and less timely, further highlighting the challenge of delivering and monitoring a complex intervention.

In addition, infant feeding presents particular challenges for women living with HIV or women whose HIV status is unknown. The evidence is clear that children who are breastfed, particularly if exclusively breastfed, have lower mortality from infectious diseases than children who are not breastfed. For women living with HIV, this creates a particularly difficult choice — if breastfeeding, risks of HIV transmission to the child rise and risks of common infectious diseases are lower while if using breastmilk substitutes, risks of common infectious diseases rise.

The UN Joint Framework for Priority Action on HIV and Infant Feeding²² states:

“When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life and should then be discontinued as soon as it is feasible.”

This approach, coupled with the biological reality of HIV transmission through breastmilk and the risk tradeoff faced by breastfeeding mothers who are infected with HIV, lies at the core of UNICEF's efforts to promote the 'right of mothers to make decisions on the basis of full and clear information on what is best for them and their infants, and to be supported in carrying out those decisions'.²³

Looking ahead, success in small-scale pilots has shifted UNICEF's role from project management to supporting scaling up. There is much work to be done in this area as, among the countries participating in the UNICEF-supported pilots, few have developed national scale

²² http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/HIV_IF_Framework_pp.pdf

²³ HIV and Infant Feeding. Fact Sheet. UNICEF, 2002.

PMTCT efforts. Botswana has the most extensive programme and uptake is reported to be only approximately 52% of all pregnant women.

With this shift, the specifics of project management give way to a much wider range of activities, which must typically be managed in partnership with local, national, and often, international partners. As UNICEF negotiates this shift, it will be critically important to ensure that the balance among the four prongs is optimized to make the best use of scarce resources. Furthermore, with the loss of direct control of PMTCT programs, UNICEF may wish to establish a strategic information support role, ensuring that adequate, accurate information is gathered, available to, and used by decision-makers.

Finally, mother-to-child transmission is also affected by changes in the population prevalence of HIV infection. A number of peer-reviewed publications have noted that the cost-effectiveness of prong 3 efforts rises with rising prevalence. Particularly in low-prevalence settings, comprehensive efforts to prevent HIV infection among women of child-bearing age and their sexual partners may warrant greater attention than prong 3 efforts. This is even more the case in settings where other antenatal interventions of demonstrated effectiveness (and particularly those of greater cost-effectiveness) have yet to reach 100% coverage of pregnant women. In all settings, the move to link treatment for mothers, their partners and children can be expected to increase uptake of prong 3 PMTCT interventions.

3.4. Protection, Care and Support for Orphans and Children

Over 11 million children under the age of 15 living in sub-Saharan Africa have been orphaned, losing one or both parents to HIV/AIDS. In addition, several countries embroiled in or emerging from conflict have significant numbers of children orphaned during conflict. Given UNICEF's particular mission on behalf of children, orphans, regardless of cause, are one of the most vulnerable groups of children on the globe today.

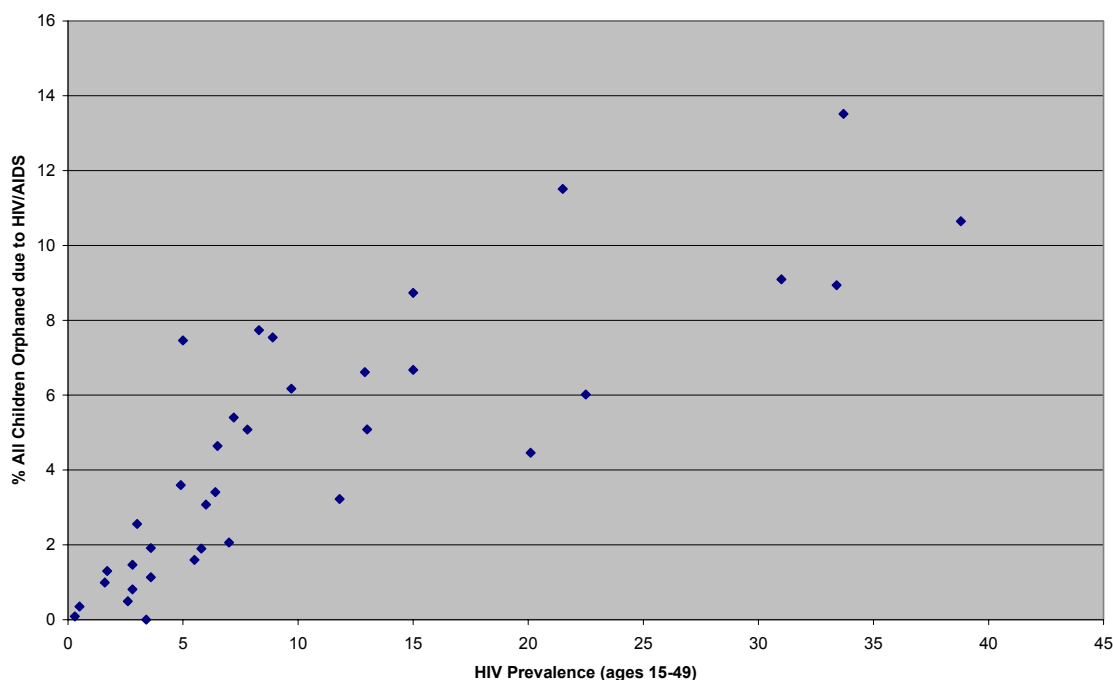
The table below highlights the impact of HIV/AIDS as a cause of orphaning. Countries listed in the top section of the table have the highest proportions of orphans due to HIV/AIDS while those in the lower section have the highest numbers of orphaned children.

COUNTRY	% Orphans due to HIV/AIDS	# Orphans due to HIV/AIDS	HIV Prevalence among adults 15-49
Zimbabwe	76.8%	782,000	33.7%
Botswana	70.5%	69,000	38.8 %
Zambia	65.4%	572,000	21.5%
Swaziland	58.8%	35,000	33.4%
Kenya	53.8%	892,000	15.0%
Nigeria	18.4%	1,000,000	5.8%
Ethiopia	25.8%	990,000	6.4%
DR Congo	33.9%	930,000	4.9%
Kenya	53.8%	892,000	15.0%
Uganda	51.1%	880,000	5.0%

These data demonstrate the impact of high rates of HIV infection in the adult population (aged 15-49) and the role of HIV as a cause of orphaning. As the figure below demonstrates, the

proportion of children orphaned by HIV/AIDS rises as the prevalence of HIV infection among adults increases.²⁴ Furthermore, the data suggest that the proportion of children orphaned begins to rise significantly once prevalence is greater than 5%.

%Orphans due to HIV/AIDS & Adult HIV Prevalence



Globally, Africa will continue to account for the largest share of children orphaned by HIV/AIDS. Numbers in regions not listed here are sufficiently small as to contribute little to the global total. The table below summarizes projections for 2005 and 2010 from 'Children on the Brink',²⁵ a joint effort of UNICEF, UNAIDS, & USAID.

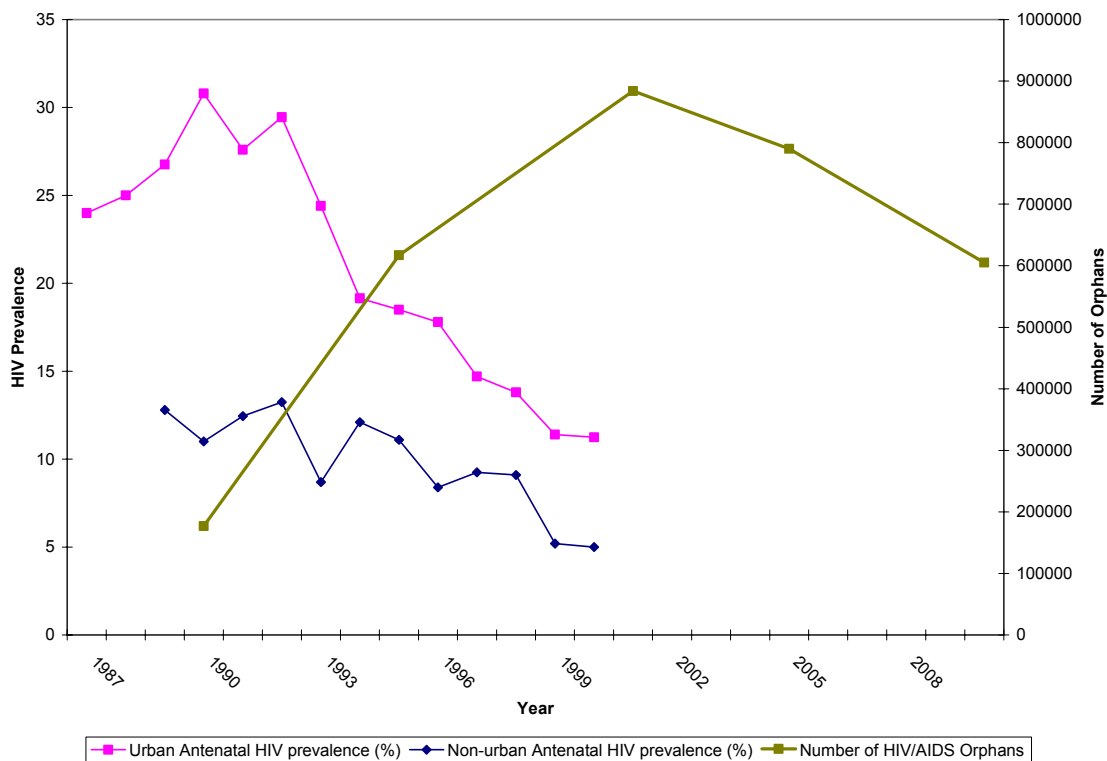
Estimated number of orphans due to HIV/AIDS (as % of all-cause orphans)	2005 (projection)	2010 (projection)
Africa	16,255,000 (41.8%)	20,078,000 (47.8%)
Asia	3,099,000 (5.0%)	4,320,000 (7.5%)
Latin America	752,000 (9.6%)	898,000 (11.9%)
Global Total	20,106,000 (18.6%)	25,296,000 (23.7%)

The natural history of HIV infection is such that even if all transmission ceased immediately, the number of orphans would likely continue to grow, creating an 'orphan overhang' in population terms. The figure below draws on data from Uganda - a country that has had real success in implementing effective HIV prevention measures and lowering prevalence. Nevertheless, the Uganda experience suggests that the peak number of orphans does not occur until roughly a decade after declines in prevalence begin. For countries that have yet to implement

²⁴ Regression analysis of data from 36 countries in Africa yields an R² of 0.68 (p<0.05) for the relationship between adult HIV prevalence and proportion of children orphaned due to HIV/AIDS.

²⁵ UNICEF. Children on the Brink 2002. UNICEF: New York, 2002.

comprehensive, effective measures to prevent HIV infection, the challenge of fulfilling the rights of all children, including orphans, to survival, growth and development will continue to grow.



3.5. Conclusion

These brief summaries of the three substantive areas of the MTSP where UNICEF has established targets highlight the reality that there is no single HIV epidemic and no single intervention for all settings. Within different countries and within different communities within the same country, patterns of transmission and vulnerability vary. In all countries, resources are limited and ideally would be allocated to the action area where impact is likely to be greatest. In addition, particularly in high-prevalence settings, HIV/AIDS renders not only PLHA vulnerable but also affects virtually everyone in these societies through its toll on people essential to the development of children and young people: parents, teachers, health care workers, civil society, and government.

Twenty years ago, the need for context-specific assessment and intervention may have been avoidable, but today, one-size-fits-all is insufficient to guide effective action. People - children and young people particularly - whose rights are the focus of UNICEF's mission are particularly vulnerable to HIV infection and to the impact of HIV infection in their parents, families and communities. The prospects for a child or young person, regardless of whether he or she is living with HIV infection are dramatically dimmed if most of the duty bearers are dead or incapacitated by illness.

4. UNAIDS, UNICEF, AND GLOBAL ACTION AGAINST HIV/AIDS

UNAIDS was created by a 1994 ECOSOC resolution and draws on the strengths of the co-sponsoring UN agencies and specialized funds, providing overall leadership for the UN response to HIV/AIDS. UNAIDS has leadership responsibility for the UN contribution to the follow-up of the Declaration of the 2001 UNGASS on HIV/AIDS.

UNICEF plays multiple roles vis-à-vis UNAIDS, including co-sponsor, non-voting member of the Programme Coordinating Board (PCB), recipient of funds from the Unified Budget and Workplan (UBW), lead roles in collecting and analyzing data for indicators, and participant in the UN Theme Groups on HIV/AIDS in many countries.

UNAIDS represents both a novel response to a cross-sectoral issue and, in the view of the UNAIDS Secretariat, a prime example of UN reform in action. The recent Five-Year Evaluation²⁶ and the Secretariat's response to the evaluators' recommendations provide a starting point for evaluating how UNICEF has managed its various UNAIDS roles. Annex 1 includes a detailed summary of the Evaluation's recommendations and the UNAIDS Secretariat's response to those recommendations.

4.1. The Five-Year Evaluation

Evaluating UNAIDS is not an easy task, given its multiple roles and stakeholders. Conceptualized as a UN-led vehicle for coordinating the response of UN specialized funds and agencies, UNAIDS represents a structure for managing change within a large, globalized bureaucracy. The tone of much of the evaluation and the response to it indicate that work on this internal UN task, while advancing, remains both unfinished and central to UNAIDS role.

On the ground, UNAIDS' success in facilitating National AIDS Plans highlights both the benefits of a coordinated UN response to HIV/AIDS and the significant work ahead to deliver a coherent, coordinated programme of implementation support to countries. Of major relevance to meeting this challenge in countries, the evaluation's recommendations to move towards unified budgets and workplans for co-sponsor activities in countries and to broaden UN Theme Group membership in countries drew the most forceful rejection from UNAIDS in its response to the evaluation.

In the absence of alignment of financial, managerial and accountability mechanisms for work in countries, UNAIDS role appears fundamentally limited by the co-sponsors' willingness to do more than merely spend the relatively small amounts of money allocated to each co-sponsor from the UBW. Estimating the transaction and duplication costs associated with country level efforts by the co-sponsors was not within the mandate of the five-year evaluation, but the evaluation's recommendations suggest that these remain not insubstantial.

UNAIDS response to the evaluation identifies four key areas of action: 1) global advocacy, 2) partnership facilitation, 3) being a centre of knowledge, and 4) continuing as a successful example of a joint and cosponsored effort within the UN system. All but item 3) of this list can be conceptualized as process functions that, one hopes, contribute to improved lives for people infected with and affected by HIV/AIDS. As external funding for HIV/AIDS rises, in part due to advocacy by UNAIDS, co-sponsors, and others regarding treatment access, there is a real

²⁶ UNAIDS. Five Year Evaluation Final Report. Version dated October 8, 2002.

possibility that without technically competent staff to assist governments and non-governmental partners, the comprehensiveness of the proposed UN response to HIV/AIDS will be insufficiently funded and rendered increasingly irrelevant in the rush to provide treatment.

On the matter of being a knowledge centre, the challenge for both UNAIDS and many UNAIDS co-sponsors is assisting their staff to develop the skills necessary to provide the assistance governments and others request or need to deliver at-scale intervention. As an example, the low transaction intensity of billboard or radio exhortations to be monogamous is dwarfed by the human resource and logistical complexities of providing VCT for pregnant women and ARVs to those who are living with HIV. Thus, a critical aspect of providing knowledge leadership will be ongoing efforts to upgrade and maintain the knowledge base of UNAIDS and co-sponsor staff members about not only innovative interventions against HIV/AIDS but also lessons learned from effective at-scale delivery approaches.

In the same vein, as efforts on sexual behavioural change poignantly illustrate, knowledge alone is rarely sufficient for change. Capacity for behavioural change communication and social mobilization is reported to be thin both in countries and among external partners who seek to assist them. On a positive note, should UNAIDS' resources increase significantly, UNAIDS could well have the opportunity to link resource allocation among the co-sponsors to evidence that programming and policy guidance is informed by up-to-date knowledge. This shift to evidence-based activities and away from an obsession with apparently novel, but rarely so, small-scale efforts at the country level would be an especially valuable medium-term contribution of UNAIDS. The likelihood of such a transformation is, as yet, unclear. Without stronger links between resource allocation and results, knowledge management is likely to remain underdeveloped, with small-scale passive distribution of eloquent reports of essentially duplicative small-scale efforts by the co-sponsors and others.

4.2. UNAIDS & UNICEF: Multiple Roles

The evaluation also provides an opportunity to explore how UNICEF's multiple roles can most effectively contribute to progress in the fight against HIV/AIDS. As a co-sponsor, UNICEF is among the larger co-sponsors both in terms of its financial flows and its staff presence in countries. Perhaps as a result, UNICEF's initial response to UNAIDS was marked by a relative scepticism and minimal enthusiasm. As UNAIDS has matured, UNICEF and UNAIDS relationship has evolved into a more multi-faceted one.

In countries, reticence about country-level collaboration and partnership among disparately sized and resourced co-sponsors is not surprising given the absence of alignment of financial, managerial and accountability mechanisms for work in countries. UNICEF's budgets in the field are generally sufficiently large that access to PAF funds has been of insignificant material relevance to the projects and strategies that UNICEF wished to support. Although exact numbers are not available, UNICEF Representatives chairing the UNTG on HIV/AIDS in countries are cited as an example of UNICEF's deepening engagement in UNAIDS' approach to countries.

Significant potential collaboration with UNAIDS partners occurs through Interagency Task Teams (IATT). Document review identified the following IATT: orphans and vulnerable children, young people, injection drug use, condoms, education & HIV/AIDS, and PMTCT. The first and last of this list are reported to be useful for advancing UNICEF's approach to HIV/AIDS by the

staff members who participate on UNICEF’s behalf. No evaluations of the IATTs were identified during this review.

From the UNICEF Headquarters perspective, one of the most obvious links between UNICEF and UNAIDS is funding from the Unified Budget and Workplan (UBW). For the 2002-2003 biennium, UNICEF received US\$14.5 million from the UBW. This was allocated to HQ activities (\$5.5 million, 38%) and Regional Office activities (\$9.0 million, 62%). Majority opinion is of the view that UBW funds have yielded identifiable short-term positive impact for UNICEF, particularly with regard to staffing in New York, but may have sown the seeds for medium-long term sustainability concerns. Data from the Programme Management Information Unit of Programme Division indicate that HQ HIV/AIDS work is, in fact, slightly less reliant on other resources, (UBW funds are included as ROR) than HQ activities in general, but significantly more reliant than country offices, aggregated by region, in all but one region. The table below provides additional details.

Percentage of Expenditure Attributed to Other Resources (ROR & EOR)									
	HQ-all	HQ-HIV	CEE/CIS	EAPR	ESAR	MENA	ROSA	TACR	WCAR
2002	81.5%	78.9%	60.8%	46.2%	51.6%	48.2%	40.5%	43.9%	19.0%
2003	73.7%	68.0%	52.0%	66.9%	63.4%	58.1%	49.7%	62.0%	31.8%

Finally, UNICEF provides significant leadership and resources on the collection and analysis of data essential for monitoring progress on HIV/AIDS. Through participation in the UNAIDS Monitoring and Evaluation Reference Group (MERG), UNICEF has been able to disseminate accurate, quality data that is not only relevant to UNICEF’s own objectives but, particularly in the areas of young people and orphans, has come to be widely-used global data on the state of HIV/AIDS. Although MERG membership is a part of UNICEF’s role as a co-sponsor, UNICEF appears to have actively engaged to mutual advantage on issues of high relevance to two of the four priority areas of action outlined in the MTSP. This has had the consequence of moving UNICEF’s own perspective on HIV/AIDS to be more evidence-based and making that strategic information available to underpin a more co-ordinated UNAIDS response.

4.3. Conclusion

At this point in the evolution of HIV/AIDS, one should take care not to infer from Secretariat and Headquarters-originating pronouncements that all is well at the ‘coal face’ in countries, often resource-constrained, that are hardest-hit by HIV/AIDS. The evolving relationship between UNICEF and UNAIDS will play out largely through the UN Theme Groups in countries. Evaluating the functioning of those groups, coupled with outcome-focused budgeting and accountability mechanisms, and matched with access to support for improving performance would be particularly valuable for both UNICEF and UNAIDS.

UNICEF’s commitment to strategic information, particularly regarding orphans and young people, has both informed its own activities and provided leadership within UNAIDS’ MERG. This dual role is widely seen as mutually beneficial to both UNICEF and UNAIDS and should be affirmed and supported. As UNICEF determines its medium-long term role in the effort to expand access to ARV and care and support for PLHA, ensuring commensurate commitment to MERG-relevant data and information gathering and analysis, as has been the case with UNICEF’s leadership on data for young people and orphans, would yield potentially significant benefits for both UNICEF and UNAIDS.

Finally, given UNICEF's particular success in branding its activities, the ongoing process of UN reform — of which UNAIDS is perceived to be in some ways emblematic — creates an opportunity for strategic thinking about how the UNICEF brand can both thrive. It also contributes to better outcomes for people infected with and affected by HIV/AIDS — outcomes that depend on intervention implementation by networks of actors: UN, governmental, and non-governmental, working through effective partnerships.

5. MTSP HIV/AIDS PRIORITY: ISSUES RELEVANT TO ASSESSING PROGRESS TO DATE

The sections that follow address aspects of UNICEF's internal response, primarily at Headquarters, to the organizational change inherent in the priority attached to fighting HIV/AIDS. In order, they address organizational structure and process (workplans), resource allocation, use of information (HQ-RO-CO flows and knowledge management), and finally and potentially most important, HIV/AIDS impact on UNICEF staff.

5.1. Structure: Mainstreamed via Matrix Management

Within UNICEF HQ Programme Division (PD), an HIV/AIDS Unit was created prior to adoption of the MTSP. This unit is responsible for overall coordination of the HQ contribution to the MTSP work. With the goal of mainstreaming HIV/AIDS to reflect the intersectoral aspects of UNICEF's proposed actions, staff accountable to and located within the various PD sections (health, nutrition, education, adolescent development and participation, and child protection) were then designated as task team leaders and members for each of the four HIV/AIDS workplan teams: HIV and young people; prevention of mother/parent-to-child transmission; care and support; and orphans and vulnerable children. This matrix management/distributed staff approach is seen as innovative for UNICEF.

Some HQ advisors working on HIV/AIDS note that this approach offers the potential for mobilizing an established base of staff and relationships in RO and CO (e.g. all education officers or all nutrition advisors) to take action on HIV/AIDS. However, this is not a universal view. In several areas of UNICEF's HIV activity, staff new to the organization provide the HQ lead, and these people would not have had such established relationships available to them. In addition, particularly in the area of health, unfilled CO positions and offices without broadly competent health staff are cited as a limit to the usefulness of sectoral networks.

Furthermore, this potential 'network' benefit should be offset against three potentially adverse consequences: i) uncertainty about who speaks for UNICEF on HIV/AIDS, a concern raised by some staff, ii) the question of how supervision and performance appraisal of staff by their Section chiefs/supervisors dovetails with workplan leadership and direction from the HIV Unit, and iii) the critical need for leadership and vision within PD to ensure engagement of Section chiefs on HIV/AIDS. Given that performance appraisal of PD staff assigned to the task teams is done by Section Chiefs or supervisors within PD sections, and that the bulk of UNICEF's UBW resources have been disbursed by the HIV Unit to support regional activities coupled with very modest amounts of HIV-related RR flowing to PD sections, the current approach to mainstreaming may be based primarily on good will rather than an optimal alignment of financial, HR, managerial, and accountability mechanisms consistent with effective mobilization of PD sections around the HIV/AIDS priority. A review of the matrix management model could be particularly valuable at this time to ensure that UNICEF HQ's structures are best-suited to achieving UNICEF's MTSP targets.

5.2. Structure: Task Teams & Workplans

The MTSP approved by the UNICEF Board identifies four priority areas of action. Workplans for each have included the development of technical guidance. Two years after approval of the MTSP, technical guidance is available on the UNICEF Intranet for all four areas. The guidance

provided for care and support is noted to be a 'draft' dated October 2003.²⁷ These documents reportedly underwent internal review by UNICEF staff prior to their posting on the Intranet. While respecting the scope of the MTSP, a compelling argument can be made that the relative underdevelopment of guidance for care and support may reflect an artificial separation of care and support from UNICEF's core areas of activity.

At this point in the life of the 2002-2005 MTSP, an alternative conception may merit consideration – integrating care and support into the three other actions, rather than treating it in isolation. For each of the priorities, care and support is a critical enabling or facilitating factor for progress. For young people, campaigns and life skills efforts can mobilize them to seek HIV testing. Several UNICEF documents give high priority to expanding voluntary counselling and testing (VCT) targeting young people. Yet if no care, support or referral is available for those who discover they are infected with HIV, not only is participation likely to be low, but the UNICEF-supported campaign and education efforts may run counter to generally accepted ethical principles regarding diagnosis and consent to testing.

Furthermore, in the priority area of preventing parent/mother to child transmission, 'PMTCT-Plus, both the specific programme for which UNICEF provides contracted procurement services and the more general recognition that treatment for women, their partners and children is important, is fundamentally about strengthening the care, treatment and support aspects of an existing programmatic and policy approach. Integrating care and support would create a strong argument that any UNICEF-supported effort must be premised upon integrating other interventions that may benefit the mother and family's health (e.g. provision of insecticide-treated bednets in malarial areas) and providing postpartum care for the mother, including ARVs where appropriate, as patient/client, particularly if she is now aware that she is living with HIV/AIDS, rather than being treated merely as the means of transport for the child.

Finally, in the area of orphans and vulnerable children, where UNICEF's global leadership is particularly evident, integration of care and support points to two key areas of action. First, in settings where UNICEF's situation analysis identifies the need for an 'emergency response', commodity distribution (e.g. blankets, water pumps, bicycles) may represent one of the most impactful efforts at care and support. Second, and crucial to a deeper understanding of orphaning, integrating care and support within the OVC (orphans and vulnerable children) work area points incontrovertibly to the reality, now supported by UNICEF data, that keeping parents or adult caregivers alive and healthy can not only prevent or delay orphaning, but also addresses the biggest health risk facing many orphaned children, namely illness or death of their caregiver.²⁸

Where orphans reside with a surviving parent, that person is often also living with HIV/AIDS. Even when caregivers have no access to antiretroviral drugs (ARV), inexpensive, effective treatments of candidiasis, diarrhoea and pneumonia can reduce the frequency and morbidity of opportunistic infections and thus, reduce the likelihood of prolonged periods of debility and decreased household income due to illness. The health of caregivers is critical to the health of children residing in the household through two primary mechanisms: 1) household members with some infectious diseases can transmit these to immunocompetent household members (e.g. diarrhoea, tuberculosis), and 2) when caregivers fall ill, children are often removed from school to provide care in the home, perform household chores or engage in income-generating activity.

²⁷ UNICEF Intranet. Accessed 30 March 2004.

²⁸ UNICEF. Africa's Orphaned Generations. UNICEF: New York, 2003.

Regardless of the decision made regarding the organization’s workplan response to the issues of care and support, care and support issues are integral to all of UNICEF’s priority areas of action in the fight against HIV/AIDS.

5.3. Resource Allocation: UBW Funding & UNICEF

Globally, multilateral action on HIV/AIDS has been shaped significantly by the role of UNAIDS. UNICEF is a co-sponsor of UNAIDS and receives unified budget and workplan (UBW) funds from UNAIDS that appear within ROR available to the organization. As noted in the previous section, HIV/AIDS activities at Headquarters are similarly reliant on ROR as other activities at HQ, but other activities are reported to have a greater number of sources of ROR.

Data on contributions for 2003, provided by the HQ HIV Unit identify three sources of funds as detailed in the table below. Note that these numbers are contributions and thus differ from the expenditure data used in a previous section discussing the RR and OR sources of funds.

	Source	2003 Contribution	Share (%)
RR		792,700	20.7
OR	UBW	2,080,000	54.3
	US Fund	958,756	25.0
Total		3,831,456	100

Thus, the UBW funds likely play a unique and significant role in the HQ components of the organization’s response to this MTSP priority when compared to activities related to other MTSP priorities.

UNICEF’s reliance on UBW funding for much of its HIV/AIDS activities in NY may have contributed to sustainability concerns identified by several respondents. Specifically, funds from both the 2000-01 and to a lesser degree, 2002-03 and 2004-05 UBWs were reportedly used to fund temporary fixed-term staff in Programme Division. With UBW funds available, UNICEF may have been spared redeploying internal resources commensurate with its stated commitment to fighting HIV/AIDS. For example, by early 2004, 3 positions originally stated to be UBW-funded in the Health Section had been reduced to one person assigned to HIV/AIDS, as UBW funding was otherwise allocated by the HIV Unit, and alternative resources within the Health Section were not used to maintain these positions.

Given the importance of financial resources to deliver on UNICEF’s commitments in the MTSP and its contribution towards the achievement of the MDG and UNGASS Declaration goals, a more detailed analysis of financial flows and allocations may be appropriate. If such an analysis has been done, a more thorough dissemination to relevant staff would likely foster transparency.

5.4. Resource Mobilization: Responding to ‘Scale Up’ Needs

Whether because of the need to chase smallish amounts of UBW money, or because UNICEF’s analysis of the global HIV/AIDS situation requires such a broad programmatic focus, much of UNICEF’s programmatic activities in the four priority areas for action have been pre-scale up.

The 2003 Mid-Year Review of the HIV Workplan prepared by the HIV Unit²⁹ noted that ‘supporting country implementation and scale up continues to be the #1 priority’. Neither the workplan nor the Review provide information that would enable a differentiation of ‘scaling up’ activity from the innovation that has marked much of UNICEF’s support on PMTCT and orphan programming. In part this is due to the increasing diversity of actions that UNICEF country programmes support as scaling up occurs in a range of contexts.

The same report also states that ‘the development and approval of an HIV/AIDS resource mobilization strategy early in the year is starting to have a positive impact on fundraising’. No data on levels of or trends in new resources are provided, however the report’s states that ‘there remains a significant gap between resources secured and the resource mobilization goals set for this OP’.

The table below compares reported HIV/AIDS expenditure for 2002 and 2003 with a straight-line trend of expenditure targets (M: million). This trend is based on the MTSP text which reports programme expenditure on HIV/AIDS of \$30 million in 2000 and a projected target of \$169 million for 2005.³⁰

	2000	2001	2002	2003	2005
Reported Expenditure	\$ 30 M		\$ 94.3 M	\$ 111.3 M	
Projected Expenditure		\$ 57.8 M	\$ 85.6 M	\$ 113.4 M	\$ 169 M

While caution is warranted in interpreting these numbers indicating that resource mobilization is on track in light of the view that resources are insufficient, one possible explanation is that the scope of ‘scaling up’ requires a resource mobilization effort that is beyond that initially proposed at the MTSP’s adoption. UNICEF’s resource mobilization skills may be particularly useful to scaling up in settings with clearly defined interventions & plans for scaling up, coupled with clear role definition of who does what in supporting local and national bodies to operationalize these plans.

5.5. Enabling Environment: Linking Monitoring and Evaluation to Programme Action

On HIV/AIDS, HIV Unit staff have invested significant energy in developing a coordinated workplan with regional HIV/AIDS advisors. Implementation has been supported through allocation of UBW funds received by UNICEF to regional offices. This move in the direction of coordination is a significant achievement. Realizing the full potential of this workplan approach raises two key challenges if it is to be more than a mere planning exercise

The first of these challenges is one of linking monitoring & evaluation results to technical leadership and communication. In the absence of a culture of evaluation, and accountability for performance in relation to benchmarks or ‘best practices’, HQ, RO and CO staff appear effectively free to do ‘what they think is best.’ Given the breadth of the organization’s HIV/AIDS

²⁹ Mid-year Review of HIV Workplan. Internal UNICEF document. 2003.

³⁰UNICEF Executive Board. Medium-term strategic plan for the period 2002-2005. E/ICEF/2001/13. November 7, 2001; Tables 3a & 3b.

programming, the result is that the increasing emphasis on 'evidence-based' activity in the health sector may be completely foreign to a regional advisor drawn from a youth participation background and vice versa. In some cases this gives rise to innovative approaches to programming, but even in those positive situations, without some form of consistent evaluation and more important, use of evaluation results to inform decisions, the benefits to the organization and moreover, other children, young people and women who might benefit is forever lost. In short, many wheels are reinvented as institutional learning opportunities go unrealized..

UNICEF's support to PMTCT pilots highlights this challenge. With several million dollars in donor support, UNICEF set out to demonstrate the feasibility of providing pregnant women with counselling, HIV testing, antiretroviral drugs demonstrated to reduce the risk of mother-to-child transmission, and infant feeding counselling. In 2001-2002, most participating pilot sites forwarded required quarterly monitoring data to NY and a series of summary reports were produced in NY. However, with NY gathering these data and RO staff doing whatever technical support was occurring, improved communication between those delivering the services, those collating the data, and those providing technical support might well have accelerated the pace of learning by doing by providing feedback and comparison data to the people responsible for delivering a complex programme in resource-poor settings. NY staff report that this situation changed in the second half of 2002 with improved information flows from country offices to regional offices to NY and back, ensuring regional offices are now playing a more significant nodal role in information flow. However, since 2003, with UNICEF's diminishing role in direct PMTCT project management, flows of monitoring information have become increasingly erratic. Finally, staff could not identify any documented uses of the analyses of these performance data to identify issues requiring technical assistance or as a benchmark for monitoring progress after such support in a particular country's PMTCT programme or at a particular service delivery site.

This example highlights two related issues for linking monitoring & evaluation efforts to decision-making. First, as efforts demonstrated to be effective are scaled up, a fundamental tactical shift for UNICEF may be needed. One such approach would be to support development of national or district-level information systems to ensure that up-to-date monitoring information is available to decision-makers, both front-line providers and those responsible for overall programme management. Second, even when accurate, timely information from a UNICEF-directed pilot project is available, opportunities to use this to guide decisions and support are going unrealized.

The second challenge arises from the reliance on 'occurrence assessment', (i.e. using statements in country office annual reports that a policy exists), for measuring progress to UNICEF's 2002-2005 targets. While the stated existence of a policy is an encouraging step to action, reliance solely on this type of reporting may be of limited impact unless accompanied by some capacity for not only verifying the existence of policies and action plans but also evaluating their implementation in terms of outcomes that matter for children, young people and others infected and affected by HIV/AIDS. This issue may be addressed through activities planned for 2004-2005 by DPP. In any event, verifiable sources of information remain essential to assessing impact.

5.6. Enabling Environment: Transforming UNICEF into a Knowledge-based Organization

The priority attached to HIV/AIDS in the MTSP and the accompanying strategy describing what UNICEF proposes to do highlight the fundamental shift from advancing the rights of children and young people primarily through advocacy and the distribution of commodities to a rather more complex model of development rooted in long-term capacity development and support for at-scale intervention delivery.

As the MTSP text notes, in all of its action areas on HIV/AIDS, UNICEF is increasingly called upon to perform a series of roles that have knowledge or strategic information at their core. UNICEF has been and continues to advocate for the fulfilment of the rights of children and young people and evidence-based advocacy (e.g. participatory survey results demonstrate that 80% of orphaned children miss at least 6 months of school, rather than general statements that orphans are vulnerable because they are orphaned) can only strengthen the effectiveness of efforts in this area. The information needed to inform advocacy represents an important asset that may be undersupplied at present.

With the increasing emphasis on capacity development over project management, UNICEF faces the challenge of not only identifying best practices from its project portfolio but also widely disseminating both the ideas that informed these successes and tools to adapt them to other settings and circumstances, with accompanying means to assess performance based on incorporation and adaptation of such practice. Dissemination via 'pull' strategies — that rely primarily on the initiative and motivation of the target audience — such as the UNICEF Intranet has expanded significantly. However, the necessary complement, 'push' strategies that incentivize or compel staff to turn to these disseminated best practices and to be expected to maintain up-to-date knowledge are vestigial at best. Strategic information management requires both capture of the results of UNICEF's efforts and dissemination of these in an environment that creates incentives for adaptation and learning from others rather than misconstrued novelty and reinvention of wheels.

5.7. Enabling Environment: Caring for Us

Finally, one of UNICEF's greatest strengths is the diversity of its staff. While this brings energy and a wide range of perspectives, it highlights the need for significant training and knowledge management if the organization is to move ahead in a manner consistent with having identified priorities. Shifting from a permissive mission defined in general terms by the articles of the Convention on the Rights of the Child to an outcome-focused, results-based implementation of actions flowing from technical guidance would be a challenge in any sphere of activity. For people working in the area of HIV/AIDS, this is likely further complicated by the intensely private nature of many of the risks for HIV infection and by the toll HIV/AIDS is taking on the lives of UNICEF staff members in all parts of the organization, their families, and those for whom they care — particularly, the sick and orphans.

In this regard, the recent Executive Directive on 'Caring for Us' (CFU) dated July 24, 2003,³¹ represents a potentially significant advance towards ensuring that those the organization counts on to move ahead on HIV/AIDS are themselves not completely preoccupied with its impact on

³¹ UNICEF. "Caring for Us" - Setting Minimum Standards in UNICEF Offices Globally on HIV/AIDS in the Workplace Programmes. CF/EXD/2003-016.

their own lives. The commitment to minimum standards, including confidential, affordable access to medical care, is an important step forward and close monitoring of progress in this area should be a high priority for the organization. In addition, succession planning, particularly for CO and RO in high prevalence settings, would be a prudent step that does not appear to have occurred.

A toolkit for implementing CFU efforts together with a video in which UN staff talk about HIV/AIDS has been prepared, approved for distribution by the GMT, and distributed to all UNICEF offices by the first quarter of 2004. A planned complementary effort to inform all UNICEF staff members of the basic facts around HIV/AIDS is hoped to contribute to reducing HIV-associated stigma and ignorance in UNICEF's workplaces. Managing such an effort requires not only timely, up to date information but also safeguards that protect individual identity and confidentiality of sensitive health information, and assurance that no staff member is required or coerced to disclose HIV status to colleagues or superiors in order to receive the information and medical care to which s/he has the right. For UNICEF to speak and act with impact on HIV/AIDS, delivering improved care for its own staff is essential.

5.8. Conclusion

- Organization-wide efforts to integrate and coordinate workplans and budgeting for HIV/AIDS activities have acted as a pathfinder. Realizing their full benefit will require renewed attention to linkages and accountabilities regarding financial matters and staff performance assessment between HQ, RO and CO. PD may wish to evaluate whether the current matrix management/distributed staff model would benefit from modification.
- Care and support remains underdeveloped within UNICEF's activities. The '3 by 5' initiative (WHO's stated goal of 3 million people in resource-poor settings receiving ARV by 2005), representing a clear commitment to increasing the numbers of people in high prevalence, resource-poor settings who receive treatment for HIV/AIDS suggests that the time is ripe for some strategic thinking about what role UNICEF is to play in both the '3 by 5' initiative and the broader area of care and support. One option would be a conceptual integration, accompanied by technical guidance, of care and support into the other three action areas: preventing HIV infection among young people, preventing parent/mother-to-child transmission and meeting the needs of orphans and vulnerable children. In addition, UNICEF's Supply Division may represent an underutilized resource in improving access to commodities and pharmaceuticals that can prolong the life of people living with HIV/AIDS. For HIV/AIDS, Supply Division can play two distinct but critical roles. The first of these is the more obvious one of procurement but the second is arguably as or more important, namely to contributing to the strengthening of delivery systems. Such strengthening cannot be the sole responsibility of programme or supply but requires a working integration of the two.
- Approaching the MTSP's midpoint creates an opportunity to ensure that capturing and disseminating strategic information receives greater attention. Regardless of the form of particular goals, systems to monitor progress, disseminate successes, and identify laggards for intensified mentoring or coaching in a more up-to-date fashion than the midterm review of the country programme, and with strengthened verification means beyond the current annual report approach, are needed. If implemented, such measures would also provide valuable input to evidence-based advocacy and contribute to creating

a culture of evaluation as part of ensuring the optimal protection and promotion of the rights of children and young people.

- Particularly in highly affected countries, it would be impossible to underestimate the impact HIV/AIDS is having and will have on the lives of UNICEF staff, particularly national officers. While stigma reduction and anti-discrimination consciousness-raising efforts are helpful, there is no substitute for ensuring that all UNICEF staff and their family members, regardless of level or country of origin, have access to confidential treatment for HIV infection. For staff hired on limited-term contracts, consideration should be given to how continuity of care can be ensured. Succession planning should also become a standard part of UNICEF's operations in highly affected countries. The expense, while an increase from current spending, is negligible in comparison to the positive impact of putting into practice what the organization has called on others to do.

6. ACHIEVEMENTS & CHALLENGES TO DATE

The following material was provided by the HIV Unit, part of UNICEF HQ's Programme Division, summarizing key achievements and challenges for 2003.

6.1. Key Achievements

Advocacy

UNICEF engaged in extensive advocacy and with particular focus on effective action to address orphans and other children made vulnerable by HIV/AIDS. In 2003, at the request of the UN Secretary General, UNICEF chaired the Task Force on Women, Girls and HIV/AIDS in Southern Africa. A regional consultation of Task Force members – eminent leaders and activists on gender and HIV/AIDS in the nine countries most affected by HIV/AIDS contributed to a report and recommendations submitted to the Secretary General in early 2004. In order to engage and strengthen capacity of leaders, UNICEF and its partners organized major initiatives, studies and workshops for religious leaders in East Asia and the Pacific, South Asia, and East and Southern Africa Regions.

Orphans and Vulnerable Children

In 2002, major events included regional workshops on Orphans and Vulnerable Children in Western and Central and Eastern and Southern Africa. UNICEF convened the first Global Partners Forum on orphans and vulnerable children in 2003. A *Framework for Care, Protection and Support of Orphans and Vulnerable Living in a World with HIV/AIDS* was developed as the widely accepted normative framework to guide action among orphans and vulnerable children. The framework targets leaders and decision makers and serves to guide programming.

PPTCT

In 2003, UNICEF and its partners provided direct support to prevent parent-to-child transmission (PPTCT) programmes in 70 countries (up from 58 in 2002). Five UNICEF-supported countries had nationwide programmes and more than 20 countries are in process of scaling up PPTCT.

Prevention among Young People

UNICEF provided leadership and extensive global advocacy on "Education for All" with a particular focus on girls' education. Life skills based education (LSBE) for HIV prevention expanded as a major intervention supported by UNICEF in most high prevalence countries. In 2003, 71 countries reported that national strategies for LSBE were in place (up from 64 in 2002). The organization is supporting increased access to youth-oriented health services in more than 20 countries. The awareness-raising initiative on "What every adolescent has a right to know" was implemented in 15 countries worldwide.

Care and Support

More than 30 countries have developed national care and support strategies. Technical guidance notes on HIV care and support were developed and revised in light of the '3 by 5' Initiative. For VCT, UNICEF assisted countries on policy, training and needs assessment in Eastern and Southern Africa, Latin America and the Caribbean and Central and Eastern Europe. UNICEF supported the development and implementation of community-based strategies to provide care and support to HIV-affected children and families in need.

Strategic Information

In addition to *Framework for Orphans*, UNICEF has produced alone and with partners several key global documents: *Children on the Brink* (2002), produced with UNAIDS and USAID, achieved high-level global media attention regarding the needs of HIV-affected children; *Africa's Orphaned Generations* (2003) defines the scale of the crisis and the impact on families, communities and children; *Young People and HIV/AIDS: Opportunity in Crisis* (2002) is the first compilation of country-specific data to be used in monitoring the UNGASS HIV goals for young people. UNICEF issued an *Executive Directive on Minimum Standards of Attainment for all UNICEF Offices on HIV/AIDS in the Workplace*. A Office Managers' toolkit and video were produced to support this.

Monitoring and Evaluation

UNICEF's Multiple Indicator Cluster Survey (MICS) is one of the largest population-based surveys of social indicators for children in 70 countries. MICS provided invaluable information on young people's HIV-related knowledge and behaviours to guide the design of effective programmes. In collaboration with partners, UNICEF developed core sets of indicators and monitoring guidance on orphans and vulnerable children, PPTCT, young people and care and support.

Partnerships

To help guide involvement of new partners in the response to HIV/AIDS, UNICEF produced two key documents: *What religious leaders can do about HIV/AIDS: action for children and young people* and *What Parliamentarians can do about HIV/AIDS*. These were developed through a participatory process, involving such fora as the African Religious Leaders Assembly on Children and HIV/AIDS and the African Leaders Consultation on Orphans, and have stimulated concrete actions.

Internal Capacity

All 127 country offices reported engaging in HIV/AIDS advocacy and programming. UNICEF significantly expanded its capacity to provide leadership on HIV/AIDS, increasing HIV-related expenditure from US\$ 67 million in 2001 to US\$ 111 million in 2003 (preliminary figure). UNICEF has 406 full time staff working on HIV/AIDS, 34 at HQ, 37 in RO and 335 in countries.

6.2. Gaps and Challenges

Bringing Programmes to Scale

UNICEF and its partners need to intensify actions to scale up essential HIV/AIDS programming for national coverage (for example, broadening coverage of PMTCT from pilots to national programmes).

Insufficient Resources

While financial resources have increased dramatically, the availability of funds are still not commensurate with the need in UNICEF and amongst partners.

Children Living with HIV

UNICEF has a key role to play in the development of guidelines and programmes for children living with HIV/AIDS. The Global Fund has started to take up this leadership role, but faster progress is needed.

Participation of People Living with HIV

UNICEF endorses the principle of greater involvement of people living with HIV/AIDS, but could do more to promote genuine and effective participation by this important stakeholder group.

6.3. Conclusion

Globally, thousands of new HIV infections occur daily, thousands of people die from AIDS and larger numbers are affected by both. At this point in the evolution of HIV/AIDS, the way ahead requires integrative approaches, intensified linkages among partners to deliver outcomes that matter for people infected and affected by HIV, and a strengthened commitment to evidence-based advocacy and intervention. That HIV/AIDS will have broad impacts on development is beyond debate, but effective action requires understanding and influencing some of the most private human behaviours.

HIV/AIDS will be a major factor in UNICEF's work, whether as an explicit organizational priority or as a major determinant of development. Building on the organization's efforts to date to move from establishing global level actions to evaluated, effective efforts to prevent, treat and mitigate HIV/AIDS cannot happen too quickly. That transformation will continue to raise key internal issues for UNICEF, particularly the impact of HIV/AIDS on staff and their families, resource allocation, and management structures to facilitate effective programming and advocacy. UNICEF recognizes that progress to date, while not inconsiderate, is still insufficient. UNICEF's medium term aim of reaching the target set by the 2001-2005 MTSP is to support and strengthen the capacities of individuals, families, communities and nations to prevent HIV infection and ensure protection and care for children and young people infected and affected by HIV and AIDS. Ultimately, the goal is to prevent HIV infection and improve the outcomes for those infected and affected by HIV and AIDS.

ANNEX I

Given the multiple perspectives on the fight against HIV/AIDS, it is perhaps no surprise that UNAIDS's contribution itself and the UN contribution have been matters of much discussion. Furthermore, the recent external five-year evaluation of UNAIDS and the organization's response to the evaluators' 29 recommendations provide a basis for an assessment of the way ahead. The tables below lists the evaluation's 29 recommendations and excerpts from the report of the UNAIDS Executive Director outlining the response to these.

Recommendation Text from Evaluation Report	Excerpts from Executive Director Report
UNAIDS Strategic Vision	
Recommendation 1 The current ECOSOC objectives should be replaced by a single goal supported by specific roles. This will need to be determined by ECOSOC, but the following statement is proposed: To achieve the adoption of an expanded response appropriate to the state of the epidemic in all member countries through nationally-led provision of adequate and satisfactory services for reduction of risk, reduction of vulnerability, and reduction of impact of the disease.”	No comment on the goal's proposed text
Recommendation 2 The roles of the programme need to be redefined, with specific allocation of responsibility. All roles should be supported by functions with objectively verifiable indicators and targets. This recommendation is addressed to the PCB. The following statements are proposed. In a subsequent recommendation, a new MOU would require that Cosponsors specify outcome objectives for their contribution to these roles.	Agreement on redefinition of programme. No targets or indicators specified.
Recommendation 3 UNAIDS, working at country level through the theme group, should support the Global Fund in a number of practical ways: monitoring trends in the national response and advising on how applications to the fund can be designed to conform with an expanded response and align with the national strategy; advising how expenditure under the fund can support scaling-up; promoting learning from the experience of expanded theme groups by promoting joint membership of eligible parties on both the expanded theme group and CCM; monitoring funds made available through the Global Fund to determine whether they are in addition to other committed national and international funding; and providing guidance and technical support for monitoring and evaluation of Global Fund programmes.	Agreement with broadening from GFATM focus to GFATM and other major financing partners
Recommendation 4 That the Secretary-General and undg take note of UNAIDS' experience and promote reforms that: denote clear and visible lines of management authority with objectives and measurable indicators; create personnel and financial incentives for agencies to programme jointly; and shift the accountability of the country team to a demand-driven service to meet the needs of national stakeholders.	Interpreted as a commendation of UNAIDS. Agree with 'pathfinder' characterization
UNAIDS Governance	
Recommendation 5 That the PCB review and adopt an expanded model of governance, drawing on the scenario in Annex 7 of the Evaluation Report, in order to focus all actors on boosting the complementarity of their actions to supporting the expanded global response. Most significant, at global level, is to replace the CCO by a Management Board with wider representation than the current Cosponsors. The PCB is urged to implement a rapid process, similar to the creation of the	Rejected – described as 'perhaps the most difficult proposal to respond favourably to'

Recommendation Text from Evaluation Report	Excerpts from Executive Director Report
GFATM, in order to accomplish the change within a short period.	
Recommendation 6 A new Memorandum of Understanding should be drawn up for all the Cosponsors. It should state clearly the goal and roles of UNAIDS (the subject of Recommendations 1 and 2); it should set out the obligations of each Cosponsor, the obligations of the Secretariat, and set objectives and indicators for the Secretariat and each Cosponsor, both in terms of substantive progress towards the UNAIDS goal, and process objectives of being a member of the joint programme at global and national levels.	Agree in spirit and counter with 'a more incremental and iterative approach'; details of this alternative not provided here
Recommendation 7 That the status of NGO members of the PCB be changed to that of full voting members.	Counter-proposal Rejected; propose 'a global-level Partnership Forum as a basis for broadening this inclusiveness' (referring to inclusion of NGOs as full voting members of PCB)
Recommendation 8 That a direct link be created between the PCB and governing bodies of the Cosponsors, by changing the representation of each Cosponsor at the PCB to be a member of the Cosponsor's governing body. If this change is made, the status of the Cosponsor could be changed to that of full voting membership.	No comment
Recommendation 9 a) that the PCB change the meeting agenda to allocate time for substantive discussion; and b) that the PCB delegate the roles of budget scrutiny and performance assessment to the Management Board or designated subcommittees.	No comment
Global-level work of the Programme	
Recommendation 10 That UNAIDS, through the work of the Secretariat and all cosponsors, maintain global advocacy, with particular emphasis on political and resource commitments. Opportunities need to be taken to advocate a gendered response and to promote the successful techniques of partnerships and horizontal learning.	Agree
Recommendation 11 That the Secretariat expand current work on information into a substantial functional area to support the roles of coordination, advocacy and capacity building.	Agree
Recommendation 12 The Secretariat should work with Cosponsors to develop a strategy and workplan to promote evaluations and research into impact at national and regional levels, with the aim of generating data to inform national responses. Priority should be given to studies of behavioural change and contextual factors, including gender, stigma and poverty (Chapter 5).	Agree
Recommendation 13 Develop CRIS with objectively measurable indicators of an expanded response at country level, and report annually, in a published and publicly available format (paragraph 5.11).	Agree
Recommendation 14 The good work done in the UBW to bring together all planned expenditure on HIV/AIDS by the Cosponsors at global and regional levels should be continued and expanded to reflect all country-level expenditure as well.	Agree with global and regional UBW; UBW for country-level expenditure rejected
Regional and inter-country work in support of countries	
Recommendation 15 UNAIDS should continue to support regional initiatives that are demand-driven by the needs of countries in the region and, where possible, linked to existing institutions. Opportunities should be taken to develop new services such as regional skill-building workshops. The resources of the Secretariat through the Inter-Country Teams should not be used for coordination among regional offices of the Cosponsors.	Agree. Proposed action 27 suggests that UBW funds flow for ICTs to 'coordinate regional submissions to the UBW process and the articulation of regional-level UN system priorities on HIV/AIDS'; unclear whether this addresses the recommendation that UBW resources 'should not

Recommendation Text from Evaluation Report	Excerpts from Executive Director Report
	be used for coordination among regional offices of the Cosponsors'.
Country level	
Recommendation 16 A contingency plan for a humanitarian response at country level should be prepared under the direction of the PCB.	Agree
Recommendation 17 The Cosponsors should promote high standards of transparency and reporting by publishing and making publicly available all Cosponsor country and regional budgets and the annual out-turn. This will address an original expectation that UNAIDS would provide governments with a clearer, more comprehensive view of the financial and technical support available from UN organizations. Improved information will enable all stakeholders to interact in support of the expanded response. This recommendation is challenging, as complications of budgetary cycles and mainstreaming of activities make identification of HIV/AIDS expenditure and allocation of staff resources difficult. As noted above, this is a challenge to be overcome and not a reason for procrastination.	Agree. UN-ISP (UN Country Team Implementation Support Plan) proposed as framework to achieve this.
Recommendation 18. In view of the importance of multisectoral expenditure towards an expanded response, Recommendation 18 is that, in those countries where a medium-term expenditure framework and public expenditure review process is underway, HIV/AIDS be treated as a specific crosscutting topic for monitoring and reporting. This is an important role for all Cosponsors, but especially the World Bank, in view of its convening power with ministries of finance.	Agree. Comment that principal actor in this area is World Bank with implication of minimal roles for other co-sponsors.
Recommendation 19 OECD donors should link their own bilateral country programmes to national HIV/AIDS strategies and make financial contributions to HIV/AIDS work by the Cosponsors conditional on demonstrated integration and joint programming, reflecting the comparative advantage of the Cosponsors at country level.	Agree. Proposed action: 'that the PCB urge national governments to give HIV/AIDS high priority...'
Recommendation 20 is to continue with and expand the PAF facility, especially to support monitoring and evaluation, if current initiatives by the Secretariat can be shown to improve the allocation process, utilization and speed of processing. Alternative procedures should be examined to improve effectiveness.	Agree. No comment offered on recommendation to examine alternatives of improved effectiveness.
Recommendation 21 is to endorse the work of the Secretariat and for the PCB to keep total numbers of CPA under review and, as appropriate, authorize and fund an expansion to enable deployment to additional countries as information about the evolving state of the disease changes	No comment
Recommendation 22 The UN Theme Group on HIV/AIDS and its associated Technical Working Group provides a service as a technical secretariat to the national response. In this role, all theme groups should have clear objectives with monitorable indicators of both substantive change and process contributions to the national strategy. It must be clear that the chair of the theme group is accountable for the joint programme of the Cosponsors being aligned to the national strategy and to reflect the comparative advantages of the UN system agencies in that country.	Agree to 'revise, update and clarify the expected method of work'. No further details provided
Recommendation 23 Where circumstances permit, expanded theme groups should evolve into partnership forums, led by government, in line with the scenario set out in Annex 7 of the Evaluation Report. In such cases, theme groups may then revert to UN-only membership. In any event, as theme group expansion occurs, the CPA and UNTWG should report to the UN Country Team on HIV/AIDS issues.	Agree to 'revise, update and clarify the expected method of work'. No further details provided
Recommendation 24 UNAIDS at country level should expand and strengthen national systems to	Agree. CRIS and UNISP proposed as integral to

Recommendation Text from Evaluation Report	Excerpts from Executive Director Report
monitor and evaluate interventions, and analyse surveillance data, building on the methods and tools developed by the programme. Countries with severe generalized epidemics should be supported in conducting repeated national surveys on high-risk behaviours. This will require funding and is therefore directed at both UNAIDS and donors.	this strengthening.
Recommendation 25 That a programme of joint reviews led by national governments be launched, building on current practices for mid-term reviews and rapid impact assessments among development organizations. Reviews should be programmed according to priority outcome objectives in national strategies, and examine both the effectiveness of interventions and the supporting performance of institutions, including national AIDS programmes and UNAIDS (Secretariat and Cosponsors). They should be conducted by teams drawn from government, civil society, UNAIDS and OECD donors. This will require funding and is therefore directed at UNAIDS, donors and national governments.	No comment
Recommendation 26 To maintain and expand the successful work of advocacy, the UN system at country level must take a strategic view of implementation of national policies and strategies and exploit opportunities for synergy between the sectors. Capacity of national actors must come 'from the heart' and not fail to include gender competence. Since the aim is to get incremental processes going, the UN role is mostly that of an enabler, helping to create good examples where none exist, and reinforcing good examples where they do.	No specific details identified
Recommendation 27 As a service to national governments, partner donors, the private sector and NGOs to act as brokers of good practice for local-level efforts that are designed for horizontal learning and replication, and that comprise the combined principles of good practice identified in the Global Strategy Framework and in the UNGASS Declaration. In this, to give particular emphasis to the interface of local services and community response (Theme Groups, Secretariat and Cosponsors).	Agree
Recommendation 28 Increase support for scaling up by developing strategies as a service both to national governments and to partner donors. These strategies should build in horizontal learning and be linked to information derived from monitoring and evaluation (Secretariat).	Agree on general need for strengthened M&E; no comment on linkage between scaling up strategies and information derived from monitoring and evaluation
Recommendation 29 The MERG should develop a programme of evaluation studies to look at issues of performance for the programme as a whole, as a set of building blocks to contribute to a global evaluation of UNAIDS five years after this study is presented to the PCB, in 2007 (PCB, MERG and donors for financing).	Unclear as to how UNAIDS-facilitated MERG activity provides an appropriate framework for a global evaluation of UNAIDS