This file contains full versions of the four in-depth case studies submitted as part of the Evaluation of UNICEF’s PMTCT/Paediatric HIV Care and Treatment Programme

Cameroon

India

South Africa

Zimbabwe
EVALUATION OF UNICEF’S PMTCT/PAEDIATRIC AIDS PROGRAMME
CAMEROON CASE STUDY REPORT

June 2016

Results in development
Acknowledgements

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The findings within this document, however, are entirely the responsibility of the evaluation team.
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<th>Description</th>
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<tbody>
<tr>
<td>AMP</td>
<td>Annual Management Plan</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<td>ART</td>
<td>Antiretroviral Treatment</td>
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<td>ARVs</td>
<td>Antiretroviral drugs</td>
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<td>CAGR</td>
<td>Compound Annual Growth Rate</td>
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<td>CBCHS</td>
<td>Cameroon Baptist Convention Help Services</td>
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<td>CCO</td>
<td>Cameroon Country Office</td>
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<td>CNPS</td>
<td>Caisse Nationale de Prevention Sociale</td>
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<td>CO</td>
<td>Country Office</td>
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<td>CP</td>
<td>Country Programme</td>
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<td>CPAP</td>
<td>Country Programme Action Plan</td>
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<td>CPD</td>
<td>Country Programme Document</td>
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<td>Country Programme Management Plan</td>
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<td>DFW</td>
<td>Department of Family Welfare</td>
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<td>DDC</td>
<td>Department of Disease Control</td>
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<td>EID</td>
<td>Early Infant Diagnosis</td>
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<td>e-MTCT</td>
<td>Elimination of Mother-to-Child Transmission</td>
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<td>GARPR</td>
<td>Global AIDS Response Progress Reporting</td>
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<td>IATT</td>
<td>Inter-Agency Task Team</td>
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<td>ICAP</td>
<td>International Centre for AIDS Care and Treatment Programmes</td>
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<td>IDA</td>
<td>International Development Association</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>M&amp;E</td>
<td>Monitoring &amp; Evaluation</td>
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<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
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<td>MOPH</td>
<td>Ministry of Public Health</td>
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<td>NACC</td>
<td>National AIDS Control Council</td>
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<td>ODA</td>
<td>Official Development Assistance</td>
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<td>OR</td>
<td>Other Resources</td>
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<td>ORE</td>
<td>Other Resources for Emergencies</td>
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<td>NSP</td>
<td>National Strategic Plan</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<td>RECAP+</td>
<td>Reseau Camerounais des Associations des Perrsonnes vivant avec le VIH</td>
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<td>RR</td>
<td>Regular Resources</td>
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<td>TA</td>
<td>Temporary Appointment</td>
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<td>ToR</td>
<td>Terms of Reference</td>
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<td>TWG</td>
<td>Technical Working Group</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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WASH  Water, Sanitation and Hygiene
WHO  World Health Organization
Executive summary

Introduction

UNICEF has commissioned an evaluation of its activity in the area of prevention of mother to child transmission (PMTCT) of HIV, and paediatric HIV care and treatment during the period 2005-2015. The purpose of the evaluation is to improve accountability and learning in relation to UNICEF’s efforts to support the scale-up of these programmes, and will examine four dimensions of its engagement:

1. Leadership, advocacy, coordination, and partnerships
2. Resource mobilisation
3. Strategic information, knowledge generation, and dissemination
4. Key aspects of UNICEF’s organisation

This report summarises the findings of the Cameroon case study, which is one of four in-depth case studies being undertaken as part of this evaluation. The case study was conducted during May 2016, and included a documentation review and interviews or group discussions with 19 stakeholders (including UNICEF staff, government, development partners and civil society). Semi-structured interview guides were used to elicit perspectives on the four key dimensions of the evaluation, as well as the three cross-cutting issues of gender, equity and human rights.

Summary of findings

Some of the key findings of the case study are as follows:

- **UNICEF has played a critical role in the scale-up of the PMTCT programme since 2005 and the more recent start-up of the paediatric HIV care and support efforts**, through its targeted advocacy for children affected by HIV and its support for policy development, programme planning and knowledge-building activities. National stakeholders give credit to UNICEF for its early promotion of the “district approach” to implementation. They also appreciate UNICEF’s subsequent support to some priority districts for its contribution to building capacity, addressing implementation bottlenecks and supporting programme scale-up in those districts.

- **UNICEF’s support to programme implementation at district level has been uneven over the period of interest.** Frequent shifts in the distribution of development partner support across the country have taken place, partly due to inadequate coordination mechanisms, fragmentation of approaches to programming, and the scarcity of shared funding mechanisms. In the geographical areas it has supported, UNICEF has had to face a number of health system issues that slowed down responses, and results have fallen short of expectations. A refocusing of UNICEF’s efforts took place in 2015 to improve their effectiveness and efficiency.

- **UNICEF has provided useful support for tracking progress in HIV programme scale-up and identifying coverage gaps that affect women and children.** It has provided technical and financial support for conducting progress reports, focused reviews, evaluations and studies, which have informed strategic planning and approaches to implementation. It also spearheaded the bottleneck analysis, which has served to identify problems and solutions at various levels of implementation, and to guide investment.

- **UNICEF has also played useful advocacy and technical support roles with the government and with other agencies to make sure HIV in children is considered part of the integrated multisectoral humanitarian response.** UNICEF has also ensured that its own strategies and plans take into account the needs of refugees and internally displaced persons and other problems facing the affected parts of the country.

- **UNICEF has been a valued partner for its flexibility and responsiveness.** National stakeholders generally commend the small number of staff in the country office who work on HIV, together with their regional counterparts, for their commitment and dedication to advancing the programme and their willingness to address technical and financial gaps that cannot readily be met by partners. UNICEF has struggled, however, to
manage the fragmentation of responsibilities for PMTCT and paediatric HIV care and treatment across different government structures

- The UNICEF Country Office (CO) faces a large resource gap for its work on HIV/AIDS, which has led to a recent decrease in the numbers and seniority of staff available to work on PMTCT/paediatric HIV care and treatment in the CO HIV team, and a dwindling of funds available for activities.

- While partners recognise that human rights and equity are components of UNICEF’s response to HIV, these issues are not visible in its programming around HIV/AIDS. There is scope for greater prominence to be given to human rights and equity as part of a holistic response to HIV in children.

- Gender mainstreaming presents a challenge for both UNICEF and the broader programme in Cameroon – there is a need for gender-transformative programming, moving beyond a focus on more gender-specific approaches.

- UNICEF has strengthened linkages between HIV and nutrition programming in emergency settings, to support case finding of HIV-positive children and improve the case management of severe malnutrition. However, it faces organisational challenges in achieving programme linkages and integration, while ensuring that the HIV function has adequate leverage and influence across programme areas. UNICEF’s planning systems need to better reflect programme interdependencies through shared targets and accountabilities.

**Implications**

UNICEF may wish to consider the following suggestions to guide the way forward:

- **Continue its efforts to increase the CO resource base and use available resources as strategically and efficiently as possible.** The CO’s strategic focus on adolescents could usefully be seen to encompass a range of HIV services at all ages, given that increasing numbers of adolescents in sub-Saharan Africa acquire HIV perinatally but do not learn about their status until much later. The high rate of early marriage among adolescent girls in Cameroon also calls for the integration of PMTCT interventions (all prongs) into adolescent health and HIV programming. UNICEF’s current effort to refocus its support for implementation on to only a few geographical sites should help to improve efficiency.

- **Seize opportunities to innovate and build on comparative advantages**, including UNICEF’s unique role in advocacy and social mobilisation around equity issues and its global experience with gender-transformative, rights-based and family-centred approaches to policy development and programming.

- **Strengthen linkages across programmes and sectors at every level and, as appropriate, promote integrated services at the point of service delivery, with a strong but not exclusive focus on HIV, health and nutrition services for women and children.** This implies that UNICEF should make a greater effort to identify opportunities for critical linkages and foster joint planning, financing and reporting approaches, both within its own office and with key stakeholders. UNICEF could be doing more to model multisectoral and integrated programming and implementation, and bold measures are required to work around current financing mechanisms and government structures.
1. Overview of UNICEF’s Country Programme in Cameroon

1.1. Cameroon context

Cameroon faces a number of development challenges. It is a lower middle-income country that is endowed with significant natural resources and agricultural products but faces many challenges to consolidate its economic growth and improve the quality of life of its population. Despite more than a decade of economic growth, poverty levels in Cameroon have remained almost unchanged for many years (40% in 2001 and 37.5% in 2014). Changes in poverty between 2001 and 2014 show an unambiguous regional pattern, with northern Cameroon becoming poorer and southern Cameroon becoming wealthier. Cameroon suffers from weak governance, which affects the country’s development and ability to attract investment. Cameroon ranks 130th out of 168 countries in the 2015 Transparency International corruption perceptions index.

The humanitarian crisis in the far north and eastern regions continues to deteriorate. The increasing number of internally displaced persons and refugees from Nigeria and the Central African Republic, on top of the pre-existing nutrition crisis and increasing food insecurity has resulted in a complex humanitarian emergency. Access to basic social and health services is gravely threatened in these parts of the country.

There has been some, but insufficient, progress in reaching the Millennium Development Goals (MDGs) related to maternal and child health. The maternal mortality ratio actually increased from 430 in 1991 to 782/100,000 live births in 2011. In the last decade, the child mortality rate declined, however, from 151 to 103/1000 deaths among live birth children under five between 2004 and 2014. Cost recovery arrangements are in place and a charge is made for the use of basic services including antenatal and maternity care and a number of health tests. Access to and use of antenatal and maternity care services remains inadequate, with antenatal coverage use at 61% for one visit at least (or 69.5% according to population estimates), and the skilled birth attendance rate at 48.5%, with large regional disparities.

The burden of HIV and AIDS remains high. A number of national strategic plans (NSPs) for control of HIV/AIDS have been implemented since 2000 (NSP 2000-2005; 2005-2009; 2010-15; and 2014-17), to frame a national, multisectoral and decentralised response. The epidemic in Cameroon is generalised, with HIV prevalence rates decreasing from 5.5% in 2004 to 4.3% in 2011. Women face strikingly greater risks than men (with prevalence rates of 5.6% vs 2.9% respectively), especially in the younger age groups (with prevalence rates 5 to 6 times higher among 15-24 year old girls than among boys of the same age).

Access to antiretroviral treatment (ART) has increased over time but coverage remains low. A number of policies and measures have contributed to improved access to ART for those in need. These include the decentralisation of care and treatment down to district levels; the government’s decision in 2007 to offer antiretroviral drugs (ARVs) free of charge; the gradual implementation of task-shifting and

3 Ibid.
4 UNICEF, Cameroon Humanitarian Situation Report, 31 August 2015.
6 National Institute of Statistics, Demographic and Health Survey-Multiple Indicators Cluster Survey, 2011.
mentoring strategies for building the capacity of peripheral health workers to provide HIV services; and more recently the adoption and roll-out of the Option B+ approach to provide ART to all HIV-positive pregnant women. With increasing numbers of health facilities offering HIV care and treatment, the number of people receiving ART has increased steadily from 17,156 in 2005 to 145,038 in 2014 (Figure 1)\textsuperscript{13}. Nonetheless, ART coverage remains inadequate, with coverage dropping sharply to its present level of 27% after changes in eligibility criteria in 2010 and 2013. Women account for the majority (70% in 2014) of people on ART, while children represent only a small minority (4% in 2014)\textsuperscript{14}. ARV stockouts remain a major concern.

**Figure 1: ART use and coverage rates from 2005 to 2014\textsuperscript{15}**

Coverage with PMTCT interventions has increased steadily over time but remains inadequate. PMTCT has been prioritised as a key strategy in the HIV response. Pilot projects were initiated in 2000, and extended to some other regions in 2002, before going to scale in 2003 in a “district approach” with support from technical and financial partners. Various scale-up plans have been developed since 2005. In 2012, Cameroon adopted a national plan for the elimination of mother-to-child transmission (e-MTCT) of HIV by 2015. From 2010 to 2014, the number of health facilities offering PMTCT services increased rapidly, and by 2015 all health districts had at least one health facility offering such services. In 2014, uptake of HIV testing in pregnant women seeking antenatal care was 86%, but only 66% of those who tested HIV-positive received ARVs to prevent mother-to-child transmission\textsuperscript{16}. Estimated population-level coverage of ARVs among HIV-infected pregnant women was 32.7% in 2013, and increased to 53.5% in 2014, mainly due to reductions in the denominator following adjustments to the expected fertility rate. Furthermore, large geographical disparities in PMTCT coverage persist. The main problems are the low overall antenatal care (ANC) attendance rate, and gaps in service delivery all along the PMTCT cascade\textsuperscript{17}. The estimated mother-to-child HIV transmission rate remained high at 25% in 2013 (with only a small decline from 32% in 2009)\textsuperscript{18}, and remains far from the 5% elimination target.

\textsuperscript{13} National AIDS Control Committee, 2014 Annual Report, 2015.
\textsuperscript{14} Ibid.
\textsuperscript{15} Ibid.
\textsuperscript{16} Ibid.
\textsuperscript{18} UNAIDS, Global Response Report, 2014.
Paediatric HIV treatment coverage remains very low. The decentralisation of access to ARVs in 2005 marked the slow start of paediatric HIV care and treatment in public health facilities beyond the main cities of Yaoundé and Douala. Even though the PMTCT programme went to scale at the national level in 2004, the expansion of services for early infant diagnosis (EID) and care and treatment for HIV-infected children did not take off until much later. By 2014, the number of health facilities that sent at least one dried blood spot sample for EID to one of the three national reference laboratories had increased to 1306 sites (from 124 in 2010). However, this still represented only 60% of all sites offering PMTCT services, and only 30% of HIV-exposed children received EID services. Case finding in other child health services remains inadequate, and paediatric HIV care and treatment services have not yet taken hold in the centres providing ART to adults. As a result, ART access for children in need remains very low. In 2014, it was estimated that 58,009 children (under the age of 15) were living with HIV, of which only 6,099 were on ART, a coverage rate of only 10.5%.


UNICEF’s country programme priorities during 2005-2015 are outlined in the Country Programme Documents (CPDs) that cover this period (CPD 2008-12 and CPD 2013-17). The focus was on progress towards the MDGs and the goals of the Plan of Action for A World Fit for Children, in line with UNICEF’s Medium-term Strategic Plan 2005-2013, its Strategic Plan 2014-17 and the UNICEF Regional Leadership Agenda. An overview of some key events in the context of Cameroon is included in Annex V.

The UNICEF country programme thus placed a strong focus on scaling up the response to HIV/AIDS, including accelerating access to PMTCT towards e-MTCT and access to comprehensive HIV care and treatment services for women and children on the route towards achieving universal access. UNICEF’s work was positioned as a key contribution to United Nations Development Assistance Framework (UNDAF) outcomes and outputs and was closely aligned with the country’s NSPs.

Over the period of the evaluation, UNICEF contributed to the design of large-scale HIV/AIDS prevention and care interventions within the context of United Nations joint programming, as well as the leveraging of resources; the dissemination of relevant knowledge and guidelines; improved national and district level progress tracking systems; and capacity-building and other technical and financial support for effective programme implementation in a number of “priority” districts. Most of these activities were conducted in close collaboration with other partners, within and without the United Nations’ system. The programme’s main counterparts in this area have been the National AIDS Control Council (NACC) (placed in the Ministry of Public Health (MOPH), but responsible for coordinating the multisectoral response), and the MOPH’s Departments of Family Welfare (DFW) (responsible for PMTCT since 2010) and of Disease Control (DDC) (responsible for paediatric HIV care and treatment, and prior to 2010, for PMTCT as well).

UNICEF participates in a number of partnership arrangements, including the Technical Working Group (TWG) on PMTCT and paediatric treatment that is convened monthly by the DFW and brings together the President’s Emergency Plan for AIDS Relief (PEPFAR), UNICEF, UNAIDS, the Clinton Health Access Initiative (CHAI), the World Health Organization (WHO), and Cameroon Baptist Convention Help Services (CBCHS). Other important partnerships in which UNICEF has served as the lead on PMTCT and paediatric HIV include the Joint UN Team on HIV and the H4+ for maternal and child survival. The Joint UN Programme of Support on AIDS is mainstreamed into the UNDAF and aligned with the relevant NSPs.

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2. Findings from Cameroon

This section provides the team’s detailed findings on the four key dimensions of the evaluation, as well as the cross cutting issues. A summary of the evidence related to each of the strategic directions underpinning these dimensions and issues, as well as against intermediate outcomes identified in the Theory of Change guiding the evaluation, is presented in Annex VI.

2.1. Thematic Leadership, Advocacy, Partnerships and Coordination

UNICEF is widely recognized as a lead player and critical voice on issues related to children, including children affected by HIV. In the period 2010-11 UNICEF was very active in securing national commitments to e-MTCT and in supporting the development of related strategies and plans. All stakeholders commended UNICEF for raising awareness in recent years about children being left behind in ART programme scale-up and for building commitment to close the gap. Stakeholders also pointed to UNICEF’s strong advocacy for ensuring wide access to services for Maternal, Newborn and Child Health (MNCH)/PMTCT and paediatric HIV care and treatment in regions receiving refugee and internally displaced populations. Global initiatives introduced in the last decade that have served to build the national commitment for scaling up access to services to prevent or treat HIV infections in children include the Global Plan to Eliminate New HIV Infections in Children and Keep their Mothers Alive in 2011, the “Double Dividend” initiative launched in 2013 by UNICEF with key partners, and the “Accelerating Children’s HIV/AIDS Treatment” initiative launched by PEPFAR and UNAIDS in 2014. National partners previously working in the PMTCT programme expressed their appreciation for UNICEF support in representing Cameroon at regional and international meetings related to these initiatives, and study tours to share knowledge and experiences with other countries. The political commitment of the government to e-MTCT and more recently to paediatric HIV care and treatment is manifest. As discussed below, however, support for implementation at scale is lagging behind.

UNICEF has provided substantial support for the development of strategic and operational plans for programme scaleup. Of note are the 2005-2009 HIV/AIDS NSP, which adopted the district approach for scaling up PMTCT, the 2011-15 e-MTCT Plan and the 2013-2014 operational plan for EID. UNICEF technical support often drew in regional staff, and on occasion the Inter-Agency Task Team (IATT), which came with strong partner representation and helped to align the inputs of partners at country level. UNICEF also provided technical and financial support for the development of applications to the Global Fund, including the Concept Note submitted in 2015. In the last year, UNICEF has provided technical and financial support for the intensification of efforts for both e-MTCT and paediatric HIV care and treatment through the development of operational plans (for e-MTCT 2016-2017 and paediatric HIV care and treatment 2016-2018), to give greater emphasis and visibility to these two programme areas, and to promote active case finding of mothers, children and their family members affected by HIV in various health care and community settings. Some partners complain about the multiplicity of strategic and operational plans, preferring to consolidate planning processes and focus available resources on implementation, while others express the view that this planning effort is required to maintain the visibility of children as key beneficiaries in the response. There is general agreement, however, about the need to resolve implementation problems and to close the resource gap (see section 2.2). Some partners suggested that the focus on e-MTCT was very useful to build commitments around an important issue, but that it did not help to find solutions to the formidable health system challenges faced in Cameroon.

“Là où il y a un maillon faible nous ne verrons pas de résultats.”
(“We won’t see results where there is a weak link in the chain.”)
(A UNICEF staff member).
UNICEF is recognized as a trusted partner in mechanisms to coordinate the response on HIV and health at the national level. For children affected by HIV the main coordination body is the TWG on PMTCT and paediatric treatment that is convened monthly by the DSF (see section 1.2). UNICEF has struggled, however, to manage the fragmentation of responsibilities for PMTCT and paediatric HIV care and treatment across different government structures. At the beginning of the period of interest, the DDC was responsible for both PMTCT and paediatric HIV care and treatment. The responsibility for PMTCT was moved to the DSF in 2010 to facilitate the integration of HIV services into MNCH services. However, there appears to be some confusion about which directorate is responsible for the various services needed for the follow-up and diagnosis of HIV-exposed children. The TWG run by the DFH serves more as an information-sharing platform among partners than a decision-making body, and the DDC tends not to be fully engaged (in fact, the DDC is seeking to set up its own TWG focused on paediatric HIV care and treatment). Many stakeholders indicated that the separation of roles and responsibilities on related issues and competition over scarce resources have hampered decision-making, weakened coordination mechanisms and fragmented the response, thereby contributing to the hiatus in services for children affected by HIV (see section 1.1). At the same time, some respondents reflected that they looked to UNICEF to stay above the fray and, when necessary, to play the role of arbitrator.

Partner coordination arrangements within and without the UN system ensure alignment on established roles and responsibilities, and overall complementarity. Current arrangements support the effective division of labour but do not, however, seem to favour pooled funding, joint action and rapid responses to address major systemic issues that are holding back progress in health and development. UNICEF has nonetheless forged bilateral partnerships with some significant players in scale-up of HIV services for women and children, such as UNITAID during the early part of the period of interest to secure access to paediatric medicines, and more recently, CDC, PEPFAR, EGPAF, CHAI and a range of other international technical and financial partners. Most partnerships, however, have not been formalized and have been limited in scope and duration, in part due to limitations in funding. There is little evidence of partnerships with the private sector.

UNICEF has also made substantial efforts to build capacity for programme planning and implementation in the districts that it has prioritised for its HIV work. Many stakeholders pointed to UNICEF’s strengths in working at the district level. They particularly commended UNICEF’s support with bottleneck analyses and microplanning, which were instrumental in identifying districts with the greatest programme coverage gaps, and approaches to addressing these gaps. Bottleneck analyses to some degree guided decisions on which districts should receive support from the various partners. Over the period of interest, UNICEF provided specific technical and financial support for HIV programme implementation in a varying number of districts (and within districts, sites), taking into account the presence of other partners and available resources. Some stakeholders indicated that UNICEF’s work lacked visibility in comparison to that of partners, such as PEPFAR, which came in at a later stage with much greater resources concentrated in fewer locations. Generally, the fragmentation and differentiation of partner inputs across regions and districts and weak coordination mechanisms at regional and district levels were highlighted by many respondents as major challenges to programme scale-up and sustainability. While development partners have prioritised different regions and districts for their technical and financial support in implementation, duplication of effort in some settings is reported, while some districts in need receive very little support. These concerns have been exacerbated following PEPFAR’s decision to move out of a number of districts due to its current policy of concentration on high impact areas. UNICEF recognised these problems in the 2015 mid-term review of its HIV sector support\(^\text{21}\), and has recently decided to reduce the number of districts that it supports to improve the effectiveness and efficiency of its investments.

**UNICEF is praised for its efforts to involve civil society organisations in PMTCT programming.** In its priority districts, UNICEF supported the development of community-based structures and networks to promote demand for HIV services for women and children and their families and to strengthen follow-up of clients at the community level. More needs to be done, however, as civil society engagement in PMTCT/pediatric HIV care and treatment scale-up is not institutionalised and remains dependent on local funding opportunities. The recent development of harmonised guidelines for the development of community systems in support of the HIV response should help to point the way ahead to strengthening service delivery at community level. More is required, however, to strengthen civil society’s role beyond service delivery and support their engagement in local and national level accountability mechanisms for ensuring that children are adequately addressed in the HIV response.

**UNICEF has struggled to build strong linkages across sectors and programmes in relation to PMTCT and paediatric HIV care and support.** UNICEF has worked hard in this area, and was successful in strengthening linkages since 2013 between HIV and nutrition programming in emergency settings, to support case finding of HIV-positive children and improve the case management of severe malnutrition. At this time, some efforts are under way to strengthen collaboration between health, nutrition and HIV programmes involved in the introduction of HIV services in nutrition rehabilitation, and other services for sick children. However, more could be done to integrate HIV into health programming. Collaborative efforts are hampered by vertical government structures, geographical fragmentation of development partner support to different intervention areas across the country, and scarcity of shared funding mechanisms.

**Another specific concern raised by a national stakeholder related to the promotion by UNICEF in 2010 of the “Mother-Baby Pack” to be provided to mothers in PMTCT services,** as part of an initiative rolled out in four countries (Cameroon, Kenya, Lesotho and Zambia). The pack included a complete, pre-packaged set of drugs for mother and infants to prevent vertical transmission of the virus. Respondents indicate that this initiative was not successful, primarily due to concerns about the use of drugs given early in pregnancy (some of which were intended for use after delivery) and also because the packs were associated with stigmatisation of HIV-infected mothers.

### 2.2. Resource Mobilization

#### 2.2.1 Internal resource mobilisation functions

The resources available to the Country Office for HIV/AIDS work have decreased over recent years, and are currently under 50% of planned budget levels. As shown in Figure 2, the amount budgeted for HIV/AIDS for 2012 (US$2.1m)\(^{22}\) in the Country Programme Action Plan (CPAP) was slightly lower than actual expenditure that year (US$2.4m). In the CPAP 2013-2017, the amount budgeted for HIV/AIDS

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increased to US$3.8m per year (that is, US$25m for the five years), but expenditure levels for HIV/AIDS actually fell in 2013 and are now picking up with some difficulty. Expenditure in 2015 represented only 48% of the amount budgeted for HIV/AIDS in the CPAP.

Figure 2: UNICEF budget and expenditure for HIV/AIDS in Cameroon 2012-2015

As shown in Table 1, the CCO estimates that expenditure for PMTCT and paediatric AIDS care dropped from US$1.6m in 2012 to US$1.1 m in 2015, while expenditure for the total Country Programme (CP) nearly doubled over the same period.

Table 1: UNICEF expenditure for PMTCT/paediatric HIV as a percentage of HIV/AIDS and total expenditure in Cameroon 2012-2015

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL PMTCT/paediatric HIV</td>
<td>1,632,098</td>
<td>1,108,912</td>
<td>992,654</td>
<td>1,186,099</td>
</tr>
<tr>
<td>TOTAL HIV</td>
<td>2,376,769</td>
<td>1,703,461</td>
<td>1,758,144</td>
<td>1,850,631</td>
</tr>
<tr>
<td>TOTAL CP</td>
<td>17,611,845</td>
<td>26,502,059</td>
<td>29,379,493</td>
<td>34,803,916</td>
</tr>
<tr>
<td>% HIV from overall CP expenditure</td>
<td>13%</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>% PMTCT/paediatric HIV from overall HIV expenditure</td>
<td>69%</td>
<td>65%</td>
<td>56%</td>
<td>64%</td>
</tr>
</tbody>
</table>

Source: Analysis of internal UNICEF data

Resource mobilization for HIV/AIDS has proved challenging in recent years and the majority of HIV/AIDS expenditure between 2013-2015 has been supported from Regular Resources (RR). This is ascribed to the difficulties of fundraising for HIV/AIDS in a middle-income country that currently receives large amounts of funds for this programme area from the Global Fund and PEPFAR. As shown in Figure 3, 54% of UNICEF expenditure on HIV/AIDS in Cameroon over the period 2012-2015 was sourced from RR. Denmark (11%), the US (6%) and Andorra (7%) were the main external contributors (under Other Resources (OR)) in that period. Table 2 indicates that the proportion of OR among overall allocations for HIV/AIDS has steadily decreased, from 59% in 2012 to only 18% in 2015. In the same period, however, allocations from Other Resources for Emergencies (ORE) have formed an increasing proportion, from 4% in 2012 to 16% in 2015. They account for 7% of the total US$7,721,633 for the period in question. In this context, the CCO has increased cross-sectoral efforts in resource mobilization for HIV/AIDS, in particular with nutrition and health.

23 It is noted, however, that there is considerable variation both in the value of UNICEF’s budgets between CPAPs and sectoral/thematic reports, and in the value of expenditure between UNICEF’s central database, sectoral/thematic reports, and the CO records.
2.2.2 External resource mobilisation functions

UNICEF in Cameroon has provided some support to leverage additional global resources for PMTCT/paediatric care and treatment. In particular, stakeholders cited and praised UNICEF’s technical and financial support in 2015 for the preparation of the Global Fund Concept Note. In addition, UNICEF has contributed to resource mobilisation activities through its support for the identification of needs and the development of costed strategic and operational plans. For example, it provided technical and financial support for the preparation of the first e-MTCT plan (2011-15). The initial costing of the plan showed that the required resources would exceed the entire health budget. Hence, prioritisation was essential. This was done using the bottleneck analysis, which led to the identification of priority districts with the greatest coverage gaps. Development partners (including PEPFAR) helped to resource the plan.

The financing gap for programming for HIV/AIDS in general and for PMTCT and paediatric HIV in particular remains substantial despite massive investments in Cameroon by key donors such as the Global Fund and PEPFAR. The gap is estimated at €44.1m (US$50m) for PMTCT (62.3% of the total €70.8m) and €159m (US$180m) for care and treatment of adults and children (61.1% of the total €260.1m) over the period 2014-201724.

The HIV/AIDS programme is very dependent on external financing. Over the period of interest, domestic public contributions have increased as a proportion of HIV/AIDS expenditure in Cameroon (from 5% in 2004 to 23% in 2013), in part in response to counterpart funding requirements, as shown in

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24 Global Fund Concept Note, 2016-2017, p. 36
Figure 4. The largest providers of Official Development Assistance (ODA) for HIV/AIDS between 2005 and 2014 were the Global Fund (55%) and the United States (22%) (Figure 5). Expenditures vary considerably from year to year. For instance, a spike in expenditure is observed in 2009, related to the availability of increased funding from the Global Fund (from $15.6 m in 2007 to $36m in 2009). Although the country only devotes approximately 8% of its budget to health, the case study did not find evidence that development partners, including UNICEF, have advocated for greater investment of domestic resources in health and HIV/AIDS (beyond the issues of identifying counterpart funding, for example, in Global Fund proposals). As far as PMTCT is concerned, for example, the Cameroon government is expected to cover only 1.5% of the requirements for 2014-2017.

Figure 4: Expenditure on HIV/AIDS in Cameroon by source 2005-13 (US$m)

Source: AIDSinfo database.

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25 AIDSinfo Online Database.
26 AIDSinfo Online Database
27 Global Fund Concept Note 2016-2017 p. 36
28 Data was collected from the AIDSinfo Online Database, which presents country-reported Global AIDS Response Progress Reporting (GARPR) data. It should be noted that there are often substantial differences between GARPR country reported data and donor reported data through the OECD CRS database; and data reporting is likely to have improved over time. As such, changes over time may not be fully representative.
While total ODA for HIV/AIDS grew at a compound annual growth rate (CAGR) of 0.12 between 2005 and 2014, this was largely driven by a strong increase in funding from the United States, at a CAGR of 0.71. Funding from the Global Fund and France also grew, but at a much slower pace, with a CAGR of 0.07 (although funding was only provided by France from 2007 onwards), while funding from the International Development Association (IDA) and Germany decreased over the period.

2.3. Strategic Information, Knowledge Generation and Dissemination

UNICEF has made appreciated investments in national processes to build knowledge on women and children and translate this knowledge into strategies, plans and activities. Data on children and women across the country made available through Demographic and Health and Multiple Indicator Cluster Surveys (MICS) contributed significantly to the development of estimates on the burden of infection in these population groups and the design of the NSPs, e-MTCT strategic plans and UNDAF. UNICEF is active, along with UNAIDS, in relevant working groups such as the TWG on monitoring and evaluation led by the NACC. UNICEF also participates in the quantification group that supports procurement, distribution and management of drugs and commodities for the programme, including paediatric ARVs. As noted in section 2.1, UNICEF has spearheaded the application of innovative tools to identify problems and solutions, such as bottleneck analysis, which is now extensively used to identify needs and define programme priorities at various levels of implementation.

UNICEF has in particular provided critical support for tracking progress in HIV programme scale-up and identifying coverage gaps that affect women and children. Its role in producing the progress reports on PMTCT and paediatric HIV care and treatment scale-up is widely appreciated. It has also provided technical and financial support for focused reviews, evaluations and studies, including the 2015 evaluation of the e-MTCT programme and the 2015 situation analysis of paediatric HIV care and treatment in Cameroon. UNICEF also supports programme data collation and validation processes at national and district levels to help track progress in programme implementation. These inputs are particularly valued in a context in which data quantity, quality and relevance are challenged by complex and disconnected data management systems and the high turnover and limited capacity of staff at the peripheral level. More work needs to be done in support of measures taken to improve the quality of

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29 Figures calculated using the OECD CRS sector codes 13040 (STD control, including HIV/AIDS) and 16064 (Social mitigation of HIV/AIDS).
PMTCT and paediatric ART data. With the support of the International Centre for AIDS Care and Treatment Programmes (ICAP), Cameroon introduced in 2014 an Integrated Data Aggregation Tool as a platform for entry and automatic analysis of data from district health facilities. This is a temporary solution pending the gradual establishment of a District Health Information Software device already used in other countries to strengthen the entire NHIS.

Together with WHO and other partners, UNICEF, through its country and regional offices and through the global IATT, has made useful contributions to supporting the NACC and the MOPH to shift their strategies, policies and guidelines based on global guidelines and country experiences. UNICEF’s role in supporting the widespread dissemination and application of national guidelines and knowledge is appreciated, though many stakeholders felt that it could do even more in this area. In addition, a number of stakeholders expressed the wish that UNICEF be more engaged in recording and sharing best practice.

The procedures for developing, authorising and disseminating national guidelines are cumbersome and lengthy in Cameroon. The pace of change introduced over the period of interest has on occasion led to confusion, as the previous shift in guidelines has not always been fully absorbed before a new one is initiated. Respondents pointed to UNICEF’s role in ensuring even more systematic and sustained orientation of health providers, to facilitate more rapid shifts in practices and procedures at national level (and not only in priority districts). For example, the 2015 situation analysis of paediatric HIV care and treatment identified 10 relevant sets of guidelines of which five were produced in 2013. Yet, only the 2008 PMTCT and paediatric HIV care and treatment guidelines (based on 2006 WHO recommendations) were found in health facilities. The other guidelines had not been distributed widely enough and capacity-building efforts had not been sufficient. This slow uptake is of concern given the proven potential of simplified approaches to PMTCT and paediatric treatment to streamline service delivery and improve quality of care.

Accordingly, in collaboration with its partners, UNICEF provided support for updating the national PMTCT and treatment guidelines in line with the WHO recommendations (issued in 2013) from the initially selected option A towards option B+, which does not require the use of CD4 count technology. Cameroon adopted the option B+ strategy in principle in 2012, and some technical and financial partners were able to introduce it immediately in the sites they were supporting. An operational plan was then developed for the phased implementation of the option B+ approach, starting with higher volume sites, supported by a memorandum signed by the MOPH in November 2014. By December 2015 the MOPH issued instructions that all sites still using option A should switch to option B+. It will be important to ensure that these instructions are understood and implemented across the country.

### 2.4. UNICEF Organisational Structure

#### 2.4.1 Skills and competencies

UNICEF staff are experienced and well regarded by partners. Government and partners value UNICEF staff for their responsiveness and flexibility in providing financial and technical support as necessary. Their active participation in various fora has supported the building of trusted relationships with key stakeholders. The government appreciates UNICEF’s efforts to work closely with MOPH structures and systems, which has the potential to build ownership and sustainability and strengthens national capacity. All the same, some respondents hinted at the limited capacity of some HIV/AIDS staff present during the period in the CCO, particularly in terms of managerial skills and up-to-date technical knowledge on HIV/AIDS.

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2.4.2 Organisational structure

The team working on PMTCT/paediatric care and treatment has shrunk in recent years, mainly due to financial constraints. The number of staff working on these issues, including the HIV/AIDS Section Chief and the Programme Assistant, dropped from five (of which two were national and three international staff) in 2010 to only three since 2014. In 2010-11 an international consultant was present as well for one year. In May 2016, the staff available to work on PMTCT and paediatric care and treatment comprised the section Chief (P4) and the Programme Assistant, who have fixed-term contracts with RR funding, and one staff member dedicated to this work but with a Temporary Appointment (TA) status only (and on a mandatory contract break during our visit). An additional international P4 PMTCT programme officer post was abolished following the 2015 MTR because of lack of resources and has not been filled since March 2014. It is useful to note, however, that the team in Yaoundé is supported by two staff members in the subnational offices of Maroua and Bertoua, whose job descriptions have recently been modified to include HIV.

The decrease in staff numbers has led to a drop in the visibility and reach of UNICEF’s work. The current team working on PMTCT/ paediatric HIV care and treatment is perceived as small, especially given the diversity of activities the team is expected to engage in at national and subnational level. Most stakeholders highlighted this problem in a vivid and concerned way:

“Personne s’occupe de la PTME […] Les bureaux sont vides”
(“Nobody is in charge of PMTCT […] The offices are empty”).
(A Government stakeholder)

“Je ne sens pas Unicef comme avant. Unicef était très très présent financièrement, dans le leadership de la PTME […]. Je ne sais pas s’il y a quelqu’un qui s’occupe vraiment de la PTME à Unicef […] maintenant”
(“I don’t perceive UNICEF as I used to. UNICEF was very very present financially, in a leadership role for PMTCT […]”)

I don’t know whether there is somebody that is in charge of PMTCT at UNICEF now”.
(A development partner)

The fact only one dedicated staff member must now handle most of the PMTCT/ paediatric HIV work means that this person is overburdened and there are gaps when he is on periodic contract breaks, leave or mission.

Integration and maternal child-centred approaches require closer internal collaboration between teams. Staff members interviewed are aware that organizational ‘silos’ and stand-alone programmes need to be avoided to achieve e-MTCT. In practice, however, this presents challenges, especially given the high workload and the limited time available to engage in collaborative activities. Teams report that the division of labour is clear and that relevant information is shared among them. HIV interventions seem to be fairly well integrated in the planning and implementation of UNICEF’s humanitarian response, as highlighted in annual office workplans and UNICEF’s Cameroon Humanitarian Situation Report 2016. Examples of collaboration between different sections and teams beyond that, however, are fairly limited in number, scope and duration. Examples of incentive systems to encourage internal collaboration and joint planning across sections are also absent at systemic level. Without a formalized matrix management system the CCO relies on collaboration across teams, which is variable and heavily dependent on personalities.
2.4.3 Organizational culture

UNICEF’s organizational culture is hands-on and solution-focused with a strong emphasis on programme implementation. Current staff are said to have responsive and flexible attitudes, which contribute to positive relationships with government and partners (though some stakeholders criticised some previous staff members). The field experience of UNICEF staff is valued.

2.4.4 Analysis against the INK Management model

The INK Management Model provides a diagnostic framework to explore the extent to which UNICEF as an organization is set up to leverage its comparative advantage, respond over time to the changing external environment, and deliver on its overall objectives. The INK Management model focuses on five organizational elements – leadership, strategy and policy, staff management, resource management and progress management. The table below provides a summary of elements observed at CCO and will contribute to a more comprehensive global analysis for the final report.

Table 3: Analysis of CCO HIV section against elements of the INK Management model

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Evident in the CCO HIV section</th>
<th>Not so evident in the CCO HIV section</th>
</tr>
</thead>
</table>
| 1. Leadership – attitude and behaviour of people with guiding responsibility | • Clear mandate on PMTCT/paediatric HIV issues  
• Trusted relationships with government  
• Good engagement with key partners                               | • Limited human resources in recent years have diluted its thematic leadership role in relation to PMTCT/paediatric HIV issues |
| 2. Staff Management – fully using the potential of knowledge and expertise | • Capacity strengthening, eg. in C4D and M&E, is seen as a priority in Country Programme Management Plans (CPMPs) and Annual Management Plans (AMPs) | • Skills could still be strengthened in some areas, eg. managerial skills and up-to-date technical expertise related to HIV/AIDS |
| 3. Strategy and Policy – the way in which strategy is translated into objectives | • Organizational structure has changed over time to respond to changing needs. For instance, the two sub-national offices in the east and in the north have been created to better respond to recurrent crises in those areas | • Child- and family-centred approaches to programming rather than narrowly defined vertical approaches to programming could have been more evident in earlier years and need reinforcement now |
| 4. Management of resources – how resources are handled | • The need to mobilize and allocate more resources to the HIV section and to use existing resources more efficiently is recognised  
• The need to strengthen strategic partnerships (eg. with NGOs, government structures and the private sector) is recognised as a priority in CPMPs and AMPs | • Resources to replace staff leaving the organisation have been insufficient since 2012  
• Workplans need to be modified to make more strategic use of available resources |
| 5. Process and systems – how the organisation identifies, designs, manages, improves or innovates systems | • The need to strengthen synergies and complementarity across programme components is recognised as a priority in CPMPs and AMPs  
• There is evidence of joint work across HIV and nutrition  
• The need for a Knowledge Management strategy and mechanisms is recognised as a priority in CPMPs and AMPs | • Cross team working and shared outputs were somewhat constrained  
• There is limited evidence of joint targets and shared accountabilities which could aid internal planning for horizontal/integrated programming |
2.5. Cross-cutting Issues

2.5.1 Gender

Gender equality issues are present but not prominent in UNICEF programmatic documents. The CPAP 2013-2017 highlights, for example, how social norms such as child marriage, teenage pregnancy and unwillingness to be attended by a male health worker continue to have a negative impact on mother and child health. Specific attention to tackling gender inequalities was, however, more apparent in the results framework annexed to the CPAP 2007-2012 than in the current framework annexed to the CPAP 2013-2017. The CPD 2007 mentions gender equality as one of UNICEF’s key priorities, but there is no explicit mention of gender equality in the section on HIV/AIDS. The CPMPs do not contain many references to gender.

At present, gender is not mainstreamed throughout the CCO programmes. A Gender Focal Point has been appointed, but she can only devote less than 50% of her time to the role. Most sections, however, are reported to work on gender issues in some way. The education section, for example, works on programs aimed at keeping young girls in school by involving male community and religious leaders. The Child Protection section has initiatives on gender-based violence and is carrying out a study on social norms around child marriage.

There is an untapped potential, however, for a more systematic inclusion of gender issues in the context of a multisectoral response inside and outside UNICEF. There is scope for better inclusion of gender equality issues in PMTCT/paediatric HIV care and treatment programming, to tackle for instance the fact that “due to their low economic, negotiation and decision-making power […] some women have to obtain the approval of their spouses in order to seek health services when they need them.” Taking into account its mandate (ie. the focus on women, girls and children), UNICEF would be well positioned to lead in this area. The gender assessment that the CCO is preparing to undertake with the support of the Regional Office is seen as a good opportunity to establish gender priorities and a vision for the entire CCO.

2.5.2 Human rights

Human and child rights are present in UNICEF programmatic documents and in its advocacy efforts towards the government. The CPDs 2007–11, for example, put rights at the centre of the overall goal of the country programme. This is also reflected in the CPAP that accompanies the latest CPD:

CPD 2007–11: “The overall goal of the country programme is to contribute to poverty reduction by strengthening an enabling environment where the rights of every child to survival, development, protection and participation are fulfilled in a sustainable manner by the year 2012.”

CPAP 2013-2017: “The program aims to accelerate the progress towards the achievement of the MDGs […] It will pay special attention to survival, development and integrated protection of children, in particular the most vulnerable ones.”

There are some good examples of where the rights of the child are put at the centre of programme approaches in Cameroon. For instance, UNICEF is supporting the training of social workers that are responsible for identifying child protection cases. An explicit focus on human and child rights is less visible, however, in its PMTCT/paediatric HIV care and treatment actions at country level.

UNICEF could more actively promote the positioning of human/child rights within a holistic HIV response. Several stakeholders have highlighted how issues such as teenage pregnancy, school drop-

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31 Source: CPAP 2013-2017 p.5
32 Global Fund Concept Note reference
out, child marriage and gender-based violence are linked not only to risk of contracting HIV but also to access to care and treatment. There is therefore scope for a more integrated response, tackling multiple child rights at once.

### 2.5.3 Equity

UNICEF has played an advocacy role and attracted government attention to equity. The CPAP 2013-2017 highlights, for example, the need for updated and disaggregated data to measure performance and equity of interventions in favour of children and disadvantaged groups.

UNICEF’s approach to equity is viewed through the lens of universal access to quality care, as well as a special focus on the most disadvantaged districts. UNICEF has been instrumental in ensuring that attention is paid to the most disadvantaged districts (i.e. those with the biggest coverage gaps), and its work on bottleneck analyses is recognized as a critical contribution. Government and partners felt that the application of bottleneck analysis had been a critical contribution by UNICEF to the HIV response so far as it helped focus resources on districts with the greatest need (in terms of coverage gaps).

There seems to be a tension between achieving results at country level and tackling the most disadvantaged. Vulnerable and hard-to-reach populations (irrespective of their district) are not necessarily a key target of UNICEF PMTCT and paediatric HIV care and treatment in Cameroon. UNICEF’s role in advocating for women and children has manifested itself in different forms over time – for example, the initial focus on scale-up of PMTCT, then an evolving recognition of the need to prioritise paediatric HIV care and treatment, and most recently a focus on adolescent girls. However, as coverage of PMTCT and paediatric ART increases, Cameroon, as well as UNICEF and its partners, will need to strengthen the equity focus to ensure that all are reached.

### 2.5.4 Humanitarian response

The country is facing multiple humanitarian crises. In the east and the far north instability in the CAR and Boko Haram respectively have spurred consistent migratory flux. The country is now hosting more than 267,000 refugees from the CAR, more than 72,000 refugees from Nigeria and more than 170,000 internally displaced persons. The Sahel nutrition crisis has also caused more than 195,000 malnourished children in Cameroon, of which at least 61,000 have severe acute malnutrition.

UNICEF has successfully advocated for an integrated emergency response package covering education, Water, Sanitation and Hygiene (WASH), child protection, nutrition, health and HIV/AIDS. As stated in the CPD 2008-2012, the Cameroon National Contingency Plan has been adapted to take into account the UNICEF Core Commitments for Children (including HIV/AIDS as one of the six programme commitments, together with nutrition, health, WASH, child protection and education) in emergencies and these priorities are also included in UNDAF. No parallel structures have been created in UNICEF intervention zones, but the refugees have access to PMTCT services in local health structures and Option B+ and child HIV treatment are free for everybody. Children suffering from severe acute malnutrition seen in health centres in emergency areas are increasingly offered HIV testing, given the linkages between the two conditions.

The office team structure supports integration between PMTCT/paediatric AIDS and humanitarian issues. In order to facilitate and support its emergency responses, UNICEF established 2 sub-national offices in the emergencies areas of Bertoua in the East region and Maroua in the Far North region.

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33 CPAP 2013-17, p. 11.
35 Source: CPD 2007 p. 5.
these offices, two staff members have been recently designated to cover HIV as part of their job descriptions. In the central office, the PMTCT specialist also serves as focal point on humanitarian issues.

3. Achievements and Challenges

3.1. Achievements

- **UNICEF has played a critical role in the scale-up of the PMTCT programme since 2005 and the more recent start-up of the paediatric HIV care and support efforts**, through its targeted advocacy for children affected by HIV and its support of policy development, programme planning and knowledge-building activities. UNICEF is credited for its early promotion of the “district approach” to implementation. Its subsequent support for some priority districts is also appreciated for its contribution to building capacity, addressing implementation bottlenecks and supporting programme scale-up in those districts.

- **UNICEF has also provided useful support for tracking progress in HIV programme scale-up and identifying coverage gaps that affect women and children.** It has provided technical and financial support for conducting progress reports, focused reviews, evaluations and studies, which have informed strategic planning and approaches to implementation. It also spearheaded the bottleneck analysis, which has served to identify problems and solutions at various levels of implementation and guide investments.

- **UNICEF has played useful advocacy and technical support roles with the government and other agencies to ensure HIV in children is considered part of the integrated multisectoral humanitarian response.** UNICEF has also ensured that its own strategies and plans take into account the needs of refugees and internally displaced persons and other problems faced in the affected parts of the country.

- **UNICEF has been a valued partner for its flexibility and responsiveness.** The small number of staff in the country office who work on HIV, together with their regional counterparts, are generally recognised for their commitment and dedication to advancing the programme and appreciated for their willingness to address technical and financial gaps that cannot readily be met by partners.

3.2. Challenges

3.2.1 Programmatic challenges

- **The national PMTCT and paediatric HIV care and treatment programme has experienced large funding gaps.** Resources are also highly concentrated among a few donors, raising critical concerns about financial sustainability.

- **The division of labour between government departments and the streams of donor funding present disincentives and barriers to horizontal collaboration.** In particular, the fragmentation of roles and responsibilities for children with HIV across the DFH and the DDC have improved integration of HIV into MNCH programming but led to increased transaction costs for partners and poor coherence and continuity in programming services for HIV-exposed children.

- **The health system is not currently sufficiently robust in many parts of the country to support the scale-up of HIV services for women and children.** More upstream work is needed to address critical issues that beset programme activities, such as user fees for basic services (eg. ANC), essential drug procurement and supply (including ARVs) and health information systems.
• Inadequate partner coordination mechanisms, fragmentation of development partner support to different intervention areas across the country, and the scarcity of shared funding mechanisms have led to inequitable distribution of support and, on occasion, duplication of effort. Government and partners need to work more closely to map current investments and carefully plan approaches to meet the future needs of the population.

• Coverage with key interventions for mothers and children affected by HIV remains low, and is growing very slowly. Geographical disparities are marked and in some parts of the country most of the population do not have access to these interventions. **Innovative approaches will be needed to reach underserved populations**, including women and children who do not use formal health services for various reasons.

• As the programme matures and coverage expands, **there will be a need for a shift in focus and tactics** to achieve e-MTCT and universal care and treatment coverage for all, including children and their families, to ART. Greater attention needs to be placed on improving service quality and leveraging community-based systems to improve uptake and adherence levels.

### 3.2.2 Challenges for UNICEF

• **The UNICEF CO has found it difficult to raise funds for its work on HIV/AIDS.** This is in part ascribed to the lack of opportunities for fundraising for HIV/AIDS in a middle-income country receiving major support from the Global Fund and PEPFAR. As a result, the CO HIV team has dwindled over time and programme funds are limited. Available financial and human resources will need to be used very strategically and efficiently going forwards.

• **UNICEF’s support for programme implementation at district level has been uneven over the period of interest.** Since 2005, UNICEF has been present in a variable number of districts, and implementing a limited set of activities in specific sites in each district. This approach has not managed to address the major health systems issues that are slowing down the response, and results have fallen short of expectations.

• While partners recognise that human rights and equity are components of UNICEF’s response to HIV, these issues are not visible in its programming around HIV/AIDS. There is **scope for greater prominence to be given to human rights and equity** as part of a holistic response to HIV in children.

• Gender mainstreaming presents a challenge for both UNICEF and the broader programme in Cameroon – there is a **need for gender-transformative programming**, moving beyond a focus on more gender-specific approaches.

• While some useful work has been done (in particular to strengthen linkages between HIV and nutrition programming om emergency settings) there are **organisational challenges in achieving programme linkages and integration** while ensuring that the HIV function has adequate leverage and influence across programme areas. UNICEF’s planning systems need to reflect programme interdependencies through shared targets and accountabilities.

### 4. Implications for UNICEF

The evaluation team has identified the following implications for the CCO, in consolidating its work to date and strengthening its approach for the future.

• **Continue efforts to increase the CO resource base and use available resources as strategically and efficiently as possible.** This should enable the CO to more fully explore innovative programme solutions, with a particular focus on preventing HIV among children but also detecting HIV-infected children through whatever means and wherever they are in order to provide them and their
families access to long-term care, treatment and support. HIV could be placed more clearly the CO’s strategic focus on adolescents, and expanded beyond HIV prevention in adolescents to encompass a broader range of HIV services. These would take into account the fact that increasing numbers of adolescents in sub-Saharan Africa acquire HIV perinatally but do not learn about their status until much later. The high rate of early marriage among adolescent girls in Cameroon also offers opportunities to integrate PMTCT interventions (all prongs) into adolescent health and HIV programming. UNICEF’s current effort to refocus its support for implementation on to only a few geographical sites should help to improve efficiency.

- **Seize opportunities to innovate and build on comparative advantages**, including UNICEF’s unique role in advocacy and social mobilisation around equity issues and its global experience with gender-transformative, rights-based and family-centred approaches to policy development and programming.

- **Strengthen linkages across programmes and sectors at every level and as, appropriate, promote integrated services at the point of service delivery**, with a strong but not exclusive focus on HIV, health and nutrition services for women and children. This implies that UNICEF should make a greater effort to identify opportunities for critical linkages and foster joint planning, financing and reporting approaches, both within its own office and with key stakeholders. UNICEF could be doing more to model multisectoral and integrated programming and implementation, and bold measures are required to work around current financing mechanisms and government structures.

“We need a better analysis of bottlenecks and an effort to work out solutions among partners. The solutions must be contextualised.”

(A UNICEF staff member)

### Implications for the evaluation

The Cameroon case study has served the two purposes laid out in the evaluation design well\(^{36}\). It has documented in some detail how UNICEF’s engagement in PMTCT and paediatric HIV/AIDS played out in a particular setting over the period 2005-15, in support of resolute and steady programme advances, despite an unfavourable political and economic context. It has also tested and validated the Theory of Change developed to guide the evaluation (see Annex VI). It should be noted however that many of UNICEF’s activities in Cameroon were conducted in close partnership with other multilateral and bilateral agencies, with limited specific funding available to support large-scale activities. It is therefore challenging to define UNICEF’s unique contributions to the progress or otherwise of Cameroon’s programme, except in a broad and informal manner.

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\(^{36}\) Further details are included in the Inception Report for this evaluation.
Annex I: Terms of Reference for in-Depth Country Studies

Overview of the evaluation
Itad is a UK-based consultancy company that has been commissioned by UNICEF to undertake an evaluation of its activity in the PMTCT and Paediatric HIV treatment, care and support. The purpose of this evaluation is to support accountability and learning in relation to UNICEF’s efforts to scale up PMTCT and Paediatric care and treatment programmes and to document its contribution toward elimination of mother to child HIV transmission and an AIDS-free generation for children. By looking over the past 10 years of UNICEF’s PMTCT and paediatric HIV engagement, the evaluation will provide evidence and lessons learnt to enhance the understanding of the organisation and other stakeholders on how strategies and programmes have evolved, what has worked, has not worked, and why.

The evaluation will assess four particular aspects of PMTCT and paediatric HIV treatment programming, namely:

1) Thematic leadership, advocacy and partnership
2) Resource mobilisation
3) Strategic information, knowledge generation and dissemination, and
4) Key aspects of UNICEF’s organisation.

It will also consider the crosscutting issues of gender, equity, and human rights. The findings will be used to guide i) effective action toward the achievement of the UNICEF strategic plan HIV outcome and ii) UNICEF positioning in the post-2015 HIV agenda as guided by the UNAIDS 2016–21 strategy.

As part of the data collection for this evaluation, Itad is undertaking case studies in a total of seven countries – four involving country visits and three conducted remotely through a desk review and phone interviews. The findings from country level are being supplemented with a structured document review, an online survey, and interviews with key stakeholders at global and regional levels.

This document details the process for the country visits in ESARO and WCARO, to be undertaken during the period of April–May 2016.

Purpose of the country case studies
The evaluation is taking as its starting point the Theory of Change (ToC) for UNICEF’s work in PMTCT and paediatric HIV over the period of 2005–15. The purpose of the case studies is to record how UNICEF’s engagement in this area has played out at country level, and help test and validate the ToC. It is important to note the following:

- Each case study has been selected because of the learning opportunity offered to the evaluation.
- The approach to each is focused on recording experiences rather than measuring or assessing individual country performance.

Approach to data collection and analysis
Each mission will last seven working days37 (over a period of two weeks). Each team will arrive in-country with a clear case study ToR, detailed draft agenda, and having already performed a remote desk study and stakeholder listing to ensure that the time the evaluators spend in-country can be used as effectively and efficiently as possible. Figure 1 below summarizes the proposed process through which each of the country studies will be implemented. However, the first country case study visit will be used as an opportunity to refine the process. This will be attended by four members of the core team to gain consensus and maximise consistency of approach.

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37 In the case of Zimbabwe, in consultation with EO and the Zimbabwe CO, this has now been reduced to five days given that four team members are attending and therefore can cover double the number of interviews.
Figure I.1 Process for conducting country studies

**Step 1:** Prior to the visit, a *desk review phase* will focus on enabling the team to gain a comprehensive understanding of the background to PMTCT/Paediatric HIV/AIDS programme activities in each case study country, and extracting available secondary evidence – for example on key events.

**Step 2:** During this stage, an *agenda for the country case study* will be agreed, based on a *stakeholder mapping* exercise undertaken by the evaluation team and UNICEF country office (CO). The evaluation team will contact the CO to discuss this agenda including possible stakeholder interviews.

**Step 3:** Each mission will start in-country with a *brief kick-off meeting* with UNICEF staff to orientate the team to the national context, provide background to the UNICEF office, and to enable an initial exploration of issues arising from remote desk review.

**Step 4:** Following this workshop, the evaluation team will then conduct *semi-structured interviews* (and where appropriate, small group discussions) with key in-country stakeholders – including UNICEF staff, government, and partners. These interviews will be designed to elicit further information on the thematic areas of interest.

**Step 5:** At the end of the country visit, the evaluation team will share debriefing notes of observations and preliminary findings through a *slide set with the UNICEF CO*, and hold a feedback discussion.

**Step 6:** Subsequently, a *case study report* will be written up for each country and shared with the CO for comments (approximately two weeks after the end of the country visit).

**The team**

The country case studies will be conducted by a team of two consultants belonging to the core evaluation team, over a total input period of seven working days in the field per country. This team will be complemented by a national expert who will be normally resident in-country and can support on collation of documents and identification and contacting of stakeholders, and will bring in-depth understanding of the country context. One consultant will act as lead consultant in order to ensure that responsibility for delivery of the report is clearly located.

**Guidance to case study country offices**

The agenda should ideally be agreed between the CO and the evaluation team at least a week before the visit to allow sufficient time for in-country preparation. In order to appropriately support the case study visit, the team suggest that the CO:

1. **Confirm suitability of suggested dates** as soon as possible.
2. **Identify someone to act as a point of contact** to organise the schedule proposed below.
3. **Share the ToRs** with those who might be consulted during the visit.
4. **Identify documents**/create a list of key documents that would be useful to share with the evaluation team.
5. **Consider which staff members** it would be useful for the evaluation team to meet and whether this is most appropriate on a one-to-one basis or in a focus group (or both). Ideally, this should include current staff members as well as staff who were involved during the period of interest for the evaluation (2005–15). If necessary, interviews can be conducted remotely over Skype.
6. **Consider which external stakeholders** the evaluation team should meet. This should include representatives from all key development partners working in HIV/AIDS at country level, as well as relevant government stakeholders. Ideally, this should include stakeholders who were involved during the period of interest for the evaluation (2005–15), as well as those who are currently in post.

7. **Feedback on preliminary findings**: Please consider which staff members should be included in the meeting to discuss preliminary findings.

The schedule for the visit is projected to look like this:

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Monday</th>
<th>AM: Meeting with UNICEF CO PM: Stakeholder interviews (UNICEF staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2</td>
<td>Tuesday</td>
<td>Stakeholder interviews (UNICEF staff)</td>
</tr>
<tr>
<td>Day 3</td>
<td>Wednesday</td>
<td>Stakeholder interviews (external – government and partners)</td>
</tr>
<tr>
<td>Day 4</td>
<td>Thursday</td>
<td>Stakeholder interviews (external – government and partners)</td>
</tr>
<tr>
<td>Day 5</td>
<td>Friday</td>
<td>Stakeholder interviews (external – government and partners)</td>
</tr>
<tr>
<td>Day 6</td>
<td>Saturday</td>
<td>Stakeholder interviews (as required) and internal team working</td>
</tr>
<tr>
<td>Day 7</td>
<td>Monday</td>
<td>Presentation of initial findings to CO (plus additional interviews as required)</td>
</tr>
</tbody>
</table>
### Annex II: Cameroon Country Visit Agenda

#### Day 1: 3 May, 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:30-10:15</td>
<td>Briefing meeting and discussion of the agenda with Thérèse Nduwimana, Chief HIV/AIDS, UNICEF</td>
<td>UNICEF</td>
</tr>
<tr>
<td>10:15-11:45</td>
<td>Interview with Ibrahim Mugnol, PMTCT officer (TA), UNICEF</td>
<td>UNICEF</td>
</tr>
<tr>
<td>11:45-12:15</td>
<td>Briefing meeting with Felicité Tchibindat, the CCO Representative</td>
<td>UNICEF</td>
</tr>
<tr>
<td>12:45-14:15</td>
<td>Interview with Michel Irogo, President Reseau Camerounais des Associations des Perrsonnes vivant avec le VIH (RECAP)</td>
<td>UNICEF</td>
</tr>
<tr>
<td>15:00-16:15</td>
<td>Meeting with Christophe Awono, Programme Assistant PSP, UNICEF on the budget</td>
<td>UNICEF</td>
</tr>
<tr>
<td>17:30-20:00</td>
<td>Registration and assisted with official opening session of the 10th International workshop on HIV treatment pathogenesis and prevention research in resource limited setting (INTEREST).</td>
<td>Hilton</td>
</tr>
</tbody>
</table>

#### Day 2: 4 May, 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:30-10:30</td>
<td>Interview with Jean Bosco Elat, Permanent Secretary of the NACC</td>
<td>NACC</td>
</tr>
<tr>
<td>10:45-12:00</td>
<td>Interview with Ebogo Mbezele Mesmey, Country Director, ICAP</td>
<td>ICAP</td>
</tr>
<tr>
<td>13:15-14:30</td>
<td>Interview with Patrice Tchenjou, M&amp;E Supervisor (consultant), EGPAF</td>
<td>UNICEF</td>
</tr>
<tr>
<td>16:00-17:00</td>
<td>Interview with Belyse Halmata Nguum, Health, UNICEF</td>
<td>UNICEF</td>
</tr>
<tr>
<td>16:30-17:15</td>
<td>Interview with Claire Mulanga, Country Director, UNAIDS</td>
<td>Hilton</td>
</tr>
<tr>
<td>17:30 -18:00</td>
<td>Interview with Anne Esther Njom Nlend, Paediatrician, Caisse Nationale de Prevention Sociale (CNPS)</td>
<td>Hilton</td>
</tr>
</tbody>
</table>

#### Day 3: 5 May, 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:30-11:30</td>
<td>Interview with Etienne Kembou, HIV-AIDS, Nutrition and Food Safety, Program Officer, WHO</td>
<td>WHO</td>
</tr>
<tr>
<td>12:00-14:00</td>
<td>Interview with Thérèse Nduwimana – part 1</td>
<td>UNICEF</td>
</tr>
<tr>
<td>15:00-16:00</td>
<td>Interview with Alain Charlie Mbo’o, former Head (“chef de service”) of HIV, DDC</td>
<td>Hotel La Falaise</td>
</tr>
<tr>
<td>18:00-18:45</td>
<td>Interview with Ida Penda, Paediatre, Laquintinie Hospital, Douala</td>
<td>Hilton</td>
</tr>
<tr>
<td>18:00-18:45</td>
<td>Interview with Zeh Kakanou, Chargée de la Réponse Santé VIH, DDC</td>
<td>Hilton</td>
</tr>
</tbody>
</table>

#### Day 4: 6 May 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:50</td>
<td>Ngono Marie Louise, former Head (“chef de service”) of PMTCT, DDC and then DFH</td>
<td>UNICEF</td>
</tr>
<tr>
<td>10:15-11:15</td>
<td>Gabriel Tchokomakwa, Programme Analyst Reproductive Health/Youth and Humanitarian National Programme Officer, UNFPA</td>
<td>UNFPA</td>
</tr>
<tr>
<td>12:00-13:00</td>
<td>Tjek Biyaga Paul, Head (“chef de service”) of PMTCT and Seidou Moluh, Director of Reproductive Health Unit, DFH</td>
<td>DFH</td>
</tr>
<tr>
<td>15:30-16:30</td>
<td>Interview with Thérèse Nduwimana – part 2</td>
<td>UNICEF</td>
</tr>
</tbody>
</table>

#### Day 5: 7 May 2016

<table>
<thead>
<tr>
<th>Activity</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document review, interview analysis, preparation</td>
<td>La Falaise</td>
</tr>
</tbody>
</table>

#### Day 6: 8 May 2016

<table>
<thead>
<tr>
<th>Activity</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document review, interview analysis, preparation</td>
<td>La Falaise</td>
</tr>
</tbody>
</table>
### Day 7: 9 May 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00-12:30</td>
<td>Debriefing with Representative, Deputy Representative and HIV Chief</td>
<td>UNICEF</td>
</tr>
<tr>
<td>15:00-16:00</td>
<td>Meeting with Ange Geneviève Epee, Human Resources Assistant</td>
<td>UNICEF</td>
</tr>
<tr>
<td></td>
<td>Brigitte Matchinda, Education Specialist and Gender Focal Point, UNICEF</td>
<td>UNICEF</td>
</tr>
</tbody>
</table>

**END OF MISSION**

After the mission ended, one more interview was carried out by Skype with Daniela Luciani, Chief Child Protection specialist on Thursday 12 May 2016.
### Annex III: Stakeholder List

<table>
<thead>
<tr>
<th>Name of Person</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alain Charlie Mbo’o</td>
<td>Former Head (&quot;chef de service&quot;) of HIV</td>
<td>DDC</td>
</tr>
<tr>
<td>Ange Geneviève EPEE</td>
<td>Human Resources Assistant</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Anne Esther Njom Nlend</td>
<td>Paediatrician</td>
<td>CNPS</td>
</tr>
<tr>
<td>Belyse Halmata Nguum</td>
<td>Chief, Health</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Brigitte Matchinda</td>
<td>Education Specialist and Gender Focal Point</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Christophe Awono</td>
<td>Programme Assistant Programme Support &amp; Partnerships</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Claire Mulanga</td>
<td>Country Director</td>
<td>UNAIDS</td>
</tr>
<tr>
<td>Daniela Luciani</td>
<td>Chief, Child Protection</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Ebogo Mbezele Mesmey</td>
<td>Country Director</td>
<td>ICAP</td>
</tr>
<tr>
<td>Etienne Kembou</td>
<td>HIV-AIDS, Nutrition and Food Safety, Programme Officer</td>
<td>WHO</td>
</tr>
<tr>
<td>Felicité Tchibindat</td>
<td>CCO Representative</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Gabriel Tchokomakwa</td>
<td>Programme Analyst, Reproductive Health/Youth and</td>
<td>UNFPA</td>
</tr>
<tr>
<td></td>
<td>Humanitarian National Programme Officer</td>
<td></td>
</tr>
<tr>
<td>Ibrahim Mugnol</td>
<td>PMTCT officer</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Ida Penda</td>
<td>Paediatrician</td>
<td>Laquintinie Hospital</td>
</tr>
<tr>
<td>Jean Bosco Elat</td>
<td>Permanent Secretary</td>
<td>CNLS</td>
</tr>
<tr>
<td>Marie Louise Ngono</td>
<td>Former Head (&quot;chef de service&quot;) of PMTCT</td>
<td>DLMEP and then DSF</td>
</tr>
<tr>
<td>Michel Irogo</td>
<td>President</td>
<td>RECAP</td>
</tr>
<tr>
<td>Patrice Tchenjou</td>
<td>M&amp;E Supervisor (consultant)</td>
<td>EGPAF</td>
</tr>
<tr>
<td>Seidou Moluh</td>
<td>Director of the Department of Reproductive Health</td>
<td>DFH</td>
</tr>
<tr>
<td>Thérèse Nduwimana</td>
<td>Chief HIV/AIDS</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Tjek Biyaga</td>
<td>Head (&quot;chef de service&quot;) of PMTCT</td>
<td>DFH</td>
</tr>
<tr>
<td>Zeh Kakanou</td>
<td>Responsible for HIV Response</td>
<td>DDC</td>
</tr>
</tbody>
</table>

Geography and Population

Cameroon is a central African country, which lies at the far end of the Gulf of Guinea and is situated immediately north of the equator. It comprises 10 administrative regions, and is divided into 58 counties (Département) and 306 Districts (Arrondissement). To the west lies Nigeria, to the north east Chad, to the east the Central African Republic, and to the south are the Congo, Gabon and Equatorial Guinea. The Atlantic Ocean marks its south west boundary. A wide range of biologically and geographically diverse areas can be found in Cameroon.

In terms of demographics, the western and northern regions are linked to the highly populous areas of the Gulf of Guinea, while the southern and eastern regions have the very low population densities typical of central Africa. This explains why Cameroon is often called a “miniature Africa”. In 2015 the whole population of Cameroon was estimated to be 21 million\(^38\), 51% of which were women and 49% men. The way the population is spread out across the country is uneven: two cities alone, Douala and Yaoundé, are home to almost 20% of the country’s population. The most populated areas are the centre (18.7%), the far north (18%), the coastal area (15.1%) and the north (11.0%). In 2010, 52% of the population lived in urban areas. It is mostly young: people below the age of 15 make up 44% of the population, while children less than 5-year-old make up 15%. As a result of this demographic structure, there exists a high dependency ratio, and infrastructures and basic social services such as education, health, access to energy and clean water, food security and land tenure security\(^39\) are heavily under pressure.

Economy

Cameroon’s economy is central Africa’s most diversified economy, thanks not only to numerous foreign establishments but also many domestic industrial groups. The country is host to a wide range of industries, including forestry and agriculture (cash crops and food crops); hydrocarbon processing; beverage, sugar, oil mill and soap industries; flour-milling; aluminium; cement; metallurgy; and primary wood processing. The primary sector absorbs over 70% of the workforce, mainly in agriculture and livestock farming.

In the early 1980s, Cameroon was amongst Africa’s most flourishing economies. Cameroon’s economy recorded real growth rates of around 7% while experiencing two decades of steady growth until 1985. Cameroon went into a deep recession in the following years. One reason was falling market prices for coffee, cocoa and oil, and, as a consequence, deteriorating terms of trade.

After the 1985 crisis broke out, as evidenced by the 1994 currency devaluation of the CFA franc, the government adopted stimulation policies and implemented stabilization and structural adjustment programmes, backed by donors, which resulted in the freezing out of any medium and long-term thinking.

Cameroon successfully achieved the completion point for the Heavily Indebted Poor Countries Initiative , which aims to redirect funds from debt relief to development projects, in late April 2006, following its postponement in August 2004. This entitled Cameroon to a US$3 billion debt cancellation from the Paris Club creditors (bilateral creditors) in June 2006. A cancellation of Cameroon's debt by commercial creditors (London Club) and multilateral ones (MDRI: Multilateral Debt Relief Initiative) is currently being considered.

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\(^39\) MINEPAT & UNFPA, Étude sur les conditions du bénéfice du dividende démographique au Cameroun, 2012
In 2014, nearly two in five people (37.5%) were living below the poverty line, mostly in rural areas (about 90%) and in northern regions (over 52%)\textsuperscript{40}. With a Human Development Index score of 0.512, Cameroon ranked 153 out of 188 countries globally (total number of countries being assessed in 2014). However, the Inequality-adjusted Human Development Index increased slightly from 0.156 to 0.161. This reflects an increase in living standard inequalities, particularly in the areas of health, education and income\textsuperscript{41}.

**The health system**

Cameroon’s health system comprises three levels with the shape of a pyramid:

- At the bottom lies the peripheral level with 191 Health Districts (DS in French), each fulfilling the role of an operational unit. The District itself is divided into several health areas\textsuperscript{42}.
- In the middle lies the intermediate level with 10 Regional Delegations for Public Health, each being responsible for technical support at the operational level. They are accountable for the strategic implementation of the National Health Policy.
- At the top is the central level responsible for the development of health policies and strategies, fundraising, quality assurance, monitoring and evaluation, inspection and control. It also ensures good governance in the implementation and management of the health system. It includes services and further core structures belonging to the Ministry of Public Health.

Since 2010, social and health policies have been revised to align with the Strategy Paper for Growth and Jobs (2010-20 SPGJ or DSCE in French), which aims to move Cameroon within the group of emerging countries by 2035. In this perspective, various Health Plans have been developed with a view to meeting the 2015 MDGs. Some policies are being updated to align with the Sustainable Development Goals. Following up on the President’s initiative, the Government adopted the ‘Three-year National Emergency Plan (PLANUT) for Accelerated Growth’ in December 2014. The health area of PLANUT has two main components: i) infrastructure rehabilitation and ancillary services upgrade for hospitals in Douala, Yaoundé and the University Hospital of Yaoundé; ii) building and equipment of Regional Hospitals\textsuperscript{43}.

Public health facilities are more easily accessible to the well-off: 14.5% of the poorest fifth of the population against 25% of the richest fifth in 2007. Indeed, while nearly 43% of the richest half had access to a public health physician, only about 3% of the poorest did. Furthermore, evidence shows disparities in terms of geographical access to care (disparities between rural and urban areas). For example, only 47% of births are attended by qualified personnel in rural areas, against 87% in urban areas\textsuperscript{44}.

**Financing for health**

Cameroon does not have a national strategy for health financing. The different functions covered by financing (resource mobilization, risk pooling mechanisms, and purchasing of health services) do not therefore fit into a national logical framework. However, many projects and programmes have

\textsuperscript{40} Institut National de la Statistique (Cameroon’s Office for National Statistics), Fourth Cameroon Household Survey (ECAM III), 2014
\textsuperscript{41} DOST, 2015.
\textsuperscript{42} Convention cadre de construction et d’équipement entre la République du Cameroun et Alliance Développement Immobilier et le Groupe Banque Atlantique du 19 décembre 2015.
\textsuperscript{43} Institut National de la Statistique (Cameroon’s Office for National Statistics), 2nd Cameroon Monitoring Survey on Public Spending and Beneficiaries’ Satisfaction Level in the Areas of Health and Education (PETS 2); main report, health section, 2010.
\textsuperscript{44} Institut National de la Statistique (Cameroon’s Office for National Statistics) and ICF International, 2012. 2011 Cameroon Demographic and Health Survey with Multiple Indicators. Calverton, Maryland, USA : INS et ICF International.
developed financing strategies, such as the Comprehensive Multiyear Plan (or ‘Plan Pluri-Annuel Complet’ in French), the Expanded Programme of Immunisation and the HIV/AIDS Funding Strategy.

According to the 2011 National Health Accounts, health funding as a whole amounted to CFA504 billion, i.e. 4% of GDP. The main funding sources are as follows: households (52%), government (33%), donors (14%) and the private sector (1%).

Public funding for health is insufficient, and this leads to a reliance on external financing. External financing (loans and grants combined) accounts for a significant share of total sectoral financing each year (14%). Besides, cost-free public health policies or subsidized inputs and services rely mainly on external financing.

The many procedures and numerous coordination bodies, the fragmentation of health financing and weak arrangements for pooling external financing result in loss of effectiveness and efficiency. As a consequence, services contribute little to strengthening the health system and meeting the vital needs of the population (horizontal equity). To be more specific: in 2014, 63% of external funding was allocated to the fight against communicable diseases (malaria 51%, HIV/AIDS 12% and tuberculosis 0.3%), 27% to mother and child care, and only 5% to strengthening the system.\(^{45}\)

In addition, a feature of external financing is that it lacks predictability affects medium-term planning (i.e. 3 to 5 year forecasts). Moreover, a significant fall in the contribution of partners is currently expected in the coming years. Key multilateral partners now make their support conditional on the prospect of a gradual withdrawal. Thus projections make Cameroon ineligible for GAVI Alliance funding by 2020. According to estimates, 2020 is when the country will reach a per capita income of US$1,580. In addition, some partners such as the Global Fund are introducing co-financing conditions with incremental state match-funding requirements.

**Annex V: Timeline of key events during 2005-15**

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
</tr>
</thead>
</table>
| 2005 | - Guidelines for ART in Cameroon  
      - Government decision on the reduction of adults ARV costs MoH  
      - Government decision on the free paediatric treatment of HIV, MoH |
| 2006 | - Cameroon National HIV/AIDS Strategic Plan 2006-2010  
      - Guidelines for infant feeding in Cameroon  
      - Training manual for the PMTCT of HIV in Cameroon, NACC/MoH  
      - Roadmap for the reduction of maternal, neonatal and child mortality, MoH 2006-15  
      - Pocket guide for PMTCT 2006-2010 |
| 2007 | - Cameroon guideline of care for children exposed and infected with HIV, MoH |
| 2008 | - PMTCT Technical Guideline of HIV, Cameroon, MoH  
      - UNICEF Cameroon CPD 2008 – 2012 |
| 2009 | - National Mentoring Guide of HIV care Units UPEC, MoH  
      - Revised health sector strategy 2001-2015, MoH |
| 2010 | - National Health Development Plan 2011-2015, MoH  
      - New PMTCT guidelines and infant feeding options in the context of HIV Cameroon  
      - National guidelines of care for antiretroviral people (adults and adolescents) infected with HIV, Cameroon  
      - Decentralization by mentoring HIV/AIDS care units in Cameroon. C2D/MoH |
      - Demographic Health Survey - Cameroon  
      - Scale-up plan of PMTCT and paediatric HIV care and treatment in Cameroon, MoH 2011-2015  
      - Strategic Plan of Campaign to Accelerated Reduction of Maternal and Child Mortality in Cameroon 2011-13, MoH |
| 2012 | - Cameroon National Plan for e-MTCT of HIV by 2015 (February)  
      - Guide for paediatric HIV/AIDS care and treatment presenting B+ option  
      - Cameroon decided to pass from Option A to Option B+ (August) |
| 2013 | - Operational plan of early diagnosis 2013-2014, MoH  
      - UNICEF Cameroon CPD 2013 – 2017 |
      - Performance standards for PMTCT services in Cameroon, MoH (validated in August)  
      - Performance standards for paediatric AIDS/treatment services in Cameroon, MoH (validated in August)  
      - Circular Letter on the implementation of PMTCT B+ Option |
| 2015 | - HIV/TB Global Fund Concept Note (covering 2016-2017) development and approval  
      - Harmonised technical note on the community strategy in the implementation of the New Financing Mechanism of the Global Fund  
      - Mid-term review of the cooperation programme Cameroon-UNICEF 2013-2017 – Sectoral HIV review (August)  
      - Evaluation of the 2011-2015 e-MTCT plan, DROS/MoH with UNICEF and UNAIDS support (December) |
### Annex VI: Analysis against the components of the Theory of Change

<table>
<thead>
<tr>
<th>Component of Theory of Change</th>
<th>Evidence from country</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic directions</strong></td>
<td></td>
</tr>
<tr>
<td>Thematic leadership, advocacy, coordination and partnership</td>
<td></td>
</tr>
<tr>
<td>SD1: Coordinate programme design, planning and implementation among partners at all levels</td>
<td>UNICEF is recognized as an active partner in mechanisms available at the national level to coordinate the response on health and HIV. It has struggled, however, to manage the verticalisation of responsibilities for PMTCT and paediatric HIV care and treatment across different government structures.</td>
</tr>
<tr>
<td>SD2: Broker partnerships at all levels, including among private sector, civil society and multi-sector stakeholders, and encourage South-South as well as triangular cooperation among partners</td>
<td>UNICEF has forged bilateral partnerships with some significant players in programme scale-up. It has to some degree reached out to civil society organisations to involve them in PMTCT programming. There is little evidence of partnerships with the private sector. Most partnerships, however, have not been formalized and have been limited in scope and duration, in part due to limitations in funding.</td>
</tr>
<tr>
<td>SD3: Ensure that HIV services for children receive adequate priority in global, regional and national decision-making</td>
<td>UNICEF is recognized as a lead player and critical voice on issues related to children, including children affected by HIV. It was in particular very active in 2010-11 in securing national commitments in support of e-MTCT and in supporting the development of related strategies and plans. It is also credited with raising awareness in recent years about children being left behind in ART programme scale-up and in building commitment to close the gap. UNICEF has not to date been successful in building strong linkages across sectors and programmes in relation to PMTCT and paediatric HIV care and treatment. Though UNICEF has worked hard in this area, integration of HIV into health programming has limited visibility beyond basic issues related to HIV testing, care and treatment for women and children in ANC and maternity care settings, though some efforts are now under way to work in nutrition rehabilitation and other services for sick children. These efforts are hampered by vertical government structures, geographical fragmentation of development partner support to different intervention areas across the country, and scarcity of pooled funds.</td>
</tr>
<tr>
<td>SD4: Support key stakeholders at all levels to plan, resource and implement HIV services for</td>
<td>UNICEF has made substantial efforts to build capacity for programme planning and implementation related to PMTCT and paediatric HIV treatment, especially at the national level as well as in the districts that it has prioritised for its HIV work. Many respondents pointed to UNICEF’s strengths in working at the district level. UNICEF’s support with bottleneck analyses and microplanning were particularly commended. However, over time UNICEF’s district focus has shifted geographically and some stakeholders indicated that its work at this</td>
</tr>
</tbody>
</table>
### Assumptions related to thematic leadership, advocacy, coordination and partnership

<table>
<thead>
<tr>
<th>Strong global, regional, and national systems of coordination exist that can be leveraged to galvanise action on HIV and children</th>
<th>Stakeholders indicate that coordination mechanisms that concern PMTCT and paediatric HIV care and support are weak at all levels in Cameroon. Verticalised structures and competition over scarce funds tend to fragment and slow down the response. Partner coordination arrangements ensure alignment with established roles and responsibilities, and overall complementarity and coherence, but do not seem to favour joint action and rapid response to address major systemic issues that are holding back progress in health and development.</th>
</tr>
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<tbody>
<tr>
<td>A wide range of partners at all levels exists that could be engaged on issues related to HIV and children</td>
<td>A wide range of international and national stakeholders work on issues related to HIV and children in Cameroon. Development partners have prioritised different regions and districts for their technical and financial support to implementation, but duplication of effort in some settings is reported, while some districts in need receive very little support.</td>
</tr>
<tr>
<td>A minimum level of capacity among key stakeholders at country level exists that can be supported</td>
<td>The technical and managerial capacity levels among stakeholders at country level are strong at the national level, but less so at peripheral levels. Governance systems, however, are weak.</td>
</tr>
</tbody>
</table>

### Resource mobilisation

| SD5: Initiate, support and coordinate movements, campaigns, and investment plans to mobilise financial resources | The resources available to the CCO for HIV/AIDS work have decreased over recent years, and are currently under 50% of planned budget levels. According to data provided by the CCO, the resource mobilization rate for HIV/AIDS (ie. expenditure/budget) was 44% in 2013, 46% in 2014 and 48% in 2015.  

The majority of HIV/AIDS funds between 2013-2015 has come from RR. In 2012, RR only represented 36% of the total. This percentage has increased in recent years to reach 56% in 2013, 64% in 2014 and 66% in 2015. In the same period, Other Resources (OR) have decreased year by year from 59% in 2012 to only 18% in 2015.  

Evidence suggest that resource mobilisation for UNICEF’s HIV/AIDS work has proved challenging in recent years. This is ascribed to the difficulties of additional fundraising for HIV/AIDS in a middle-income country that currently receives large amounts of funds from the Global Fund and PEPFAR. |
<p>| SD6: Engage with donors, governments and country | UNICEF has supported Cameroon’s access to external resources for PMTCT/paediatric HIV care and treatment, by providing technical and financial support to the preparation of proposals such as the Global Fund Concept Note; and providing support for the preparation of |</p>
<table>
<thead>
<tr>
<th>stakeholders to leverage additional global and domestic resources, and support countries to access external resources</th>
<th>costed plans (such as the e-MTCT plan 2011-15).</th>
</tr>
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<tbody>
<tr>
<td><strong>The system remains, however, very dependent on external financing.</strong> The majority of international funding for HIV/AIDS over the period 2005-2013 has come from the Global Fund (55% of ODA) and the USG (22%) – and the financing gap in Cameroon remains substantial. It is estimated to be €44.1m (US$50m) for PMTCT and €159m (US$180m) for care and treatment (of adults and children) over the period 2014-2017.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Assumptions related to resource mobilization</th>
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<tbody>
<tr>
<td><strong>Flows of total ODA, and ODA for health and HIV/AIDS specifically, remain stable or grow over time</strong></td>
<td>ODA for HIV/AIDS has grown at CAGR of 0.12 between 2005 and 2014. This has largely been driven by an increase in funding from the US.</td>
</tr>
<tr>
<td><strong>Economic growth and growth in government expenditures takes place in countries where UNICEF is active to support HIV responses</strong></td>
<td>Despite the fact that between 2007-2014 GDP increased in real terms from 3.32 to 5.9%, in 2014, 37.5% of people in Cameroon still lived under the poverty line and the proportion of national budget allocated to the MOPH was only around 8%.</td>
</tr>
<tr>
<td><strong>A minimum level of capacity at country level exists to plan and budget for HIV in children</strong></td>
<td>Capacity to plan and budget for HIV in children is good at national level, but less so at peripheral levels.</td>
</tr>
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<table>
<thead>
<tr>
<th>Strategic information, knowledge generation and dissemination</th>
<th></th>
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<tbody>
<tr>
<td><strong>SD7: Generate, collate and disseminate high-quality global and national data for scaling up effective approaches to address HIV among children</strong></td>
<td>UNICEF has made appreciated investments in national processes to build critical knowledge on women and children, track progress in HIV programme scale-up and identify gaps in programme coverage. In particular, it has provided technical and financial support to focused reviews, evaluations and studies. It has also pioneered the application of innovative tools to identify problems and solutions, such as the bottleneck analysis.</td>
</tr>
<tr>
<td><strong>SD8: Provide support for governments and country partners to generate and collate SI and knowledge</strong></td>
<td>UNICEF has provided critical support for programme data collation and validation processes for tracking progress in programme implementation at national and district levels. Its role in producing the progress reports on PMTCT and paediatric HIV care and treatment scale-up is widely appreciated.</td>
</tr>
<tr>
<td><strong>SD9: Support global- and country-level interpretation and translation of SI and evidence into sound policies,</strong></td>
<td>Together with partners, UNICEF has made useful contributions through its country and regional offices and through the global IATT in supporting the NACC and the MOPH to shift their strategies, policies and guidelines based on global guidelines and country experiences. Its role in disseminating national guidelines and knowledge is appreciated, though it is felt that it could do even more in this area. Respondents pointed to the need for even more systematic and sustained orientation of stakeholders at the operational level, to ensure</td>
</tr>
</tbody>
</table>
strategies and programmes | more rapid shifts in practices and procedures at national level (and not only in priority districts).

**Assumptions related to strategic information, knowledge generation and dissemination**

A minimum level of capacity at country level exists to generate and use SI and knowledge | Capacity at the country level to generate SI related to PMTCT and paediatric HIV care and treatment has improved over time. However, data quantity, quality and relevance remain challenged by complex and disconnected data management systems and the high turnover and limited capacity of staff at the peripheral level. Good capacity to conduct research related to health and HIV care and treatment exists, especially in some long-standing clinical research centres.

Support from technical partners is sustained for generating SI and knowledge | A number of partners contribute to this area, working together with the NACC, and the various concerned departments in the MOPH.

**Cross cutting issues**

SD10: Work to ensure that effective interventions are adequately integrated within humanitarian responses | UNICEF is advocating an integrated emergency response package to multiple humanitarian crises, covering education, WASH, child protection, nutrition, health and HIV/AIDS. No parallel structures are created in UNICEF intervention zones, but the refugees have access to PMTCT/paediatric AIDS services in local health structures.

SD11: Advocate for and support gender-equitable policies, budgeting and resource allocations, and gender-sensitive approaches to HIV programming and monitoring | At present, gender is not mainstreamed throughout the CCO programmes. A Gender Focal Point has been appointed, but she can only devote less than 50% of her time to this role. Most sections are reported to work on gender issues in one way or another. There is an untapped potential, however, for a more systematic inclusion of gender issues in the context of a multisectoral response inside and outside UNICEF.

SD12: Ensure that human rights and child rights are protected, promoted and fulfilled in HIV policies and programmes, and build related accountability mechanisms | The current approach to human and child rights in HIV policies and programmes is not holistic. CPDs and CPAP give a central place to human and child rights and there are some good examples of where these issues are put at the centre of programme approaches in Cameroon. UNICEF could, however, more actively promote the positioning of human/child rights within a holistic HIV response encompassing health, child protection, education and humanitarian responses.

SD13: Promote an equity focus in HIV services for children, and build related accountability mechanisms | UNICEF’s approach to equity is viewed through the lens of universal access to quality care, as well as a special focus on the most disadvantaged districts. UNICEF has been instrumental in ensuring that attention is paid to the most disadvantaged districts (ie. those with the biggest coverage gaps), and its work on bottleneck analyses is recognized as a critical contribution by government and partners to help focus resources on districts with the greatest need in terms of coverage gaps.
There seems to be a tension between achieving results at country level and tackling the most disadvantaged. Vulnerable and hard-to-reach populations (irrespective of their district) are not necessarily a key target of UNICEF PMTCT and paediatric HIV care and treatment in Cameroon. The focus of programming is on maximising efficiency in achieving results.

### Assumptions related to cross-cutting issues

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no convergence of unmanageable numbers of crises simultaneously</td>
<td>In the past four years, there have been multiple humanitarian crises in the country, but they remain contained and manageable for the time being.</td>
</tr>
<tr>
<td>Functional coordination systems exist in emergencies</td>
<td>At UN level, coordination is ensured by the Office for the Coordination of Humanitarian Affairs.</td>
</tr>
<tr>
<td>Political support for working toward gender equality in HIV/AIDS programming remains strong</td>
<td>At normative level, the government upholds gender equality. In practice, it is unclear to what extent gender is mainstreamed in HIV/AIDS programming.</td>
</tr>
<tr>
<td>Political support for rights-based approaches and funding remains strong</td>
<td>At normative level, the government upholds rights-based approaches.</td>
</tr>
<tr>
<td>Political support for addressing inequity remains strong</td>
<td>At normative level, the government upholds equity. In practice, resources are lacking for Universal Health Access.</td>
</tr>
</tbody>
</table>

### UNICEF’s organizational structure

<table>
<thead>
<tr>
<th>SD14: UNICEF as an organisation responds to changes in the external environment and leverages its comparative advantage in PMTCT and paediatric HIV care and treatment</th>
<th>UNICEF staff are experienced and well regarded by partners. They are valued by government and partners for their responsiveness and flexibility in providing advice and short-term expertise (through the hiring of consultants).</th>
</tr>
</thead>
<tbody>
<tr>
<td>The team working on PMTCT/paediatric care and treatment has shrunk in recent years due to financial constraints.</td>
<td>The number of staff working on these issues including the HIV/AIDS Chief and the Programme Assistant dropped from five (of which two were national and three international staff) in 2010 to three since 2014. One P4 international post for a PMTCT programme officer was abolished in 2015, due to lack of funding, and there is now only one staff member with a TA status dedicated to these areas of work.</td>
</tr>
<tr>
<td>The decrease in staff has entailed a decrease in visibility and reach.</td>
<td>The current team working on PMTCT/paediatric care and treatment is perceived as small, especially vis-à-vis the efforts needed at country level to support paediatric HIV across the country and given the diversity of activities the team needs to engage in at national and subnational level.</td>
</tr>
<tr>
<td>Internal collaboration between teams presents an ongoing challenge for staff, especially given the limited time available and the lack of systemic incentives for cross-team collaboration.</td>
<td></td>
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</table>
### Intermediate outcomes

<table>
<thead>
<tr>
<th>Intermediate outcomes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategies, policies and implementation plans are aligned and coherent across partners at global, regional and country levels</td>
<td>There is evidence that strategies and policies are aligned across partners and coherent with national and global priorities. Implementation plans, however, are not fully aligned and there is evidence of duplication in some geographical areas, while other areas receive little support.</td>
</tr>
<tr>
<td>Levels of political commitment and capacity of governments and other stakeholders to plan for and support scale-up of HIV services for children are increased</td>
<td>The political commitment of the government of Cameroon to e-MTCT and more recently, to paediatric HIV care and treatment is manifest. Support for implementation is lagging behind, however.</td>
</tr>
<tr>
<td>Resource needs for PMTCT and paediatric HIV care and treatment are met in a predictable and sustainable manner</td>
<td>There is a large gap in resources for the implementation of the HIV response, and for the implementation of e-MTCT and paediatric HIV care and treatment efforts, despite Global Fund and, more recently, PEPFAR support.</td>
</tr>
<tr>
<td>Mechanisms to ensure accountability for provision and scale-up of PMTCT and paediatric HIV care and treatment are strengthened at all levels</td>
<td>Accountability mechanisms for meeting targets at all levels of the health system are weak. There is limited evidence of the implication of civil society in supporting these mechanisms.</td>
</tr>
<tr>
<td>Strategies, policies and approaches to implementation are informed by evidence on what does and does not work and why in relation to PMTCT and paediatric HIV care and treatment</td>
<td>The MOPH and the NACC have been attentive to evidence about what works and why in this area and responsive to changes in international guidelines. However, the procedures for developing, authorising and disseminating national guidelines are cumbersome and lengthy in Cameroon. The pace of the changes made so far has taxed the health system at lower levels, and the rollout of guidelines shifts is slow.</td>
</tr>
<tr>
<td>HIV policies and programmes</td>
<td>Although gender equality, human rights and equity are present in HIV policies and programmes, the focus could be strengthened at the</td>
</tr>
<tr>
<td>are resourced and implemented in a gender-sensitive, equitable and human-rights based manner (including in humanitarian situations)</td>
<td>implementation level, in the context of an integrated multisectoral response.</td>
</tr>
</tbody>
</table>
Annex VII: Bibliography


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Acknowledgements

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The findings within this document, however, are entirely the responsibility of the evaluation team.
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Annex II: India country visit agenda
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Annex IV: Country context: An overview of India’s PPTCT and Paediatric HIV/AIDS programme
Annex V: Timeline of key events during 2005–15
Annex VI: Analysis against the components of the theory of change
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Acronyms

ART  Antiretroviral Therapy
ASHA  Accredited Social Health Activist
C4D  Communication for Development (UNICEF approach)
CAGR  Compound Annual Growth Rate
CO  Country Office
CP  Child Protection
CPD  Country Programme Documents
CPR  Centre for Policy Research
DAPCU  District AIDS Prevention and Control Unit
DFID  Department for International Development
EID  Early Infant Diagnosis
FOGSI  Federation of Obstetric and Gynaecological Societies of India
GARPR  Global AIDS Response Progress Reporting
GDP  Gross domestic product
GOI  Government of India
ICO  India Country Office
ICTC  Integrated Counselling and Testing Centre
INK  Instituut Nederlandse Kwaliteit
M&E  Monitoring and Evaluation
MCTS  Mother and Child Tracking System
MDG  Millennium Development Goal
MoHFW  Ministry of Health and Family Welfare
NACO  National AIDS Control Organisation
NACP  National AIDS Control Programme
NGO  Non-governmental Organisations
NHM  National Health Mission
NIMHANS  National Institute of Mental Health and Neurosciences, Bangalore, India
NRHM  National Rural Health Mission
ODA  Official Development Assistance
PCoE  Paediatric Centres of Excellence
PLHIV  People Living with HIV
PMTCT  Prevention of Mother-to-Child Transmission
PPP  Public-Private Partnership
PPTCT  Prevention of Parent-to-Child Transmission
PWN  Positive Women Network
RCH  Reproductive and Child Health
RMNCH  Reproductive, Maternal, Newborn and Child Health
ROSA  Regional Office for South Asia
SACS  State AIDS Control Societies
SI  Strategic Information
ToC  Theory of Change
ToT  Training of Trainers
TRG  Technical Resource Groups
UNAIDS  Joint United Nations Programme on HIV/AIDS
WHO  World Health Organization
Executive summary

Introduction

UNICEF has commissioned an evaluation of its activity in the area of prevention of mother-to-child transmission (PMTCT) of HIV and paediatric HIV care and treatment during the period 2005–15. The purpose of the evaluation is to support accountability and learning in relation to UNICEF’s efforts to support the scale-up of these programmes, and will examine four dimensions of its engagement:

1. Leadership, advocacy, coordination and partnerships
2. Resource mobilisation
3. Strategic information, knowledge generation and dissemination
4. Key aspects of UNICEF’s organisation

This report summarises the findings of the India case study, which is one of the four in-depth case studies being undertaken as part of the evaluation. The case study was conducted during May 2016, and included a documentation review and interviews or group discussions with 60 stakeholders (including UNICEF staff, government, development partners and civil society). Semi-structured interview guides were used to elicit perspectives on four key dimensions of the evaluation, as well as the three cross-cutting issues of gender, equity and human rights.

Summary of findings

Some of the key findings of the case study are as follows:

UNICEF has been a key player and valued contributor to the scale-up of PMTCT and paediatric HIV services in India, through the provision of technical and programmatic support and guidance for strategy and adaptation of global guidelines to the India context; demonstrating the benefits and practicalities of introducing prevention of parent-to-child transmission (PPTCT) and paediatric antiretroviral therapy (ART) in the country; and advocating for scale-up.

UNICEF has contributed to the strengthening of technical and programmatic capacity at all levels of the health system, including through curriculum development, support for trainings and provision of human resources.

UNICEF staff and hired consultants are technically competent, committed and well regarded by Ministry of Health and Family Welfare (MoHFW) and partners for supporting a range of programme needs.

UNICEF has worked in a highly collaborative manner with a range of stakeholders, including other UN agencies, private sector health providers, civil society and HIV-positive networks.

A key area of added value has been UNICEF’s ability to leverage its knowledge generated from having a field presence to national dialogue, including for policy, strategy and guideline development.

UNICEF has supported some promising innovative approaches for improved system efficiency, including systems for line tracking and follow-up of HIV-positive patients, and expanding services to harder-to-reach areas and populations.

The internal integration of PPTCT and paediatric HIV within the reproductive, maternal, newborn and child health (RMNCH) programme component and concomitant reductions in dedicated HIV staff numbers has reduced the visibility of these issues as an organisational priority, and reduced UNICEF’s capacity to respond to specific HIV support.

Implications

Going forward, UNICEF may wish to consider the following suggestions:

- Leverage the strong relationships with national stakeholders to maintain commitment to PPTCT and paediatric HIV within an integrated package of RMNCH services, having particular focus on securing political commitment and resources to achieve universal testing and lifelong ART for HIV among pregnant women and their infected children, and the elimination of mother-to-child transmission of HIV.

- Continue to ensure that RMNCH and other related policies, strategies and guidelines are HIV sensitive, as part of the 2013-17 CPD.

- Continue to take a strategic approach to programme engagement with a sustained focus on influencing national strategy, policy
and guideline development, with a more defined emphasis on: refocusing efforts on equity to ensure that no one is left behind; identifying and testing new processes and technologies for improved programme efficiencies; and sharing lessons learned and best practices to create ‘buy-in’ at the state level and to encourage further roll-out of PMTCT and paediatric HIV services.

- **Adequately reflect PPTCT and paediatric HIV priorities in internal performance frameworks and improve planning and accountability mechanisms** between teams with HIV responsibilities to ensure that these teams are incentivised to meaningfully contribute to the goals and objectives for PPTCT and paediatric HIV, and that resources are used optimally.
1 Objectives and scope of the evaluation

1.1 Purpose of the evaluation

UNICEF has commissioned an evaluation of its activity in the area of prevention of mother-to-child transmission (PMTCT) of HIV and paediatric HIV care and treatment. The purpose of the evaluation is to support accountability and learning in relation to UNICEF’s efforts to support the scale-up of these programmes:

- **to contribute to improving the organisation’s accountability** for its performance by defining and documenting key achievements as well as missed opportunities in UNICEF’s engagement with partners and countries in support of improved PMTCT and paediatric HIV care and treatment outcomes between 2005 and 2015;

- **to generate evidence and learning** to enhance the understanding of the organisation and other stakeholders on how UNICEF’s strategies and programmes related to PMTCT and paediatric HIV care and treatment have evolved, what has worked, has not worked and why, and make recommendations for UNICEF’s future engagement in these programme areas.

The evaluation will look at four key dimensions of UNICEF’s work in this area:

1. **Leadership, advocacy, coordination and partnerships**: the ability to foster or to be effective within partnerships by leveraging corporate knowledge and assets to become a trusted advisor for donors, national governments, and other global and national stakeholders; and the ability to influence global, regional, national PMTCT and paediatric HIV care and treatment agendas over time.

2. **Resource mobilisation**: the ability to generate the required funds for PMTCT and paediatric HIV care and treatment programmes and projects that UNICEF supports across levels; the ability to leverage major funders’ resources to achieve UNICEF’s strategic priorities; to be an effective support to governments attempting to access funds for these programmes; and helping foster an adequate global resource base for them.

3. **Strategic information, knowledge generation and dissemination**: the contribution to global and national policies and strategies through evidence generated by UNICEF and partner-supported research and programming, as well as through its global data, estimation and progress reporting; and the translation of global policies and evidence into national plans, operational guidance and tools.

4. **Key aspects of UNICEF’s organisation**: to include establishing an effective presence at the global, regional and country levels, the proper employment of UNICEF’s comparative advantages (e.g. its ability to play a convening role, its procurement functions); the ability of the organisation to adapt based on new scientific and operational information; and the extent to which UNICEF’s structures in relation to HIV have been fit for purpose over time.

The evaluation is also focusing on three **cross-cutting issues**, namely: **gender, human/child rights and equity**. While not a focus of this case study, it will also examine how the response to PMTCT and paediatric HIV is integrated within a **humanitarian** response.
1.2 Focus of the country case studies

Data collection is being undertaken in seven countries as part of this evaluation – four involving country visits (in-depth studies)¹ and three conducted through remote desk reviews and telephone interviews (light touch studies).²,³

The key purpose of the country case studies is to record how UNICEF’s engagement in PMTCT and paediatric HIV/AIDS has played out at the country level during the period 2005–15, and help test and validate the theory of change for UNICEF’s strategy. It is important to note the following:

- Each case study has been selected because of the learning opportunity offered to the evaluation.
- The approach to each is focused on recording experiences rather than measuring or assessing individual country performance.

This report on the India experience presents the findings of one of the four in-depth case studies.

2 Approach and methodology

2.1 Approach to data collection and analysis

The full methodology for the evaluation is set out in the Evaluation Inception Report produced as part of the initial phase of the evaluation. It is however noted that the India case study, unlike other country case studies, included a visit to one state, Karnataka. This was designed to provide sub-national inputs to the case study. However, the study was only able to include a visit to one state out of 29, and given the scale and diversity between states, this is noted as a methodological limitation.

Figure 1 below summarises the process through which this in-depth country study was implemented.

Figure 1: Process for conducting country studies

2.2 India visit schedule

The visit included interviews or group discussions with over 60 stakeholders and was conducted 2–10 April 2016, including a two-day visit to Bangalore, Karnataka on 5–6 May 2016. Semi-structured interview guides were used to elicit perspectives on the four key dimensions of the evaluation (see above), as well as the cross-cutting issues. Interviewees included UNICEF staff (current and former, from HIV section and others), government representatives, development partners and civil society organisations. The full agenda and the list of stakeholders interviewed are included in Annex II and III respectively. The country visit was also used as an opportunity to source additional documents from the India Country Office.

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¹ Zimbabwe, Cameroon, India and South Africa.
² Cambodia, Haiti and Ukraine.
³ Country case studies are one component of the data collection process. The evaluation also includes interviews with key stakeholders at a global and regional level, an online survey to UNICEF and partners and an extensive document review.
On the last day of the visit, the team presented its preliminary observations to the UNICEF team for their early reflection and response.

The final step in the country case study process has involved a more comprehensive analysis of interviews and documents, to produce this country report. The report is presented in six parts:

1. **Objectives and Scope of the Evaluation** – describes the aim of the evaluation.
2. **Approach and Methodology** – explains the approach to the case studies.
3. **Overview of UNICEF’s Country Programme in India** – provides an introduction to the Indian context and UNICEF’s work in PMTCT/paediatric HIV.
4. **Findings** – details findings against the four key dimensions of the evaluation, as well as the cross-cutting issues.
5. **Achievements and Challenges** – details some of the key achievements and challenges for UNICEF and India during the evaluation time period.
6. **Implications for UNICEF** – reflects on lessons learned to present some areas for UNICEF’s consideration moving forward.

Further information is presented in Annexes to this report.

### 3 Overview of UNICEF’s country programme in India

#### 3.1 India context

The sheer size of the country and the significant economic disparities and health inequities between and within states and population groups represent a key development challenge. India is a lower-middle-income country, and the second-most populous country in the world, with a pluralistic, multilingual and a multiethnic society. It represents the world’s fourth-largest economy. Rapid urbanisation and the emergence of a sizeable middle class are changing the socioeconomic situation in the country, although there are significant economic disparities between geographies and states, and by class, caste and gender. While health indicators have improved over time, maternal and newborn mortality rates are still high in some states, and child malnutrition is a significant problem.

India successfully achieved Millennium Development Goal (MDG) 6 in halting and reversing the HIV epidemic. India is a low-prevalence country with a concentrated epidemic, where even relatively minor increases in HIV incidence rates translate into large numbers of people becoming infected. Nonetheless, between 2000 and 2015, new HIV infections dropped by 66%, from 251,000 to 86,000 p.a. This progress is attributed to a simultaneous focus on prevention alongside expanded care, support and treatment services, and to India’s pioneering approach to using evidence-informed responses to the epidemic. However, there is still significant variation between states – for example, although estimated adult HIV prevalence was estimated to be 0.26% at national level in 2015, some states had much higher-prevalence levels.

However, the burden of HIV and AIDS remains high. Despite the reductions in prevalence, an estimated 68,000 people died of AIDS-related causes nationally in 2015 and the disease burden remains high, with an estimated 2.1 million people living with HIV (PLHIV) in 2015. Of these, women comprised 40.5% (almost 1 million women) and children under 15 years old comprised 6.5% (equating to 136,500

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5 UNAIDS. How AIDS Changed Everything; 2015.
7 This includes Manipur (1.15%), Mizoram (0.80%), Nagaland (0.78%), Andhra Pradesh & Telangana (0.66%), Karnataka (0.45%), Gujarat (0.42%) and Goa (0.40%).
children). The large numbers of children living with HIV in India was the reason why the country was selected as one of the 22 countries prioritised in the 2011 Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive (the ‘Global Plan’).

Antiretroviral therapy (ART) coverage among adults has increased but significant gaps in coverage remain. The ART roll-out was launched in 2004/05 with 6,845 PLHIV on first line ART in 2005. This increased to 851,000 by 2015, equating to 41% of the total number of PLHIV. It is estimated that this scale-up of ART has saved 450,000 lives in India.

PPTCT coverage has also increased, but 59% of pregnant women are still not currently tested for HIV. Following a feasibility study in 11 major hospitals in five high HIV prevalence states in 2001/02, the PPTCT programme was launched and scaled up. There has been a significant increase in the number of pregnant women being tested for HIV, from 2 million in 2006/07 to 10.6 million in 2014/15 (with 97% of identified HIV-positive pregnant women and their babies receiving antiretroviral prophylaxis for PPTCT in 2014/15). There has also been a rapid scale-up of HIV testing facilities from 4,567 stand-alone Integrated Counselling and Testing Centres (ICTCs) in 2007/08 to 18,829 by September 2015 (comprising 5,359 stand-alone ICTCs and 13,470 integrated facility ICTCs and private sector ICTCs run through a public-private partnership (PPP) model). However, the number of pregnant women being tested for HIV only represents 41% of the estimated 28 million pregnancies in India each year, meaning 59% of pregnant women are not currently tested for HIV. This led to the detection of 37% of the 35,255 estimated number of HIV-positive pregnant women in 2014/15 – as such, 63% of cases were not detected. This reflects a significant challenge in India to enhance the detection of HIV-positive pregnant women in low-prevalence areas. There are also significant barriers for pregnant women to access services, including a lack of family support, social customs, financial barriers, stigma and discrimination.

Coverage of paediatric ART remains below 40% of the estimated number of HIV-positive children. Paediatric antiretroviral treatment (ART) was initiated in 2006 with the National Paediatric ART Initiative. In 2015, the cumulative number of HIV-positive children registered for ART increased to 120,917, with the number of HIV-positive children currently alive and on ART is 50,976. This equates to approximately 37% of the total number of estimated HIV-positive children.

Funding for HIV/AIDS has increased dramatically over successive National AIDS Control Programmes (NACPs). Resources for HIV/AIDS have increased fourfold from US$725m for NACP II (1999–2006) to US$3.1bn for NACP IV (2012–17). The main driver for this has been the increase in resources from Government of India (GOI), increasing from 4% of total resources for NACP II to 85% for NACP IV. External resources, primarily from the Global Fund and World Bank, rose from US$695m for NACP II to US$1.9bn for NACP III, and then declined to US$490m for NACP IV. In this landscape, the government has reported that resource needs for HIV/AIDS, including PPTCT and paediatric HIV, are being met.

3.2 UNICEF’s work in HIV in children during 2005–15

UNICEF’s country programme priorities during 2005–15 are outlined in the Country Programme Documents (CPDs) that cover this period (CPD 2003–07, CPD 2008–12 and CPD 2013–17). The focus of UNICEF’s work has been to support progress towards the MDGs and the goals of the Plan of Action for A World Fit for Children, in line with UNICEF’s Medium-Term Strategic Plans over the period (2002-05, 2006-09, twice extended to 2013), and its Strategic Plan 2014–17. UNICEF’s work in HIV/AIDS specifically has focused on the achievement of MDG6 within the framework of successive NACP, and
the GOI Policy Framework for Children and AIDS. An overview of some key events in the India context is presented in Annex IV.

In particular, UNICEF has supported a number of initial introductions for PPTCT and paediatric ART services. This has included the introduction of PPTCT services in six higher-prevalence states in 2001, the introduction of paediatric ART that was initially trialled in 2006 in three states, and Option B that was initially trialled in 2012/13 in three states. UNICEF’s role in these processes was in the provision of technical assistance for strategy and guideline development, capacity building at both the national and state level (e.g. in terms of curriculum development, support for trainings and mentoring, provision of human resources, and monitoring and evaluation), negotiating for and managing the supply of commodities (e.g. nevirapine for HIV-positive mothers and babies, and for the introduction of EID and paediatric ART commodities) and hosting workshops and meetings.

UNICEF has advocated to the National AIDS Control Organisation (NACO) and the Ministry of Health and Family Welfare (MoHFW) for the prioritisation and scale-up of PPTCT and paediatric HIV services across the country through integration within reproductive, maternal, newborn and child health (RMNCH) service provision. This has included the shift in policy to adopt universal testing and lifelong ART for HIV among pregnant women and their babies, for which UNICEF was a strong advocate and supported the estimation of resource needs for implementation. UNICEF has also supported the scale-up of PPTCT and paediatric HIV services, and has worked to build the capacity of health and HIV staff by providing human resource capacity in the form of consultants at the state level, supporting the development of state and district-specific scale-up plans, and building partnerships with the private sector for community mobilisation and service delivery. UNICEF has also sought to focus on innovations for system efficiencies, such as for line tracking and follow-up of HIV-positive patients and expanding services to harder-to-reach areas and populations.

UNICEF is the lead technical partner for PPTCT to NACO and MoHFW, and works closely with other United Nations agencies, including the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) to input into various national technical resource groups (TRGs) for policy, strategy and guideline development. UNICEF has also worked closely with a range of other stakeholders, including:

- HIV-positive networks (e.g. the Positive Women’s Network and the Indian Network of Positive People) to mobilise communities and reduce barriers to accessing services;
- Civil society, particularly in relation to facilitating engagement in national policy, strategy and guideline development processes;
- Other donors, such as Clinton Health Access Initiative (CHAI) for the introduction of paediatric ART;
- Societies of private sector health providers to improve awareness of HIV issues and engage their members in PPTCT and paediatric HIV service provision;
- Faith-based organisations, media and celebrities for advocacy and communication initiatives to address stigma and discrimination, and raise the visibility of children and HIV/AIDS issues.

4 Findings from India

4.1 Thematic leadership, advocacy, partnerships and coordination

UNICEF is recognised as having played a strong leadership role in PPTCT and paediatric HIV care and treatment, having supported the NACO and the MoHFW in setting programme and policy direction for initial roll-out and scale-up. The GOI, through NACO and MoHFW at the national level and State AIDS

14 The NACPs have included various approaches and strategies for PPTCT, HIV/AIDS education, information and communication, advocacy and mobilisation of officials, and surveillance and monitoring.

15 The GOI Policy Framework for Children and AIDS was launched on 31 July 2007 and outlines key Ministries and their respective roles.
Control Societies (SACS) and the National Rural Health Mission (NRHM) at the state level, has maintained strong leadership of the HIV/AIDS response. However, UNICEF has contributed strongly to key policy shifts and milestones, for example related to the launch of the PPTCT programme, initiation of paediatric HIV treatment and care in 2006, inclusion of early infant diagnosis (EID) in 2009, and the development and implementation of new national guidelines for Option B (2012–13) and Option B+ (2013–14) and national strategic planning and scale up for Option B+.

UNICEF has been a lead advocate and partner to NACO in the introduction and scale-up of PPTCT, and in the roll-out of EID and paediatric HIV care and treatment. In particular, UNICEF, alongside NACO, WHO and the National Institute of Virology, was a key partner in the ‘proof of concept’ for PPTCT, selecting and positioning medical colleges as ‘centres of excellence’ for PPTCT and paediatric HIV, and was the lead partner to NACO in programme roll-out and scale-up. UNICEF supported NACO on issues related to programme delivery, commodities, human and financial resource gaps, development of guidelines and training modules. UNICEF funded national and state service and quality reviews, organised international learning exchanges and the engagement of the private sector in PPTCT services; and focused on monitoring, training and use of data.

In particular, UNICEF played a crucial role in advocating for the inclusion of PPTCT and paediatric HIV as part of the national programme when the early focus was on key populations and targeted interventions. UNICEF supported the 2006 children’s consultation in 10 states for 9–16 year olds with children calling for improved paediatric treatments, resulting in policy development for orphans and vulnerable children and paediatric treatment becoming a focus in NACP III. UNICEF played a crucial role in advocating to NACO for the adoption of Option B. The move from single dose nevirapine to Option A, and subsequently Option B, was a significant step for the country, and required substantial effort from UNICEF and UN partners to promote the benefits of shifting to the new treatment regimens, including through a national consultation workshop in 2010. Given the country’s commitment to Option B, the adoption of Option B+ was felt to be a much simpler step to take, and guidelines were approved relatively quickly in late-2013, becoming operational in January 2014.

UNICEF worked with MoHFW and NACO to increase the number of ICTCs and build linkages between primary health centres and HIV care and treatment. As noted by partners “they were able to motivate different departments and entities to work together. This was a critical role in support to PPTCT and integration support efforts”. UNICEF is appreciated for its flexibility in meeting programme gaps at state level.

UNICEF also supported work in primary prevention with a focus on at-risk and especially vulnerable adolescent and young people. UNICEF supported NACO’s decentralisation process coordinating district situational analysis in 26 districts, across 10 states and supporting development of district action plans. UNICEF supported the link workers scheme designed by NACO to respond to needs of rural populations by providing technical support to the SACS and non-governmental organisations that are implementing HIV prevention programmes for groups with high-risk behaviour in three states: Bihar, Madhya Pradesh and Chhatisgarh in 2008.

UNICEF is a credible, trusted and reliable partner coordinating with others in support of national-level strategy and policy development and state-level implementation. UNICEF has developed a strong relationship with NACO and MoHFW and is highly valued for its role in TRGs, particularly in terms of its extensive field level knowledge and practical experience that adds value to policy dialogue, including in the development of national-level guidance, complementing the technical role provided by WHO. Through its active participation in various thematic groups, UNICEF contributed to plans for implementation of Option A and was part of a UN-wide advocacy effort for the inclusion of scaling up Option B in the 2013 National Strategic Plan for PPTCT, as well as for Option B+ in 2014.

UN agencies describe a productive working relationship with UNICEF as part of the UN Development Assistance Framework with a clear division of labour according to each agency’s comparative advantages. While civil society representatives valued the relationships established 2005–10, they describe a more distant relationship from 2010 onwards. However, strong and trusted relationships
have been nurtured with SACS and NRHM through UNICEF’s state-level field offices and health and HIV consultants.

UNICEF has advocated at the community level to educate women on the change in policy and treatment regime. UNICEF is acknowledged by PLHIV networks as being a bridge between the government and community, creating platforms for civil society advocacy, which otherwise would not have existed during the period of programme roll-out. UNICEF contributed to the key shifts in prioritisation of PPTCT and paediatric HIV care and treatment through strong evidence-based advocacy, drawing on UNICEF-funded cost models for PPTCT scale-up and data showing the disparity between paediatric and adult treatment rates. UNICEF also played a lead role in advocacy, writing and proposal review for the Global Fund RCC2 (Rolling Continuation Channel) application in 2012, focused on elimination of new HIV infections among children through integrated services and greater community mobilisation. UNICEF focused the work of their Ambassador Sharmila Tagore to improve the visibility of and access to PPTCT services through radio and TV slots.

UNICEF has sought to scale up PPTCT and paediatric HIV service coverage by engaging and partnering with private sector institutions. UNICEF brokered important partnerships with the India Medical Association and Federation of Obstetric and Gynaecological Societies of India (FOGSI) to access networks of private sector providers as a means of increasing coverage. UNICEF brought FOGSI into the TRG dialogue resulting in stronger linkages with NACO, improved regulation of private sector providers, their adoption of national protocols and participation in UNICEF-sponsored training programmes.

UNICEF has further brokered international partnerships to strengthen the provision of PPTCT and paediatric HIV services. In response to national-level capacity gaps, UNICEF brokered an important partnership with Baylor College of Medicine, bringing US-based global experts to India to focus on quality of care issues and creating linkages with paediatric centres of excellence. This visit was referred to by UNICEF staff as a ‘real eye opener’ for participants, and resulted in improved quality care for children with HIV and also for adults. UNICEF was able to use its global position and reputation to reach out to important international partners. UNICEF has also leveraged international funds from the MAC AIDS Fund to pioneer the use of telemedicine for PPTCT and paediatric HIV services – see Box 1.

Box 1: Innovation through the Paediatric HIV Telemedicine Initiative

The Telemedicine Initiative allows for the video-linked delivery of expert services for paediatric HIV care and treatment to areas where such expertise is not easily accessible. The service uses Skype to host discussions between an expert call handler and staff at ART centres. The services include expert opinion and guidance on paediatric ART initiation, nutrition and adherence counselling, review for first-line failure, paediatric HIV mortality reviews, capacity building for health personnel, etc.

This decentralised and relatively low-cost model of service provision allows for patient symptoms to be reviewed by telephone, before patients are referred onto Paediatric Centres of Excellence (PCoE), thereby reducing unnecessary patient travel and burden on the centres.

The Initiative was established in Maharashtra, as a multi-partner collaboration NACO’s PCoE at Sion Hospital in Mumbai, the Maharashtra SACS, the National Health Mission in Maharashtra, Municipal Corporation of Greater Mumbai (MCGM) and UNICEF.

UNICEF supported the conceptualisation of the initiative, and provided funding to support the initial set up and proof of concept. UNICEF is now inputting into a cost-benefit analysis and 18-state feasibility study to assess whether the initiative should be scaled up.

UNICEF has supported the development of technical and programmatic capacity within the MoHFW and NACO at the national level, as well as implementation capacity at the state and district level. As noted above, the MoHFW and NACO have strong capacity in planning, budgeting, resourcing and
managing the PPTCT and paediatric HIV programme at the national level. UNICEF has worked to build this capacity over time, such as in planning processes for scale-up (e.g. related to capacity building plans, development of training curriculums, forecasting and procurement of commodities required) through its involvement in TRGs, and multi-stakeholder meetings/workshops (e.g. UNICEF co-hosted with NACO, WHO and UNAIDS a National Paediatric Conference in December 2010 to update staff on recent developments in the field, including new research, revised WHO guidelines and operational issues for optimal service provision). UNICEF has also supported the development of capacity for implementation at the state and district levels through the development of training materials, minimum standards of care, and standard operating procedures (e.g. for medical monitoring and evaluation (M&E) and surveillance officers, outreach workers, auxiliary nurse midwives, accredited social health activists, counsellors, and laboratory technicians) and support in the delivery of trainings through a training of trainers (ToT) approach, as well as through the deployment of UNICEF-funded field consultants to work within SACS in high priority states. These consultants were hired to build the planning, budgeting and management capacity of the SACS for the roll-out and implementation of PPTCT and paediatric HIV services in the states, as well as the integration of HIV into RMNCH service provision more recently.

UNICEF has also been closely involved in the development of state and district-specific PPTCT scale-up plans to ensure smooth roll-out and provision of quality services. Consultants have played an important role in in supporting SACS in promoting institutional deliveries, improving testing rates, and linking HIV-positive mothers and babies to ART centres, as well as following up processes. SACS stated that “UNICEF has been central to our achievements and we could not do without it. They provide, funding, staff, gap filling and keep us motivated”.

However, there are some concerns that UNICEF support at the state level may be too ‘hands on’ rather than focused on building the capacity of the SACS. The state visit to Karnataka highlighted the critical role that the UNICEF-supported consultants play in supporting programme implementation, such as in M&E, data analysis, planning, budgeting, management and follow-up processes. However, there is a concern that the consultant was largely taking responsibility for completing these processes, rather than building the capacity of SACS staff to complete them. This concern is balanced by the realisation that there are systemic problems in recruiting suitably qualified staff at the state level to support the programme and, as such, stakeholders fed back that without the consultant the work would simply not get done.

UNICEF’s initial role in civil society capacity development helped to raise awareness of HIV in the programme development and roll-out phase of PPTCT and paediatric HIV care and treatment. UNICEF is recognised for prioritising the strengthening of civil society organisations and individuals, bringing the voices of those living with HIV to national-level policy dialogue resulting in policies better reflecting their needs. UNICEF supported capacity building of PLHIV networks including Positive Women Network and National Coalition of People Living with HIV in India enabling them to play significant roles in policy development and in stigma reduction, demand creation, case finding especially for socially marginalised women and a focus on those lost to follow up. This work strengthened overall HIV programming. UNICEF’s work with civil society diminished over time. Many interviewees raised the need for UNICEF to re-engage civil society organisations with a strategic focus towards e-MTCT.

4.2 Resource mobilisation

4.2.1 Internal resource mobilisation functions

The India Country Office annual budget and expenditure for HIV/AIDS increased from 2005 to 2011, and then decreased before increasing slightly in 2014, broadly in line with ICO total programme budgets and expenditures. As shown in Figure 2, ICO’s annual budget for HIV/AIDS, as set out in successive country programme action plans (CPAPs; these budgets are indicative, set out in advance of the CPAP five year period, and are dependent on the availability of resources), increased from US$6.5m
in 2006 and 2007 (corresponding to 8% of total ICO programme budget) to US$12m between 2008 and 2012 (12% of total ICO programme budget). The budget for HIV/AIDS then decreased by two thirds to US$4m between 2013 and 2015 (corresponding to 3% of total ICO programme budget). Expenditure for HIV/AIDS grew steadily from US$6m in 2005 to US$6.3m in 2009, broadly meeting the budgets in 2006 and 2007, but only meeting around half of the budget in 2008 and 2009. Expenditure then rose to US$8m in 2010 before falling to US$6.5m in 2011, US$4.6m in 2012, US$1.3m in 2013 and US$2.6m in 2012. The initial increase and subsequent decline in resources for HIV/AIDS corresponded with:

- A requirement for intensive support to NACO and MoHFW in 2011 and earlier years in relation to the various changes in treatment regimens, guidelines and capacity building, and the dropping off of this requirement from 2012 onwards.
- The integration of HIV/AIDS staff within the Reproductive and Child Health (RCH) programme component in 2012, following which staff costs for HIV/AIDS specifically fell from US$1.2m p.a. to US$0.2 p.a. – this contributed to the lower levels of expenditure for HIV/AIDS in 2013 and 2014.
- A large DFID-funded primary prevention programme that ended in 2012, which also contributed to the decline in expenditure for HIV/AIDS from 2012 to 2013.
- The general trend in total ICO expenditure. We understand that the decline in ICO total expenditure between 2010 and 2013 was predominantly due to an increase in GOI expenditure on public services, and a reduced requirement for external resources, including from UNICEF, as well as a reduction in overall donor resources to the country (see below).

![Figure 2: UNICEF budget and expenditure for HIV/AIDS](image)

Source: Successive CPAPs; and analysis of internal UNICEF data

UNICEF expenditure on PPTCT and paediatric HIV/AIDS in India totalled US$4.2m between 2011 and 2014. As shown in Figure 3, UNICEF expenditure decreased from US$1.8m in 2011 to US$0.6m in 2013, before increasing to $1m in 2015. As noted above, we understand that this was due to more intensive support being required in 2011 in relation to the adoption of Option B, such as in guideline development and capacity building activities, and the dropping off of this requirement thereafter.

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16 UNICEF budgets are derived from the CPAPs. It is noted however that there is some variation in the value of UNICEF’s budgets between CPAPs and other reports, and in the value of expenditure between UNICEF’s central database and the Country Office records.
The majority of resources have been sourced through UNICEF regular resources and the UK. As shown in Figure 4, 80% of resources for HIV/AIDS between 2005 and 2014 have been from two sources – Regular Resources (46%) and the UK’s Department for International Development (DFID) (34%). Other sources have included UNAIDS through the Unified Budget, Results and Accountability Framework, the UK National Committee, UNICEF’s global thematic resources for HIV/AIDS, GOI and the United Nations Foundation.

While UK DFID funding for HIV/AIDS will no longer be available going forward, ICO has a robust resource mobilisation function and there are resources available to meet programme needs. Given the UK’s 2012 policy not to provide any new support to India, ICO will be unable to benefit from any DFID funding going forward. Although this has been a significant source of funding in previous years, we understand that ICO has sufficient resources to meet resource needs for HIV/AIDS, including significant ‘unutilised’ funds that can be deployed as and when required. This is a function of ICO’s robust resource

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17 It was not possible to source expenditure data for 2011 and 2012. As such, this is excluded from the analysis.
mobilisation function, particularly its engagement with private sector corporations (e.g. IKEA Foundation, H&M, Barclays Bank, Mittal, etc.).

The monitoring of budgets, resource needs and funding gaps, as well as fundraising for PPTCT and paediatric HIV is included within the broader RCH programme component. Budgets, resource needs and funding gaps for PPTCT and paediatric HIV are not monitored directly within the integrated programme structure, but are included within the broader RCH programme component. This was a decision taken by ICO to streamline processes and is felt by UNICEF staff to be appropriate. This is also the case for fundraising, where ICO is only seeking to raise resources for PPTCT and paediatric HIV through flexible and/or RCH-specific grants. As such, ICO is not actively targeting HIV-specific funding opportunities. It is not clear whether this is leading to ICO missing such opportunities, although there may be specific instances where targeted grants may be useful (e.g. in piloting/testing innovations).

4.2.2 External resource mobilisation functions

Resources for HIV/AIDS have increased over time, driven in particular by increased resources from GOI, while external resources initially increased and then declined. As shown in Annex IV, resources for HIV/AIDS through the successive NACPs, including resources for activities/interventions and commodities, have increased dramatically over time, from US$725m for NACP II (1999–2006) to US$3.1bn for NACP IV (2012–17). The main driver for this has been the increase in resources from GOI, increasing from 4% of total resources for NACP II to 85% for NACP IV. External resources rose from US$695m for NACP II to US$1.9bn for NACP III, and then declined to US$490m for NACP IV. In this landscape, the Government has reported that resource needs for HIV/AIDS are being met.

UNICEF’s active advocacy to prioritise PPTCT and paediatric HIV is felt to have contributed to the increase in domestic spending over time. As noted above, UNICEF has advocated for and supported policy and decision making in a number of areas that have required significant additional investment over time. In particular, this has included the shift in policy to adopt universal testing and lifelong ART for HIV among pregnant women and their babies. HIV testing had previously been funded through NACO’s budget, however, following an active advocacy effort by UNICEF and partners, it was agreed that MoHFW would set aside an additional US$7m for the testing of all pregnant women accessing antenatal in the country (estimated to be 70% of total pregnancies). This was seen as a significant decision, and evidence of HIV becoming further integrated within the RMNCH agenda.

There is however a need for greater programme expansion in order to achieve broader programme goals and push for e-MTCT. Resource needs for the universal HIV testing of pregnant women are being met. However, in the context of only 41% of the estimated 28 million annual pregnancies in the country, considerable additional effort and investment in systems strengthening will be required in future years to meet the objective of universal HIV testing. This will be accompanied by additional resource needs to ensure that the additional number of people found to be HIV+ are provided with lifelong ARVs.

UNICEF has played a limited but valued role in leveraging partner resources for PPTCT and paediatric HIV. NACO and MoHFW have strong capacity in resource mobilisation and have not required significant support in mobilising or coordinating partner resources for PPTCT and paediatric HIV. UNICEF has however supported the development of successive Global Fund funding applications through its engagement in the PPTCT Taskforce, particularly around the prioritisation and costing of activities. Through the same forum, UNICEF has also inputted into the review and course correction of aspects of Global Fund’s support (e.g. related to outreach to PLHIV). We understand that a process is currently underway to assess how and whether UNICEF and Global Fund’s support can be further linked and/or streamlined in a complementary way going forward.

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18 The IKEA Foundation was ICO’s largest donor between 2008 and 2012.
UNICEF’s role in negotiating for the supply of commodities has been highly valued by partners. At the outset of the PPTCT programme following the piloting and feasibility assessments in 2001, UNICEF negotiated with CIPLA, an Indian pharmaceutical company, to provide nevirapine free of charge for those mothers and babies found to be HIV-positive. UNICEF managed this relationship and commodities supplies over time, which has been highly valued by NACO and partners. UNICEF was also involved in the CHAI-led initiative to introduce paediatric ART in 2006 and manage the procurement of ART commodities (e.g. sample collection kits and testing reagents) for three states in 2012 for the initial roll-out of Option B, as supported by UNITAID. These short-term activities have been designed to accelerate roll out.

Given domestic ownership for resourcing HIV/AIDS, the potential for the PPTCT and paediatric HIV programme to be financially sustained going forward is strong. As shown above, financial resources from GOI for HIV/AIDS have increased dramatically over time, and are expected to account for 85% of resource needs for the implementation of NACP IV, equating to US$2.6bn between 2012 and 2017. While external contributions remain an important source of funding for HIV/AIDS, particularly from the Global Fund, USAID and World Bank, there is still felt to be strong country ownership for resourcing HIV/AIDS programme needs going forward.

UNICEF has also worked to improve programmatic sustainability, although some concerns remain. As noted above, UNICEF has supported the strengthening of capacity of the MoHFW and NACO in planning, budgeting, resourcing and managing the PPTCT and paediatric HIV programme at the national level, as well as the capacity of the MoHFW and SACS for implementation at the state and district levels. However, there is a concern that UNICEF’s support at the state level may at times be too ‘hands on’, rather than working to build the long-term capacity of SACS staff to complete PPTCT and paediatric HIV-related tasks. UNICEF has also supported a number of new and/or innovative approaches in India that have continued to be implemented and supported by the MoHFW, NACO, and partners. In particular:

- Tracking of HIV-positive pregnant women and their children for follow-up: A UNICEF supported HIV-tracking system that is integrated within the Mother and Child Tracking System (MCTS) in Karnataka has been fully rolled out and embedded within health system processes (see Box 2).
- Private sector: UNICEF’s work to engage private sector health service providers and train them in the provision PPTCT and paediatric HIV services using a PPP model has been scaled up by MoHFW to other states, with support from the Global Fund.
- Telemedicine: UNICEF is also seeking support to sustain and scale up a telemedicine initiative that allows for video-linked delivery of expert services to underserved areas on paediatric HIV (see Box 1. In particular, UNICEF is inputting into a cost-benefit analysis and an 18-state feasibility study to assess whether the initiative should be scaled up. UNICEF has also sought to raise awareness of the initiative among various global forums.

4.3 Strategic information, knowledge generation and dissemination

UNICEF’s role in the generation, analysis and dissemination of strategic information (SI) has evolved over time. In earlier years, UNICEF played an active role in supporting WHO and GOI in the design of M&E and surveillance systems, and in the monitoring of SI to check the quality of reporting. UNICEF’s field presence gave it a particular added value in this regard. Over time, as systems have become embedded and the capacity of NACO and MoHFW has been strengthened, UNICEF has not been required to play a significant role at the national level in the generation, analysis and dissemination of SI. While there are still recognised issues and limitations of these systems, other donors (e.g. World Bank) are supportive in this area. UNICEF does, however, continue to work closely with other UN agencies to support the reporting of national data to global forums, such as the UN General Assembly Special Session (UNGASS) mechanism.

UNICEF’s role in the development of national strategies, policies and guidelines is highly valued. As noted above, UNICEF participates in various technical resource groups (TRGs) and provides technical support for the development of national strategies and policies (e.g. the 2007 Policy Framework for
Children and AIDS), as well as guidelines (see next paragraph). In particular, UNICEF, as the only UN agency with state offices and a field presence, is felt to add considerable value to these processes by ensuring that the outputs of these national forums are practical and actionable in the field. This is particularly important in India given the sheer size of the country and the significant diversity between and within states and population groups. This contribution is felt to align well with that of other UN agencies, such as WHO, whose focus is solely on the technical content and translation of global evidence into national standards, guidelines and protocols. UNICEF has also facilitated the engagement of civil society in these forums, which has been highly valued.

**UNICEF has supported the guideline adaptation and adoption process at the national and state level.**

UNICEF has supported the guideline adaptation process at the national level through its engagement in TRGs, and the adoption of these guidelines at the state and field levels. This has included supporting the formulation of guidelines on paediatric management in June 2006, nutrition for children infected by HIV, early infant diagnosis (EID) in 2009, as well as organising alongside WHO and NACO a national consultation workshop on PPTCT in February 2010 where Option A was identified as a suitable replacement for single dose nevirapine. However, based on the challenges experienced with Option A in other countries, it was not rolled out and Option B was opted for in September 2010. UNICEF supported the revision of the guidelines through the TRG. Option B was initially trialled in three states from September 2012, which were scaled up nationwide from May 2013. Guidelines for Option B+ were approved in December 2013 and became operational in January 2014, leading to the national scale-up from February 2015. Stakeholders reflected that the delay in adopting the guidelines was related to the bureaucratic nature of the Indian system. There were then further delays to implementation as the decisions made centrally needed to be adopted and acted upon by state governments. We understand that this issue is not specific to PPTCT, but applies to health and other social services more broadly. UNICEF played an important role in advocating to these state governments to create ‘buy-in’ and prepare them for roll-out, including assessments on the readiness of supply systems in six states.

**UNICEF has worked to build capacity and processes for the collection, M&E, and analysis of strategic information at the state and district levels.**

UNICEF staff and consultants have worked to build the capacity of SACS staff and district field officers in surveillance, field monitoring, M&E, data analysis, follow-up processes and programme reviews at the state level. The state visit to Karnataka highlighted that these processes are mostly working well, although more could be done to fully utilise the available information for more targeted programming. For example, the data generated at the laboratory level is currently used to ensure that individuals are registered for initiation of ART and follow-up by district health officers, but might be useful for analysis at an aggregated level to inform targeted wider outreach and/or programming efforts.

**UNICEF has also sought to identify innovative technologies and/or approaches to improve programme performance and efficiency.**

In Karnataka state, UNICEF’s support for the development of an innovative HIV-tracking system has sought to improve follow-up processes and facilitate the integration of HIV services within RMNCH service provision (see Box 2). UNICEF also supported NIMHANS in the roll out of EID, and specifically in Karnataka, aided in the distribution and delivery of Dried Blood Spot samples, and a process for following up positive cases with the District Medical Officer. In Maharashtra state, UNICEF has supported the development of an ‘EID follow-up system’ that uses automated SMS and emails to remind field level staff to follow up with HIV exposed babies for testing, drawing on line list information for antenatal care.
Box 2: Innovation through the tracking of HIV-positive pregnant women and their children through the mother and child tracking system

The Mother and Child Tracking System (MCTS) is a web-based platform introduced by MoHFW to track and monitor a variety of health services for pregnant women (e.g. antenatal care, institutionalised delivery) and their children (e.g. immunisation).

UNICEF supported the piloting of a HIV tracking system that is integrated within the MCTS in Karnataka in order to record details of the mother, stage of pregnancy, date of delivery, results of HIV test, if found positive and the treatment regimen, CD4 count, testing of the newborn and follow-up tests until the infant is 18-months old.

This was designed to improve follow-up processes for those pregnant women found to be HIV-positive and ensure timely initiation of and adherence to ART, and allow for mothers to access treatment from other ART centres (that also have access to the database). The linkage with the MCTS also reduces the duplication of data entry and facilitates the integration of HIV services with reproductive, maternal, newborn and child health services.

The system has been fully rolled out and embedded within health system processes in Karnataka.

UNICEF has played a key role in conducting operational research and analysis to support national decision making for programme design. In particular, UNICEF:

- Was a key partner in the initial pilot and feasibility studies for PPTCT in 2001/02, and supported the country’s decision to introduce PPTCT.
- Conducted a comprehensive PPTCT review in Karnataka in 2005 of the quality of service provision and training needs.
- Supported a qualitative district situation analysis of five state programmes in 2007 to guide future programming.
- Assessed procurement and supply chain management capacity at NACO, SACS, ART centres and ICTCs in January 2007 to identify critical gaps and bottlenecks.
- Analysed bottlenecks for HIV testing between 2007 and 2008, and identified a lack of commodity supplies due to inaccurate estimation techniques as a critical barrier to increasing testing rates. This led to a change in the way estimations and forecasts for commodities were conducted.
- Supported strategic research on HIV transmission rates as part of a large cohort study to input into the decision on whether to adopt Option A from single dose nevirapine in 2009/10.
- Conducted assessment of the seven existing paediatric centres of excellence in partnership with the Baylor Institute on the quality of services and capacity needs.
- Supported the estimation of resource needs for programme scale-up in 2013.
- Is currently supporting a cost-benefit analysis and 18-state feasibility study into the Telemedicine Initiative.
- Is also seeking to conduct alongside Population Services International (PSI) a cohort monitoring study on the effectiveness of Option B+.

UNICEF also hosted a 3-day national workshop in 2010 where all partners were invited to discuss and define the country’s research priorities. This experience was shared with other countries, although we understand that following the change in leadership at NACO these priorities changed.
4.4 UNICEF organisational structure

4.4.1 Organisation: structure

From 2005 to 2012 a strong and effective stand alone HIV team reported to the Deputy Representative Programmes. The dismantling of the team in 2012 and integration of HIV functions across other programme components was associated with a significant reduction in the number of dedicated HIV positions with HIV functions mainstreamed and subsumed within RMNCH, child protection (CP) and communication for development (C4D), to reflect integration within the maturing national programme. The two dedicated positions focusing on PPTCT and paediatric HIV (1xNOD, 1xNOC) reduced to one (NOC) – focusing on PPTCT/paediatric HIV (60%) and RMNCH (40%). From 2005-2012 the stand alone HIV unit comprised six permanent posts lead by a Chief of HIV (LS). The Chief position and two others (GS7 and NOC) were abolished with the dismantling of the unit. While staff and external partners generally acknowledge that the time for a stand-alone HIV unit has passed, they reflect that:

- The revised structure and concomitant reductions in staff numbers have led to: reduced visibility of HIV as an organisational priority; reduced capacity to support NACO and MoHFW in the integration of PPTCT and paediatric HIV within RMNCH services in order to reach the goal of universal access; and reduced capacity to engage and advocate for areas where specific approaches are required to achieve elimination. It was noted by a member of staff that “we must realise that an integrated approach will not give the same results and we won’t have the same technical focus”.
- PPTCT and paediatric HIV receives less attention since being integrated into the much larger portfolio of RMNCH and UNICEF risks losing its knowledge base and leadership within the organisation. Various stakeholders expressed that UNICEF needs to maintain its focus on PPTCT and paediatric HIV to support progress towards e-MTCT, with a PLHIV network urging UNICEF to “remember that integration is only the ‘means’ and elimination is the ‘end goal’”, and that any successor to the current lead (Health Specialist MH/PPTCT) is likely to be less experienced in PPTCT and paediatric HIV.
- The reduction in HIV-specific positions is interpreted by some external stakeholders as UNICEF de-prioritising PPTCT and paediatric HIV care and treatment, as it has led to reduced engagement, funding and campaigns. Some respondents suggest that integration of HIV functions across various divisions has led to a reduction in overall attention on key populations and the socially marginalised, key group in terms of the equity agenda and elimination.

The ICO field office structures enable UNICEF to support state-level implementation in a practical and meaningful manner. SACS and NRHM staff in Karnataka state highly value UNICEF’s local presence, in terms of support from staff and consultants, and their direct engagement and support to ICTCs, health facilities, referral hospitals, laboratories, and civil society organisations at the state and district level. Working close to field implementation sets UNICEF apart from other UN agencies and enables UNICEF to bring practical knowledge and expertise to national policy dialogue.

Integration of HIV functions across the programme team requires closer internal management and collaboration between teams. Many interviewees spoke of the need for greater internal accountability, prioritisation and visibility of PPTCT and paediatric HIV within the current programme. The view was expressed that integration of HIV needs ‘careful nurturing’ to ensure the HIV voice and focus remains strong. Some external respondents expressed the view that as a consequence of UNICEF’s internal integration “it is harder for us to understand the different strategies and to engage, as the different staff each have different views across programme and policy on children and mothers”. Respondents referenced the need for better programme integration: for example, PPTCT and paediatric HIV treatment and care integration in the broader health package and continuum of care and in IMNCI; a broader HIV focus on the socially marginalised; stronger engagement from C4D on PPTCT and paediatric HIV treatment and care. They also referenced the need for more frequent and structured internal collaboration and planning on UNICEF’s overall role in supporting the national HIV response, including accountability across the different divisions.
ICO is appropriately supported by Regional Office for South Asia (ROSA) and HQ. Staff acknowledged the strength of the ROSA in PPTCT but noted the overall reduction in technical support, financial resources and capacity over time. Nonetheless, ROSA and HQ have made helpful contributions to the work of ICO. For example, ROSA provided quality assurance for the GF RRC2 draft proposal, strengthening the country submission. HQ have also facilitated and supported the MAC AIDS grant for the Telemedicine Initiative (see Box 1).

4.4.2 Organisation: skills and competencies

UNICEF staff are technically competent, committed and well regarded by MoHFW. Partners value the strong programme management and practical field experience that UNICEF staff bring to TRGs and policy discussions. Staff are considered to be technically strong, proactive, good advocates, and valued for bringing awareness on relevant programme issues and new approaches and technologies. Respondents noted that in the programme scale-up phase UNICEF’s PPTCT staff were strong at all levels, while some feedback suggested that there was not the same level of capacity in paediatric HIV treatment and care... “UNICEF should have had better capacity at national and regional levels, globally [it was] also weak.” Partner organisations noted that during the scale-up phase UNICEF staff had to manage a lot of money and “became project managers rather than agents for change”.

UNICEF consultants placed at the state level are particularly well regarded for their responsiveness and flexibility in supporting a range of programme needs. In Karnataka state, SACs, NRHM and other partners value the technical guidance, commitment, responsiveness, flexibility and solutions-focused approach that the UNICEF consultants bring. As noted above, UNICEF is able to recruit well-qualified and skilled consultants; however, this has in places created a dependency on these consultants.

4.4.3 Organisation: planning and systems

Systems for work plan development are rigorous and functional but weaker in linkages to individual performance monitoring. While global and regional HIV priorities are mirrored at country level and systems for translating strategy into objectives and work plans is strong, linking them with individual targets and goals is less strong. It was noted that a new performance management system is being rolled out to better reflect achievement of work plan objectives in individual performance appraisals.

Internal planning and management processes reflect the change in emphasis of PPTCT and paediatric HIV priorities over time. At the time when the HIV section was integrated in RMNCH the number of intermediary results (equivalent to outputs) focused on HIV was reduced as it was felt there was: (a) too many intermediate results for ICO to focus on; and (b) too much weight on HIV compared to other programme areas and the level of resources allocated to HIV. As a result, in 2013/14 the number of intermediate results was reduced, with one on increasing PPTCT coverage, and another focused on increasing antenatal care coverage (which includes HIV testing in the integrated model) with indicators and activities remaining the same. The 2015 mid-term review of the 2013–17 results matrix collapsed 40 outputs to 31 with HIV objectives mainstreamed across CP, education and health.

Feedback suggests that HIV priorities could be more adequately prioritised in management and coordination processes to secure commitment and accountability for programme performance at all levels, if programme goals of e-MTCT and ending AIDS by 2030 are to be reached. Concern was expressed that HIV and PPTCT and paediatric HIV progress is only discussed at key planning moments resulting in minimal cross-organisational review. It was suggested that achievement of HIV results, including PPTCT and paediatric HIV, also be regularly reviewed by relevant senior staff with a focus on high level barriers to success.
UNICEF’s internal systems can be slow during periods of dynamic change. Internal systems are reported as being restrictive in developing new partnerships during dynamic periods of change and when speedy responses are necessary. Between 2008–10, in the scale-up phase of PPTCT and paediatric HIV, staff report needing to work quicker than processes and systems allow, with formal partnership development requiring lengthy processes of internal dialogue through various levels and committee approval processes, hampering timely partnership development.

4.4.4 Analysis against the INK management model

The Instituut Nederlandse Kwaliteit (INK) Management Model provides a diagnostic framework to explore the extent to which UNICEF as an organisation is set up to leverage its comparative advantage, respond over time to the changing external environment, and deliver on its overall objectives. The INK model focuses on five organisational elements, as shown in Figure 5. The table below provides a summary of evidence against the elements observed at ICO and will contribute to a more comprehensive global analysis for the final report.

Table 1: Analysis of PPTCT and paediatric HIV within programmes section against elements of the INK management model

<table>
<thead>
<tr>
<th>Focus area</th>
<th>Evident in the ICO</th>
<th>Less evident in the ICO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Leadership</strong> – attitude and behaviour of people with guiding responsibility</td>
<td></td>
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<tr>
<td></td>
<td>• Staff from all levels of the ICO are recognised for their strong technical contribution, field knowledge and commitment to HIV issues in India.</td>
<td>• There is an absence of regular planning and review processes across health, C4D and CP following the disbanding of the HIV team in 2012</td>
</tr>
<tr>
<td></td>
<td>• Working relationships with government are productive at both national and state level</td>
<td>• HIV is less visible as an organisational priority following restructuring and HIV staff downsizing</td>
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<tr>
<td></td>
<td>• Partner engagement and collaboration is strong</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ICO is a recognised advocate for equity, rights and gender-sensitive programming</td>
<td></td>
</tr>
<tr>
<td><strong>2. Staff management</strong> – fully using the potential of knowledge and expertise</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Programme management and technical skills for PPTCT and paediatric HIV are strong and highly valued</td>
<td>• Team working and systematic collaboration across programme areas with HIV responsibilities could be stronger</td>
</tr>
<tr>
<td></td>
<td>• Field office staff and field consultants add value and are highly appreciated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Roles of CO, RO, and HQ are clear and complementary</td>
<td></td>
</tr>
</tbody>
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19 [http://www.toolshero.com/strategy/ink-model/] – it should be noted that the INK Management Model also has additional components, linked to results areas; however, this dimension of the evaluation is focused on the organisational aspects of UNICEF and therefore the focus is on these five areas.
Focus area | Evident in the ICO | Less evident in the ICO
--- | --- | ---
3. Strategy and policy – the way in which strategy is translated into objectives | * ICO is responsive to learning and new developments  
* The organisational structure has evolved over time and is adaptive to external changes  
* Field structures enable close engagement with programme delivery  
* There is a strong focus on the benefits of programme integration | * The prioritisation and sustained resourcing of PPTCT and paediatric HIV treatment and care have reduced over time  
* Visibility of PPTCT and paediatric HIV treatment and care have reduced following integration within MH

4. Management of resources – how resources are handled | * Strong systems exist for managing financial and human resources | * Systems for linking organisational objectives and personal performance are limited

5. Process and systems – how the organisation identifies, designs, manages, improves or innovates systems | * Planning and budgeting processes are transparent and effective | 

### 4.5 Cross-cutting issues

#### 4.5.1 Gender and rights

UNICEF’s mandate and its articulation of a gender-sensitive and human/child rights-based approach is visible to partners with more work to do in promoting gender and rights in integrated HIV programming. External stakeholders note UNICEF’s voice in TRGs has led to better inclusion of gender and rights issues in national policies and strategic plans over time, and has influenced guidelines and the provision of services to better recognise the needs of women and children.

Internal and external stakeholders expressed the view that UNICEF’s work on gender and rights was clear to external stakeholders in the development and roll-out phase of PPTCT and paediatric HIV programming. The work is now less visible and understood, with more work to do in positioning and promoting gender and human/child rights more actively within the framework of integrated HIV programming. For example, this might include further reflection in policies and plans on the importance of engaging men in programme delivery, given India is a patriarchal society. Gender issues and key populations were areas also mentioned for further emphasis.

UNICEF has been a strong voice in ensuring the availability of health information systems data and research to improve targeted programming and the focus on gender, equity and rights. Examples include the push for age, gender and caste-disaggregated data noted by all UN partners, and research initiated by ICO with CHAI and NACO. The research shows significant differences in the number of male compared with female children registered in ART centre and initiating ART, indicating a gender inequity in the initial access to services.

UNICEF has focused on children’s rights to HIV treatment and care through its support to PPTCT and paediatric HIV programmes, raising awareness of children’s right to treatment and care through support to nationwide children’s consultations in 2006 which influenced NACP III. UNICEF worked with child welfare committees and collaborated with non-institutional community-based support centres to

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push for child friendly procedures in the national HIV response and was an important voice in policy development and in implementation of the paediatric HIV treatment and care programme in 2006.

**UNICEF focused on legal and policy frameworks** for the rights of HIV-positive children supporting work to update the Juvenile Justice Act and support to NACP III, to better reflect their needs. UNICEF worked to link families with HIV-positive children to social protection schemes, working through district-level authorities to influence local policy and approaches. Karnataka state proved a favourable environment for taking up these issues, with strong local government and devolved responsibility. Through its child protection work, UNICEF looked at the state as the duty bearer empowering families to demand their rights. It was noted that UNICEF’s rights work was stronger from 2005 to 2012/13, with concern expressed that reduced support to civil society may impact on the rights space in India.

### 4.5.2 Equity

**UNICEF’s approach to equity** is focused on achieving universal access to quality care with a geographical focus on priority states. UNICEF’s field structure of offices has allowed it to have a strong presence in many of the country’s priority states where HIV prevalence is high. MoHFW noted that “we have a composite index of the 184 high priority, poorly performing districts and UNICEF supports us in 75% of these. They are very focused on equity”. Increasing coverage requires significant national and state-level commitment and resources to fully integrate HIV with RMNCH service provision, and stakeholders have expressed the view that new approaches and tactics are required to reach the underserved. One partner noted “equity means working with the poorest of poor and UNICEF’s contribution is very specific to ensure that there is equal emphasis on poor”. Further focus on innovations such as telemedicine were examples given for enabling improved access to services from remote and marginalised groups.

UNICEF recognised the importance of engaging civil society networks to mobilise communities to reach universal access targets in the roll-out phase of PPTCT and paediatric treatment and care, and increasing coverage will require a further focus. In Karnataka state there is evidence of UNICEF supporting Karnataka Network of Positive People’s outreach work for case finding and follow-up. Respondents reflected on the need for UNICEF to focus beyond geography and universal access and embrace an equity approach focused on coverage of the most hard-to-reach women and their children who have limited access to services (e.g. female sex workers, female injecting drug users, socially marginalised, low caste, geographically remote and the very poor). PLHIV networks expressed the need for UNICEF, in a concentrated epidemic and with a view to e-MTCT, to focus on these groups although yield may be lower rather than focusing on overall coverage as even within high performing areas, there is some sense that the most disadvantaged groups may be left behind.

**UNICEF has advocated for a greater focus on equity, resulting in an increased GOI commitment over time for universal testing and access to treatment, although there is a gap between policy and practice.** UNICEF is one of few stakeholders championing equity. UNICEF’s focus on equity helped to push NACO and MoHFW to focus on women and children, in particular UNICEF pushed for the treatment of pregnant women as well as children. With others, UNICEF’s focus on marginalised groups contributed to a change in GOI discourse and led to more equitable policies that are noted in GOI frameworks. GOI has had a greater focus on children since 2005 and UNICEF has helped shape this response in supporting NACO and SACS in programme roll-out. UNICEF is noted for supporting the inclusion of equity-specific statements in NACP IV, for its situational analysis on HIV sensitive social protection21 and the national wide study on social protection and children affected by HIV.22

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21 HIV Sensitive Social Protection – A situational analysis across different stakeholders in the district of Khurda and Koraput, Odisha, Mar2012.

5 Achievements and challenges

5.1 Achievements

- UNICEF has been a key player and valued contributor to the policy shifts to more efficacious treatment regimens and scale-up of PPTCT and paediatric HIV services through:
  - its initial role in demonstrating the benefits and practicalities of introducing PPTCT and paediatric ART (i.e. through piloting, testing and initial introduction in a few states, as well as commodity management);
  - the provision of technical and programmatic support and guidance for strategy and guideline development (e.g. through TRGs);
  - targeted advocacy efforts for the adoption of policies to offer universal testing and lifelong ART for HIV among pregnant women and their babies, alongside the integration of HIV within RMNCH service provision.

- UNICEF has made valuable contributions to building technical and programmatic capacity at the national, state and district levels, including through support for curriculum development, delivery of trainings through the ToT approach, and provision of human resources, particularly at the state and district levels through the deployment of consultants.

- UNICEF’s field structure enables support to state-level implementation in a practical and meaningful manner through direct engagement and support to ICTCs, health facilities, referral hospitals, laboratories and civil society organisations at the state and district level.

- UNICEF has worked well alongside and complemented the work of other UN agencies with a particular area of value add-in bringing knowledge and awareness of the practicalities in the field to the development of national programme strategies and guidelines to ensure that they are realistic and able to be executed in the field.

- UNICEF has successfully engaged a variety of stakeholders in PPTCT and paediatric HIV service provision and decision making, including private sector health providers in PPTCT and paediatric HIV service provision, facilitating the engagement of civil society in national policy, strategy and guideline development processes, and engaging HIV-positive networks to mobilise communities and reduce barriers to accessing services.

- UNICEF has successfully engaged private sector health service providers to increase coverage training them in the provision PPTCT and paediatric HIV and bringing them into the TRG dialogue resulting in stronger linkages with NACO, improved regulation of private sector providers and their adoption of national protocols.

- UNICEF has supported some promising innovative approaches for improved system efficiency, including systems for line tracking and follow-up of HIV-positive patients (e.g. the adjustment to the MCTS, and an SMS enabled EID follow-up system), and expanding services to harder-to-reach areas and populations through a telemedicine initiative.

- UNICEF has made a valuable contribution to the design and implementation of M&E and surveillance systems, and in the monitoring of strategic information to check the quality of reporting, particularly through its field presence.
5.2 Challenges

5.2.1 Programmatic challenges

- The significant gaps in coverage of PPTCT and paediatric HIV services mean that sustained commitment and resources are required, alongside awareness of best practices and strategies that work, to ensure that the integration agenda is fully implemented across the country and the objective of universal HIV testing is achieved.

- Given the devolved responsibility and diversity and complexity of the health system between states, there is often not a ‘one size fits all’ approach to scaling up service provision, and there are challenges in developing knowledge products on best practices and examples of success that are widely applicable to other states and settings. For example, when the MCTS initiative has been fully rolled out and embedded within health system processes in Karnataka, it would need adaptation to other settings as IT frameworks vary from state to state.

- Alongside the continued integration and roll-out of PPTCT and paediatric HIV services across the country, there are some concerns regarding the quality of service provision, and specifically a lack knowledge about the quality of service provision, due to a lack of continuous monitoring and supervision.

5.2.2 Challenges for UNICEF

- While the strategy to integrate HIV within the RCH programme internally is appropriate, given the need for a sustained response to increase India’s coverage of PPTCT and paediatric HIV services, there is a critical need to ensure that the visibility of HIV as an organisation priority is not diminished. This is important both:
  - Internally – i.e. to ensure that core office functions such as resource mobilisation and C4D are still available to support PPTCT and paediatric HIV, as required;
  - Externally – i.e. to ensure that country stakeholders remain aware of UNICEF’s active presence in this space, and UNICEF is able to continue its role in advocating for and supporting the country to scale up services and reach elimination.

- In light of the finding that some aspects of UNICEF’s support – notably through the provision of consultants working within SACS at the state level – are very ‘hands on’, it will be important for UNICEF to consider and review the role of these consultants in building local capacity for service provision to ensure longer-term sustainability. It is, however, noted that systemic problems in the recruitment of adequately qualified staff at the state level, mainly due to government salaries being too low to attract suitable candidates, to support the programme may mean that without consultants playing this active role, programme performance would suffer.

6 Implications for UNICEF

Looking ahead, the evaluation team has identified the following implications for ICO, to support the continuation of UNICEF’s work to date and the strengthening of its approach to PPTCT and paediatric HIV going forward.

- Leverage the strong relationships with MoHFW, NACO and other national stakeholders to maintain commitment to PPTCT and paediatric HIV within an integrated package of RMNCH services, having particular focus securing political commitment and resources to achieve universal testing and lifelong ART for HIV among all pregnant women and their babies, and the elimination of mother-to-child transmission of HIV.
• Continue to ensure that RMNCH and other related policies, strategies and guidelines are HIV sensitive, as part of the 2013-17 CPD – for example, it might be useful to review of the India Newborn Action Plan to ensure that this is consistent and appropriate for the elimination of mother-to-child transmission of HIV.

• Continue to take a strategic approach to programme engagement with a sustained focus on influencing national strategy, policy and guideline development, with a more defined emphasis on:
  
  o Moving beyond a focus on equity related to universal access and ensuring that no one is left behind, by identifying and targeting gatekeepers that act as bottlenecks to women accessing RMNCH services, developing a response plan to improve PPTCT and paediatric HIV service coverage rates and developing a gender action plan. UNICEF has worked to prioritise these populations in some areas and is well placed to think through these issues and approaches (e.g. employing bottleneck analysis, engagement of civil society) and promoting such approaches in national policy dialogue.
  
  o Working with staff at the field level to identify, support introduction and test new processes and technologies for improved programme efficiency – the Telemedicine and MCTS Initiatives are good examples of where UNICEF has been able to have a meaningful role and this should be replicated where possible. In particular, there is likely to be significant potential to introduce streamlined processes for the smooth integration of HIV and RMNCH services, the targeting of key populations and the hard to reach, and around the further engagement of the private sector (e.g. related to incentivising reporting and data capture).
  
  o Sharing lessons learned and best practices to create ‘buy-in’ at the state level and encourage further roll-out, as well as to promote the benefits of innovations tested in other areas for improved systems efficiencies. Given the diversity and complexity of the health system between states, a more tailored approach to sharing best practices and lessons learned is often needed to ensure they are relevant for other states. UNICEF is well placed to provide this insight.

• Adequately reflect PPTCT and paediatric HIV priorities in performance frameworks and improve management and accountability mechanisms between teams with HIV responsibilities to ensure that these teams are incentivised to meaningfully contribute to the goals and objectives for PPTCT and paediatric HIV, and resources are used optimally. For example, this might include better leveraging C4D capacity to contribute to PPTCT and paediatric HIV intermediary outcomes.

• We note that ICO is well funded and that additional resources are not necessarily required to support the national programme. Nonetheless, there may be specific instances where grant funding or in-kind support can benefit the programme, such as by testing and/or scaling up innovations. For example, the MAC AIDS grant was critical to UNICEF’s decision to explore innovative systems solutions that are inherently risky, and led to the piloting of the Telemedicine Initiative (which may not have been supported otherwise). There may also be opportunities to engage a telecommunications company for the provision of expertise and infrastructure to support the government’s future efforts to scale up the initiative. UNICEF should continue to look for further opportunities of this kind, where innovative approaches can be tested and, if successful, integrated into the wider national programme for improved system efficiency.
Implications of the country case study findings for the evaluation

The India case study has been a useful exercise and has met the purposes laid out in the evaluation design. In particular, the process has allowed for UNICEF’s role and contributions in PPTCT and paediatric HIV to be explored in some detail over the evaluation period (2005–15), as well as providing useful inputs for the testing and validation of the theory of change that will guide the evaluation (see Annex VI). However:

- In the context of programme resource needs being largely met by GOI and Global Fund, UNICEF has played an upstream/high level role, alongside that of other UN agencies and partners. As such, attribution of programme successes to UNICEF’s role is difficult.

- As previously noted, NACO and MoHFW have played a very strong role in: leading and coordinating the PPTCT and paediatric HIV programme over time; mobilising and leveraging partner resources; and in the generation, analysis and dissemination of strategic information. As such, UNICEF’s role in these areas has been less required than in other countries.

- These issues nonetheless present an interesting comparison to other country experiences and largely reflect the nature of India as a large and economically developing lower-middle-income country.

Further details are included in the Inception Report for this evaluation.
Annex I: Terms of reference for in-depth country studies

Overview of the evaluation

Itad is a UK-based consultancy company that has been commissioned by UNICEF to undertake an evaluation of its activity in the PMTCT and paediatric HIV treatment, care and support. The purpose of this evaluation is to support accountability and learning in relation to UNICEF’s efforts to scale up PMTCT and paediatric care and treatment programmes and to document its contribution towards elimination of mother-to-child HIV transmission and an AIDS-free generation for children. By looking over the past 10 years of UNICEF’s PMTCT and paediatric HIV engagement, the evaluation will provide evidence and lessons learned to enhance the understanding of the organisation and other stakeholders on how strategies and programmes have evolved, what has worked, has not worked, and why.

The evaluation will assess four particular aspects of PMTCT and paediatric HIV treatment programming, namely:

1. Thematic leadership, advocacy and partnership
2. Resource mobilisation
3. Strategic information, knowledge generation and dissemination, and
4. Key aspects of UNICEF’s organisation.

It will also consider the cross-cutting issues of gender, equity, and human rights. The findings will be used to guide i) effective action towards the achievement of the UNICEF Strategic Plan HIV outcome and ii) UNICEF positioning in the post-2015 HIV agenda as guided by the UNAIDS 2016–21 strategy.

As part of the data collection for this evaluation, Itad is undertaking case studies in a total of seven countries – four involving country visits and three conducted remotely through a desk review and phone interviews. The findings from country level are being supplemented with a structured document review, an online survey, and interviews with key stakeholders at global and regional levels.

This document details the process for the country visits in ESARO and WCARO, to be undertaken during the period of April–May 2016.

Purpose of the country case studies

The evaluation is taking as its starting point the theory of change (ToC) for UNICEF’s work in PMTCT and paediatric HIV over the period of 2005–15. The purpose of the case studies is to record how UNICEF’s engagement in this area has played out at country level, and help test and validate the ToC. It is important to note the following:

- Each case study has been selected because of the learning opportunity offered to the evaluation.
- The approach to each is focused on recording experiences rather than measuring or assessing individual country performance.

Approach to data collection and analysis

Each mission will last around seven working days (over a period of two weeks). Each team will arrive in-country with a clear case study terms of reference, detailed draft agenda, and having already performed a remote desk study and stakeholder listing to ensure that the time the evaluators spend in-country can be used as effectively and efficiently as possible. Figure 1 below summarises the proposed process through which each of the country studies will be implemented. However, the first country case study visit will be used as an opportunity to refine the process. This will be attended by four members of the core team to gain consensus and maximise consistency of approach.
**Step 1:** Prior to the visit, a *desk review phase* will focus on enabling the team to gain a comprehensive understanding of the background to PMTCT/Paediatric HIV/AIDS programme activities in each case study country, and extracting available secondary evidence – for example on key events.

**Step 2:** During this stage, an *agenda for the country case study* will be agreed, based on a *stakeholder mapping* exercise undertaken by the evaluation team and UNICEF country office (CO). The evaluation team will contact the CO to discuss this agenda including possible stakeholder interviews.

**Step 3:** Each mission will start in-country with a *brief kick-off meeting* with UNICEF staff to orientate the team to the national context, provide background to the UNICEF office, and to enable an initial exploration of issues arising from remote desk review.

**Step 4:** Following this workshop, the evaluation team will then conduct *semi-structured interviews* (and where appropriate, small group discussions) with key in-country stakeholders – including UNICEF staff, government, and partners. These interviews will be designed to elicit further information on the thematic areas of interest.

**Step 5:** At the end of the country visit, the evaluation team will share debriefing notes of observations and preliminary findings through a *slide set with the UNICEF CO*, and hold a feedback discussion.

**Step 6:** Subsequently, a *case study report* will be written up for each country and shared with the CO for comments (approximately two weeks after the end of the country visit).

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**The team**

The country case studies will be conducted by a team of two consultants belonging to the core evaluation team, over a total input period of seven working days in the field per country. This team will be complemented by a national expert who will be normally resident in-country and can support on collation of documents and identification and contacting of stakeholders, and will bring in-depth understanding of the country context. One consultant will act as lead consultant in order to ensure that responsibility for delivery of the report is clearly located.

**Guidance to case study country offices**

The agenda should ideally be agreed between the CO and the evaluation team at least a week before the visit to allow sufficient time for in-country preparation. In order to appropriately support the case study visit, the team suggest that the CO:

1. **Confirm suitability of suggested dates** as soon as possible.
2. **Identify someone to act as a point of contact** to organise the schedule proposed below.
3. **Share the terms of reference** with those who might be consulted during the visit.
4. **Identify documents**/create a list of key documents that would be useful to share with the evaluation team.
5. **Consider which staff members** it would be useful for the evaluation team to meet and whether this is most appropriate on a one-to-one basis or in a focus group (or both). Ideally, this should include current staff members as well as staff who were involved during the period of interest for the evaluation (2005–15). If necessary, interviews can be conducted remotely over Skype.
6. **Consider which external stakeholders** the evaluation team should meet. This should include representatives from all key development partners working in HIV/AIDS at country level, as well as relevant government stakeholders. Ideally, this should include stakeholders who were involved during the period of interest for the evaluation (2005–15), as well as those who are currently in post.

7. **Feedback on preliminary findings**: Please consider which staff members should be included in the meeting to discuss preliminary findings.

The schedule for the visit is presented below. This includes a two-day state visit to Karnataka. This state was selected as it has historically been a state with high HIV prevalence, one of the first states to introduce and roll-out PPTCT in the country, and has had significant support from UNICEF over the evaluation period.

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Monday</th>
<th>PM: Meeting with UNICEF ICO, followed by stakeholder interviews (UNICEF staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2</td>
<td>Tuesday</td>
<td>National stakeholder interviews, Delhi (UNICEF staff)</td>
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<tr>
<td>Day 3</td>
<td>Wednesday</td>
<td>National stakeholder interviews, Delhi (government and partners)</td>
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<tr>
<td>Day 4</td>
<td>Thursday</td>
<td>State stakeholder interviews, Karnataka (UNICEF, government, partners)</td>
</tr>
<tr>
<td>Day 5</td>
<td>Friday</td>
<td>State stakeholder interviews, Karnataka (UNICEF, government, partners)</td>
</tr>
<tr>
<td>Day 6</td>
<td>Saturday</td>
<td>National stakeholder interviews, Delhi (as required) and internal team working</td>
</tr>
<tr>
<td>Day 7</td>
<td>Sunday</td>
<td>Internal team working</td>
</tr>
<tr>
<td>Day 8</td>
<td>Monday</td>
<td>National stakeholder interviews, Delhi (government and partners)</td>
</tr>
<tr>
<td>Day 9</td>
<td>Tuesday</td>
<td>National stakeholder interviews, Delhi and presentation of initial findings to ICO</td>
</tr>
</tbody>
</table>
# Annex II: India country visit agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda</th>
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</thead>
<tbody>
<tr>
<td><strong>Day–1 (Delhi) 2 May 2016</strong></td>
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</tr>
</tbody>
</table>
| 1400–1445 | Entry Meeting  
Chair: Rep/ Dep Rep  
PPE, RCH, C4D, CDN, CP, HR Sections, m4D Unit, Hyderabad Field Office |
| 1445–1530 | Meeting with  
Dr Karanveer Singh, Nutrition Specialist, UNICEF–Delhi  
Meeting with  
Dr Mario Mosquera, Chief C4D, UNICEF–Delhi |
| 1530–1600 | Travel to Nirman Bhavan |
| 1600–1700 | Meeting with  
Dr Raghuram Rao (National Programme Officer–ICTC/ PPTCT, NACO:2010–14)  
Assistant Director General, Ministry of Health & Family Welfare, Govt of India |
| 1700–1800 | Meeting with  
Dr Dinesh Baswal, Deputy Commissioner, Maternal Health  
Ministry of Health & Family Welfare, Government of India |
| **Day–2 (Delhi) 3 May 2016** |                                                                                                                                 |
| 0730–0830 | Discussions with  
Dr Sudha Balakrishnan, Health Specialist, UNICEF–Delhi |
| 0830–0930 | Meeting with  
Mr Manoj Pardesi, General Secretary, National Coalition Of People Living With HIV in India |
| 0930–1000 | Travel to Nirman Bhavan |
| 1000–1100 | Meeting with  
Dr Damodar Bachani (DDG-BSD &CST, NACO: 2005–10)  
Deputy Director General  
Ministry of Health & Family Welfare, Government of India |
| 1100–1115 | Travel back to UNICEF |
| 1115–1200 | Interview with  
Ms P. Kousalya, President, Positive Women Network |
| 1200–1230 | Travel to Nirman Bhavan |
| 1230–1300 | Interview with  
Dr Sunil Khaparde (DDG-BSD, STI, NACO: 2015)  
Deputy Director General, Ministry of Health & Family Welfare, Government of India |
| 1300–1330 | Lunch |
| 1330–1430 | Interview with  
Dr Po-Lin Chan, (Medical Officer-HIV-WHO-India: 2005–10)  
Senior Advisor Hepatitis/HIV/STI, WHO-China |
| 1430–1530 | 1. Interview with  
Dr Mamta Manglani, Professor and Head of Department, Paediatrics, Chief, Div. of Hematology-Oncology Programme Director, Paediatric Centre of Excellence for HIV Care  
Lokmanya Tilak Municipal Medical College & General Hospital  
Sion, Mumbai, Maharashtra  
2. Interview with  
Dr Prakash Gurnani, Chief of Field Office, UNICEF Gujarat (Retd) and pioneer of PMTCT Programme in India |
<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda</th>
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</thead>
<tbody>
<tr>
<td>1530–1600</td>
<td>Travel to WHO-India Office</td>
</tr>
<tr>
<td>1600–1700</td>
<td>Meeting with Dr Nicole Seguy, Team Leader Communicable Diseases Cluster (Current) and Dr Paul Francis, National Professional Officer, MCH (Current), WHO-India</td>
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<tr>
<td>1700–1730</td>
<td>Travel back to UNICEF</td>
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**Day–3 (Delhi) 4 May 2016**

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda</th>
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<tbody>
<tr>
<td>0900–0945</td>
<td>Interview with Amit Nagaraj, World Bank</td>
</tr>
<tr>
<td>0945–1030</td>
<td>1. Discussions with Bernadette Rai, M&amp;E Officer, m4D</td>
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<tr>
<td></td>
<td>2. Discussions with Vijayalakshmi Vasudevan, Budget Officer, m4D</td>
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<tr>
<td>1030–1130</td>
<td>1. Interviews with Dr D.C.S. Reddy, WHO-India (Retd) – Surveillance</td>
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<tr>
<td></td>
<td>2. Interview with Dr Tushar Rane, Chief of Field Office, UNICEF–Guwahati</td>
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<tr>
<td>1130–1230</td>
<td>Discussions with Dr Khanindra Bhuyan, Health Specialist, UNICEF–Mumbai</td>
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<td></td>
<td>Swati Mohapatra, Communication Specialist, UNICEF–Mumbai</td>
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<tr>
<td></td>
<td>Telephone interview with Dr K. Sudhakar (CDC–India 2005–15)</td>
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<tr>
<td></td>
<td>Retd Senior Advisor CDC–India</td>
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<tr>
<td>1230–1315</td>
<td>Discussions with Dr Dick Chamla, Paediatric HIV Lead–UNICEF NYHQ</td>
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<tr>
<td>1315–1400</td>
<td>Lunch</td>
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<tr>
<td>1430–1500</td>
<td>Telephone Interview with Dr Madhulika Jonathan, Chief of Field Office, UNICEF–Ranchi</td>
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<tr>
<td>1500–1600</td>
<td>1. Discussions with Michiru Tamanai, Chief HR, UNICEF India</td>
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<td></td>
<td>2. Meetings with Shweta Dahiya, Resource Mobilisation Section</td>
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<td></td>
<td>Travel to Bangalore</td>
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</tbody>
</table>

**Day–4 (Bangalore) 5 May 2016**

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda</th>
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<tbody>
<tr>
<td>0830–0930</td>
<td>Discussions with Dr Lalitha Hande, HIV/AIDS Consultant (UNICEF supported), Karnataka</td>
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<tr>
<td></td>
<td>Dr Sanjeev Upadhayya, Health Specialist, UNICEF–Hyderabad</td>
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<tr>
<td></td>
<td>Dr Meena Som, Health Specialist, UNICEF–Hyderabad</td>
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<tr>
<td>0930–1000</td>
<td>Travel to office of Positive Network at Yeshwantpur</td>
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<tr>
<td>1000–1030</td>
<td>Discussions with Ms Saroja, Director, Karnataka Network of Positive People</td>
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<tr>
<td>1030–1100</td>
<td>Travel to Health Directorate at Anand Rao circle</td>
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<tr>
<td>1100–1330</td>
<td>1. Interviews with Dr H.C. Ramesh, retired PD RCH</td>
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<tr>
<td></td>
<td>Dr Renuka, Project Director, Reproductive and Child Health</td>
</tr>
<tr>
<td></td>
<td>Dr Dhanyakumar, former Director Health Services</td>
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<td></td>
<td>Dr Karur, retired Additional Project Director, KSAPS, Consultant Mental Health (Current)</td>
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<tr>
<td></td>
<td>Mr Chakravarthy Mohan, former Project Director, KSAPS, Commissioner, Collegiate education (Current)</td>
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<td></td>
<td>Mr Raveendra, former PD KSAPS, Commissioner BBMP (Current)</td>
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<td></td>
<td>Dr Mohan Raj, retired PD RCH</td>
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<tr>
<td>Time</td>
<td>Agenda</td>
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<tr>
<td>1330–1400</td>
<td>Dr Jagdish, I/C DPCU officer (Current)</td>
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<td></td>
<td>Dr Rajkumar, former DAPCU officer Kolar, Deputy Director ASHA programme</td>
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<tr>
<td></td>
<td>(Current)</td>
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<tr>
<td></td>
<td>Dr Ashok, former DAPCU officer, Udupi; Deputy Director Maternal Health</td>
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<tr>
<td></td>
<td>(Current)</td>
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<tr>
<td>1400–1430</td>
<td>Lunch</td>
</tr>
<tr>
<td>1430–1500</td>
<td>Interview with Mr Ajey Bhardwaj Avni Health Foundation, Maharashtra</td>
</tr>
<tr>
<td>1500–1630</td>
<td>Meeting with Dr Suresh Mohammed, Ex NPO PPTCT, NACO</td>
</tr>
<tr>
<td>1630–1700</td>
<td>Travel to MS building</td>
</tr>
<tr>
<td>1700–1730</td>
<td>Discussion with Ms Narmada Anand, PD ICPS, DWCD (9480354409)</td>
</tr>
<tr>
<td>1830–1900</td>
<td>Mr Sonykutty George, Child Protection Specialist, UNICEF–Hyderabad</td>
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<tr>
<td><strong>Day–5 (Bangalore) 6 May 2016</strong></td>
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<tr>
<td>0830–0900</td>
<td>Discussions with Dr Rehana Begum</td>
</tr>
<tr>
<td>0900–0930</td>
<td>Discussions with Dr Balasubramanaya, CEO, Swami Vivekananda Youth Movement</td>
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<tr>
<td>0930–1015</td>
<td>Travel to Victoria hospital</td>
</tr>
<tr>
<td>1015–1200</td>
<td>Discussions to understand integration of PPTCT with MCTS</td>
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<tr>
<td></td>
<td>Dr Satish Senior Medical Officer, ART centre</td>
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<tr>
<td></td>
<td>Dr Ravi Kumar, Medical Officer, ART centre</td>
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<tr>
<td>1200–1245</td>
<td>Travel to NIMHANS</td>
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<tr>
<td>1245–1400</td>
<td>Discussions with EID team</td>
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<tr>
<td></td>
<td>Dr Anita Desai, Professor and Head of Neurovirology Department, NIMHANS</td>
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<tr>
<td></td>
<td>Dr Ravi, Professor, Department of Neurovirology, NIMHANS</td>
</tr>
<tr>
<td>1400–1500</td>
<td>Lunch</td>
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<tr>
<td>1500–1515</td>
<td>Travel to IGICH</td>
</tr>
<tr>
<td>1515–1630</td>
<td>Discussions with Paediatric Centres of Excellence team</td>
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<tr>
<td></td>
<td>Dr Asha Benakappa, Director, Indira Gandhi Institute of Child Health</td>
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<tr>
<td></td>
<td>Dr G.N. Sanjeeva, Assistant Professor, IGICH</td>
</tr>
<tr>
<td><strong>Day–6 (Saturday) 7 May 2016</strong></td>
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<tr>
<td></td>
<td>Travel back to Delhi</td>
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<tr>
<td></td>
<td>Analysis and report writing</td>
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<tr>
<td><strong>Day–7 (Sunday) 8 May 2016</strong></td>
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<tr>
<td></td>
<td>Analysis and report writing</td>
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<tr>
<td><strong>Day–8 (Monday) 9 May 2016</strong></td>
<td></td>
</tr>
<tr>
<td>0835–0900</td>
<td>Travel to UNAIDS office from UNICEF office</td>
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<tr>
<td>0915–1015</td>
<td>Meeting with UNAIDS Team:</td>
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<tr>
<td></td>
<td>UNAIDS Country Director–Oussamma Tawil, Nandini Dhingra Kapoor, Savina</td>
</tr>
<tr>
<td></td>
<td>Ammassari, Taoufik Bakkali (on telephone/Skype)</td>
</tr>
<tr>
<td>1015–1045</td>
<td>Travel back to UNICEF</td>
</tr>
<tr>
<td>1200–1230</td>
<td>Meeting with Henriette Ahrens, Dep Rep</td>
</tr>
<tr>
<td>1500–1400</td>
<td>Discussions with Dr Yaron Wolman – Chief Health and Dr Gagan Gupta</td>
</tr>
<tr>
<td></td>
<td>Newborn priority Lead, UNICEF – Health section</td>
</tr>
<tr>
<td>1600–1700</td>
<td>Debriefing meeting</td>
</tr>
<tr>
<td><strong>Day–9 (Tuesday) 10 May 2016</strong></td>
<td></td>
</tr>
<tr>
<td>1400–1500</td>
<td>Discussions with Sudha</td>
</tr>
</tbody>
</table>
### Annex III: Stakeholder list

<table>
<thead>
<tr>
<th>Name of Person</th>
<th>Title</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNICEF</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Dick Chamla</td>
<td>Paediatric HIV Lead</td>
<td>UNICEF – HQ</td>
</tr>
<tr>
<td>Henriette Ahrens</td>
<td>Deputy Representative</td>
<td>UNICEF – Delhi</td>
</tr>
<tr>
<td>Dr Yaron Wolman</td>
<td>Chief of Health</td>
<td></td>
</tr>
<tr>
<td>Dr Gagan Gupta</td>
<td>Newborn Lead, Health Section</td>
<td></td>
</tr>
<tr>
<td>Dr Karanveer Singh</td>
<td>Nutrition Specialist</td>
<td></td>
</tr>
<tr>
<td>Dr Mario Mosquera</td>
<td>Chief C4D</td>
<td></td>
</tr>
<tr>
<td>Dr Sudha Balakrishnan</td>
<td>Health Specialist</td>
<td></td>
</tr>
<tr>
<td>Bernadette Rai</td>
<td>M&amp;E Officer, m4D</td>
<td></td>
</tr>
<tr>
<td>Vijayalakshmi Vasudevan</td>
<td>Budget Officer, m4D</td>
<td></td>
</tr>
<tr>
<td>Michiru Tamanai</td>
<td>Chief HR</td>
<td></td>
</tr>
<tr>
<td>Shweta Dahiya</td>
<td>Resource Mobilisation Section</td>
<td></td>
</tr>
<tr>
<td>Swati Mohapatra</td>
<td>Communication Specialist</td>
<td></td>
</tr>
<tr>
<td>Dr Madhulika Jonathan</td>
<td>Chief of Field Office</td>
<td>UNICEF – Ranchi</td>
</tr>
<tr>
<td>Dr Sanjeev Upadhyaya</td>
<td>Health Specialist</td>
<td>UNICEF – Hyderabad</td>
</tr>
<tr>
<td>Dr Meena Som</td>
<td>Health Specialist</td>
<td></td>
</tr>
<tr>
<td>Mr Sonykutty George</td>
<td>Child Protection Specialist</td>
<td></td>
</tr>
<tr>
<td>Dr Tushar Rane</td>
<td>Chief of Field Office</td>
<td>UNICEF–Guwahati</td>
</tr>
<tr>
<td>Dr Prakash Gurnani</td>
<td>Chief of Field Office (retired)</td>
<td>UNICEF – Gujarat</td>
</tr>
<tr>
<td>Dr Khanindra Bhuyan</td>
<td>Health Specialist</td>
<td>UNICEF – Mumbai</td>
</tr>
<tr>
<td>Dr Lalitha Hande</td>
<td>PPTCT Consultant (UNICEF supported)</td>
<td>Karnataka</td>
</tr>
<tr>
<td><strong>Government and health facility staff</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Raghuram Rao</td>
<td>National Programme Officer–ICTC/PPTCT and Assistant Director General, NACO</td>
<td>NACO and MoHFW</td>
</tr>
<tr>
<td>Dr Suresh Mohammed</td>
<td>National Programme Officer for PPTCT</td>
<td></td>
</tr>
<tr>
<td>Dr Dinesh Baswal</td>
<td>Deputy Commissioner, Maternal Health</td>
<td>MoHFW</td>
</tr>
<tr>
<td>Dr Damodar Bachani</td>
<td>Deputy Director General for Basic Services Department and Care Support and Treatment</td>
<td></td>
</tr>
<tr>
<td>Dr Sunil Khaparde</td>
<td>Deputy Director General for Basic Services Department</td>
<td></td>
</tr>
<tr>
<td>Ms Narmada Anand</td>
<td>Programme Director ICPS</td>
<td>Ministry of Women &amp; Child Development</td>
</tr>
<tr>
<td>Dr H.C. Ramesh</td>
<td>Programme Director, Reproductive and Child Health, Health Directorate (retired)</td>
<td>MoHFW, Karnataka</td>
</tr>
<tr>
<td>Dr Renuka</td>
<td>Programme Director, Reproductive and Child Health, Health Directorate</td>
<td></td>
</tr>
<tr>
<td>Dr Dhanyakumar</td>
<td>Ex-Director, Health Services, Health Directorate</td>
<td></td>
</tr>
<tr>
<td>Dr Mohan Raj</td>
<td>Programme Director, Reproductive and Child Health, Health Directorate (retired)</td>
<td></td>
</tr>
<tr>
<td>Dr Jagdish</td>
<td>I/C District AIDS Prevention and Control Unit (DAPCU) Officer</td>
<td></td>
</tr>
<tr>
<td>Dr Rajkumar</td>
<td>Ex-DAPCU Officer, Kolar, and Deputy Director ASHA programme (current)</td>
<td></td>
</tr>
<tr>
<td>Dr Ashok</td>
<td>Ex-DAPCU Officer, Udupi, and Deputy Director Maternal Health (current)</td>
<td></td>
</tr>
<tr>
<td>Dr Karur</td>
<td>Additional Project Director and Consultant for Mental Health (Current)</td>
<td>KSAPS, Karnataka</td>
</tr>
<tr>
<td>Mr Chakravarthy Mohan</td>
<td>Ex-Project Director and Commissioner for Collegiate Education</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Position/Positional Details</td>
<td>Organization/Location</td>
</tr>
<tr>
<td>-------------------------------</td>
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<td>---------------------------------------------</td>
</tr>
<tr>
<td>Mr Raveendra</td>
<td>Ex-Project Director</td>
<td></td>
</tr>
<tr>
<td>Dr Satish</td>
<td>Senior Medical Officer</td>
<td>ART centre, Karnataka</td>
</tr>
<tr>
<td>Dr Ravi Kumar</td>
<td>Medical Officer</td>
<td></td>
</tr>
<tr>
<td>Dr Anita Desai</td>
<td>Professor and Head of Neurovirology Department, NIMHANS, Karnataka</td>
<td></td>
</tr>
<tr>
<td>Dr Ravi</td>
<td>Professor, Department of Neurovirology</td>
<td></td>
</tr>
<tr>
<td>Dr Asha Benakappa</td>
<td>Director</td>
<td>Indira Ghandi Paediatric Centre of Excellence, Karnataka</td>
</tr>
<tr>
<td>Dr G.N. Sanjeeva</td>
<td>Assistant Professor</td>
<td></td>
</tr>
<tr>
<td>Dr Ravi Kumar</td>
<td>Medical Officer</td>
<td></td>
</tr>
<tr>
<td>Dr Anita Desai</td>
<td>Professor and Head of Neurovirology Department, NIMHANS, Karnataka</td>
<td></td>
</tr>
<tr>
<td>Dr Mamta Manglani</td>
<td>Professor &amp; Head of Paediatrics, Chief of the Division of Hematology and Oncology, Programme Director for the Paediatric Centre of Excellence for HIV Care</td>
<td>Lokmanya Tilak Municipal Medical College &amp; General Hospital, Mumbai</td>
</tr>
</tbody>
</table>

**Partners**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Positional Details</th>
<th>Organization/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr K. Sudhakar</td>
<td>Senior Advisor (retired)</td>
<td>CDC – India</td>
</tr>
<tr>
<td>Dr Rehana Begum</td>
<td>PPTCT Consultant</td>
<td>Centre for Global Health Research</td>
</tr>
<tr>
<td>Oussamama Tawil</td>
<td>Country Director</td>
<td>UNAIDS</td>
</tr>
<tr>
<td>Nandini Dhingra Kapoor</td>
<td>Senior Programme Advisor</td>
<td></td>
</tr>
<tr>
<td>Dr Po-Lin Chan</td>
<td>Medical Officer for HIV and Senior Advisor Hepatitis/HIV/STI</td>
<td>WHO- China (ex-WHO-India)</td>
</tr>
<tr>
<td>Dr Nicole Seguy</td>
<td>Team Leader Communicable Diseases Cluster</td>
<td>WHO-India</td>
</tr>
<tr>
<td>Dr Paul Francis</td>
<td>National Professional Officer, MCH</td>
<td></td>
</tr>
<tr>
<td>Dr D.C.S. Reddy</td>
<td>Surveillance expert (retired)</td>
<td></td>
</tr>
<tr>
<td>Amith Nagaraj</td>
<td>Operations Officer</td>
<td>World Bank</td>
</tr>
</tbody>
</table>

**Other**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Positional Details</th>
<th>Organization/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Ajey Bhardwaj</td>
<td>CEO</td>
<td>Avni Health Foundation, Maharashtra</td>
</tr>
<tr>
<td>Ms P. Kousalya</td>
<td>President</td>
<td>Positive Women Network</td>
</tr>
<tr>
<td>Ms Saroja</td>
<td>Director</td>
<td>Karnataka Network of Positive People</td>
</tr>
<tr>
<td>Mr Manoj Pardesi</td>
<td>General Secretary</td>
<td>National Coalition Of People Living With HIV in India</td>
</tr>
<tr>
<td>Dr Balasubramanya</td>
<td>CEO</td>
<td>Swami Vivekananda Youth Movement</td>
</tr>
</tbody>
</table>
Annex IV: Country context

Economic and socio-demographic situation

India is the largest democracy and second-most populous country in the world. It is comprised of 29 states and seven union territories within a pluralistic, multilingual, multiethnic society. India is the seventh-largest country by area and is bordered by a host of countries, including Bangladesh, Bhutan, China, Myanmar, Nepal and Pakistan.24

India has been classified as a middle-income country since 2007, with a gross national income per capita of US$1,570, making it one of the world’s poorest middle-income countries.25 However, with a population of 1.3bn, India has the world’s fourth-largest economy with gross domestic product (GDP) exceeding US$2tn.26

The country has witnessed an economic and social revolution since independence in 1947, and has become one of world’s global leaders in a number of sectors, including agriculture, steel, pharmaceuticals, and information and space technologies.27 Social indicators have also improved dramatically over this time with better health conditions and higher life expectancy rates, as well as a quadrupling in literacy rates. The country is, however, still undergoing significant economic transformation as a sizeable middle class is emerging and rapid urbanisation is taking place, with 10m people moving to urban areas each year.

However, while large numbers are escaping poverty (it is estimated that 138m people have been lifted out of poverty between since 2005) there is large-scale inequality, with 270m people still living in poverty.28 This includes inequity between geographies and states (poverty rates are up to four times higher in the poorest states compared to the richest states), and by caste and gender.

Structure of the health system

The National Rural Health Mission (NRHM) was launched in 2005 with the objective of expanding access to quality health care for rural populations. The National Health Mission (NHM) was launched later in May 2013 as a comprehensive scheme that aims to guide states towards providing universal access to healthcare, with a focus on strengthening health systems, institutions and capabilities. The NHM is comprised of the NRHM and the National Urban Health Mission, which was also launched in 2013 to meet the health care needs of the urban population having its focus on urban poor and vulnerable sections.29

The NHM has had a decentralised structure for planning, decision making and financing from national to state and district level. State project implementation plans are developed with inputs from the village to district to state level and seek to address the needs of the state.

Within this context, India has a four-tier sub-district decentralised health care infrastructure comprising district hospitals, community health centres, primary health centres and sub-centres. Auxiliary nurse midwives and accredited social health activists work at the community level to provide outreach services, health information and motivation, early recognition of childhood and maternal risk factors and ill health, and referrals to health facilities.

Table IV.1 below presents the types of health facilities within the Indian health system, the population coverage designed for each, and the number of each type of facility.

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24 National Health Profile 2015, CBHI, MOHFW
29 Budget Brief, National Health Mission (NHM) GOI, 2016–17, Accountability Initiative CPR, India.
Table IV.1: Type of health facility and population coverage

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Population coverage</th>
<th>Number of facilities (March 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>District hospital</td>
<td>One per district (671)</td>
<td>763</td>
</tr>
<tr>
<td>Sub-divisional hospital</td>
<td>Depending on size of district</td>
<td>1,022</td>
</tr>
<tr>
<td>Community health centre</td>
<td>80,000–120,000 population</td>
<td>5,396</td>
</tr>
<tr>
<td>Primary health centre</td>
<td>20,000–30,000 population</td>
<td>25,308</td>
</tr>
<tr>
<td>Sub-centre</td>
<td>3,000–5,000 population</td>
<td>153,655</td>
</tr>
<tr>
<td>Village accredited social health activist</td>
<td>One per 1000</td>
<td>80,0819</td>
</tr>
</tbody>
</table>

Health indicators

India’s health indicators have improved over time, however, maternal and child mortality rates remain high, particularly in some states (e.g. Assam, Uttar Pradesh, Uttarakhand and Rajasthan). A particular issue is the nutritional status of children. In 2013/14, approximately 29% of under 3-years old children were underweight, 15% suffered wasting and 39% were stunted.

Table IV.2 below presents some selected national health indices.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Crude birth rate (births per 1,000 population)</td>
<td>23.8</td>
<td>21.6 (2012)</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>45.6 (2001)</td>
<td>54.8</td>
</tr>
<tr>
<td>Total fertility rate (children per woman)</td>
<td>2.7</td>
<td>2.4 (2012)</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>254</td>
<td>167</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>56</td>
<td>40</td>
</tr>
<tr>
<td>Under-5 mortality rate (per 1,000 live births)</td>
<td>77</td>
<td>52</td>
</tr>
</tbody>
</table>

Financing for health

As shown in Figure IV.1 below, the GOI budget allocations for the NHM increased from US$2.6bn in 2011/12 to US$2.9bn in 2016/17. In 2015–16, this accounted for approximately 60% of funds, with the rest financed by state government budget lines.

GOI expenditure on health has risen from around 0.86% of GDP in 2005/06 to over 1% in 2013/14. However, this is still very low compared to international standards.

30 Source: Rural Health Statistics in India 2015 – MOHFW/GOI.
32 MMR Bulletin, 2011–13, MOHFW, GOI.
35 National Health profile 2015, CBHI, MOHFW India.
Alongside India’s social and economic transformation (notably leading to India’s classification as a middle-income country), the donor landscape has evolved over the evaluation period. In particular, a number of major donors have ceased to provide development assistance to India (e.g., the United Kingdom and the Netherlands) and others have scaled down their assistance (e.g., the United States and Canada). However, this has been offset by large increases from others (e.g., France, Germany, Global Fund and Japan), leading to an overall slight increase in official development assistance (ODA) between 2005 and 2014.

**HIV/AIDS structure and government response**

India initiated HIV prevention activities in the very early stages of the epidemic. The National AIDS Control Organisation (NACO) implemented the National AIDS Control Programme (NACP) I from 1992–99, which aimed to reduce the spread of HIV and the impact of AIDS through large-scale prevention strategies. By the end of NACP I, State AIDS control societies (SACS) had been set up as separate legal entities at the state level to ensure easier disbursement of funds, and more decentralised decision making. Within this framework NACO provides leadership in developing the NACPs, coordinating with partners, etc., and the SACS implement the programme at the state level, with functional independence to scale up and innovate.  

The focus of NACP II (1999–2006) remained on prevention and control, with almost 60% of funds allocated to HIV prevention, and only 14% to care and support.

NACP III was implemented between 2007 and 2012 and outlined a decentralised response to the epidemic to deliver expanded prevention, treatment and care services, with the goal of integrating HIV/AIDS services within the NRHM by 2012. Children were specifically addressed for the first time in NACP III, which aimed to ensure that every child had access to the same comprehensive set of basic health, education and social protection services, regardless of their HIV status or that of any member of their family.

NACP IV (2013–17) continues to provide care, support and treatment to all eligible population together with focused prevention services for high-risk groups and vulnerable populations, and aims to accelerate the reversal of the epidemic by integrating HIV responses. NACP IV sets out a more inclusive and focused approach on marginalised and hard-to-reach populations.

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38 Estimates between 2007/08 and 2011/12 are based on an exchange rate of INR1 : US$0.015.
39 UNGASS India Progress Report 2010
40 NACP IV Strategy Document
Financing for HIV/AIDS

As shown in Figure IV.2, resources for HIV/AIDS have increased dramatically over time, from US$725m for NACP II (1999–2006) to US$3.1bn for NACP IV (2012–17). This has been driven in particular by increased resources from GOI, which have risen from US$30m for NACP II (4% of total) to US$636m for NACP III (25% of total), and US$2.6bn for NACP IV (85% of total). External resources rose from US$695m for NACP II to US$1.9bn for NACP III, and then declined to US$490m for NACP IV.

Figure IV.2: Resources for successive NACPs by source

As shown in Figure IV.3, despite significant annual fluctuations, total ODA for HIV/AIDS generally grew from 2005 to 2011, before falling from 2011 to 2014. This resulted in an almost constant CAGR of 0.01 over the period. The growth in ODA for HIV/AIDS was solely attributable to increases in funding from Global Fund and International Development Association at a CAGR of 0.21 and 0.04, respectively. Funding from all other donors fell over the period, including from the United Kingdom at a CAGR of −31.

The largest providers of ODA for HIV/AIDS between 2005 and 2014 were Global Fund (48%), the United Kingdom (18%), International Development Association (16%), the United States (13%) and UNICEF (1%).

Figure IV.3: Gross ODA disbursements for HIV/AIDS, 2005–14 (US$m)\textsuperscript{41}
Resources for PPTCT and paediatric HIV

Figure IV.4 presents the resource requirement for the scale-up of PPTCT in India, as set out in the NACP III and NACP IV, which increases from US$35m in 2007/08 to US$60m in 2016/17.

As with funding for HIV/AIDS more generally, we understand that GOI has financed a greater proportion of expenditure for PPTCT over time. Global Fund has been the most significant donor in this space, having supported through a series of grants from 2006 onwards.  

Figure IV.4: Resource requirement for ICTC/PPTCT under NACP III and IV

Source: NACP II and IV Strategy and Implementation Plans

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42 Global Fund initially supported PPTCT in India through Round 2 and 6 in 2006. This came to an end in 2009, but funding was continued until 2012 through the Rolling Continuation Channel2 (RRC2). A proposal extension was then granted until 2015, which included aspects for the roll-out of Option B and outreach support. Since 2015, two grants are being implemented for PPTCT in India, with Plan India as the Principal Recipient for one, focused on public sector outreach support, and SAATHII as the Principal Recipient for the second, focused on engaging the private sector in PPTCT.

43 Estimates between 2007/08 and 2011/12 are based on an exchange rate of INR1 : US$0.015.
## Annex V: Timeline of key events during 2005–15

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>• National AIDS Control Programme III in place until 2006</td>
</tr>
<tr>
<td></td>
<td>• India Country Programme Document in place until 2007</td>
</tr>
<tr>
<td></td>
<td>• Initiation of National Rural Health Mission</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive PPTCT quality review in Karnataka</td>
</tr>
<tr>
<td>2006/07</td>
<td>• Launch of National Paediatric ART Initiative and initiation of paediatric HIV treatment and care</td>
</tr>
<tr>
<td></td>
<td>• Guidelines for paediatric ART developed</td>
</tr>
<tr>
<td></td>
<td>• Paediatric HIV package of care defined by Indian Institute of Paediatrics</td>
</tr>
<tr>
<td></td>
<td>• Children’s consultation on paediatric ART</td>
</tr>
<tr>
<td>2007</td>
<td>• National AIDS Control Programme III 2007–12</td>
</tr>
<tr>
<td></td>
<td>• Policy Framework for Children and AIDS</td>
</tr>
<tr>
<td></td>
<td>• District Situation Analysis of five state PPTCT programmes</td>
</tr>
<tr>
<td></td>
<td>• Assessment of procurement and supply chain management capacity</td>
</tr>
<tr>
<td></td>
<td>• Initiation of engagement of private sector in PPTCT service provision</td>
</tr>
<tr>
<td>2008</td>
<td>• India Country Programme Document 2008–12</td>
</tr>
<tr>
<td></td>
<td>• Bottleneck analysis for HIV testing</td>
</tr>
<tr>
<td></td>
<td>• UNGASS Report on HIV and AIDS</td>
</tr>
<tr>
<td>2010</td>
<td>• Initiation of Early Infant Diagnosis</td>
</tr>
<tr>
<td></td>
<td>• National Paediatric Conference</td>
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<tr>
<td></td>
<td>• Initial adoption of Option A, and subsequent adoption of Option B</td>
</tr>
<tr>
<td></td>
<td>• UNGASS Report on HIV and AIDS</td>
</tr>
<tr>
<td></td>
<td>• Global AIDS Response Country Progress Report</td>
</tr>
<tr>
<td>2011</td>
<td>• Launch of Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive</td>
</tr>
<tr>
<td></td>
<td>• Initiation of Paediatric Centres of Excellence for HIV care, support and treatment</td>
</tr>
<tr>
<td></td>
<td>• National workshop on research priorities</td>
</tr>
<tr>
<td>2012</td>
<td>• Finalisation of guidelines, capacity building activities, and initial roll-out of Option B</td>
</tr>
<tr>
<td></td>
<td>• National AIDS Control Programme (NACP) IV 2012–17</td>
</tr>
<tr>
<td>2013</td>
<td>• India Country Programme Document 2013–17</td>
</tr>
<tr>
<td></td>
<td>• National Strategic Plan for PPTCT multi-drug regimen roll-out</td>
</tr>
<tr>
<td></td>
<td>• Scale-up of Option B</td>
</tr>
<tr>
<td></td>
<td>• Initiation of Paediatric HIV Telemedicine Initiative</td>
</tr>
<tr>
<td>2014</td>
<td>• Roll-out of Option B+</td>
</tr>
<tr>
<td></td>
<td>• UNGASS Report on HIV and AIDS</td>
</tr>
<tr>
<td></td>
<td>• Global AIDS Response Country Progress Report</td>
</tr>
<tr>
<td>2015</td>
<td>• Revision to EID algorithm</td>
</tr>
<tr>
<td></td>
<td>• 18 state feasibility study on Telemedicine Initiative</td>
</tr>
<tr>
<td></td>
<td>• Global AIDS Response Progress Report</td>
</tr>
<tr>
<td></td>
<td>• Cost-benefit analysis and 18-state feasibility study on the Telemedicine Initiative</td>
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### Annex VI: Analysis against the components of the theory of change

<table>
<thead>
<tr>
<th>Component of theory of change</th>
<th>Evidence from country</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SD1: Coordinate programme design, planning and implementation among partners at all levels</strong></td>
<td>UNICEF had played a critical role in programme design, in alignment of strategies and policies and in implementation support at the state level. In particular UNICEF is recognised as having played a strong leadership in setting programme and policy direction and as a lead advocate and partner to NACO in the introduction and initial scale-up of PPTCT, and in the roll-out of EID and paediatric HIV care and treatment. UNICEF is a credible, trusted and reliable partner coordinating with others in support of national-level strategy and policy development and state-level implementation.</td>
</tr>
<tr>
<td><strong>SD2: Broker partnerships at all levels, including among private sector, civil society and multi-sector stakeholders, and encourage South-South as well as triangular cooperation among partners</strong></td>
<td>UNICEF has sought to scale up PPTCT and paediatric HIV service coverage by engaging and partnering with private sector institutions and brokering international partnerships to strengthen the provision of PPTCT and paediatric HIV services. In response to national-level capacity gaps, UNICEF brokered an important partnership with Baylor College of Medicine, bringing US-based global experts to India to focus on quality of care issues and creating linkages with paediatric centres of excellence. UNICEF is acknowledged by PLHIV networks as being a bridge between the government and community, creating platforms for civil society advocacy, which otherwise would not have existed during the period of programme roll-out.</td>
</tr>
<tr>
<td><strong>SD3: Ensure that HIV services for children receive adequate priority in global, regional and national decision making</strong></td>
<td>UNICEF played a crucial role in advocating for the inclusion of PPTCT and paediatric HIV as part of the national programme when the early focus was on key populations and targeted interventions. UNICEF supported the 2006 children’s consultation in 10 states for 9–16 year olds with children calling for improved paediatric treatments, resulting in policy development for orphans and vulnerable children and paediatric treatment becoming a focus in NACP III. UNICEF played a crucial role in building capacity for scale-up, particularly at the state level through deployment of consultants. UNICEF advocated at the community level to educate women on the change in policy and treatment regime. UNICEF supported the development of technical and programmatic capacity within the MoHFW and NACO at the national level, as well as implementation capacity at the state and district level, with some concerns that UNICEF support in Karnataka state may have been too ‘hands on’ rather than focused on building the capacity of the State AIDS Control Societies (SACS).</td>
</tr>
<tr>
<td><strong>SD4: Support key stakeholders at all levels to plan, resource and implement HIV services for children</strong></td>
<td>UNICEF’s initial role in civil society capacity development helped to raise awareness of HIV in the programme development and roll-out phase of PPTCT and paediatric HIV care and treatment. UNICEF supported the development of capacity for implementation at the state and district levels through the development of training materials, minimum standards of care, and standard operating procedures (e.g. for medical M&amp;E and surveillance officers, outreach workers, auxiliary nurse midwives, accredited social health activists, counsellors, and laboratory technicians) and support in the delivery of trainings through a ToT approach, as well as through the deployment of consultants to SACS in high priority states.</td>
</tr>
</tbody>
</table>

### Assumptions related to thematic leadership, advocacy, coordination and partnership

**Strong global, regional, and national systems of coordination exist that can be leveraged to galvanise action on HIV and children**

As noted, effective national and state-level coordination mechanisms exists under the leadership NACO and the MoHFW at the national level and SACS and NRHM at the state level, with the active participation of a wide range of partners.
**A wide range of partners at all levels exists that could be engaged on issues related to HIV and children**

A wide range of international and national stakeholders work on issues related to HIV and children in India.

**A minimum level of capacity among key stakeholders at country level exists that can be supported**

Key stakeholders at national and state level have strong technical and managerial capacity.

**Resource mobilisation**

**SD5: Initiate, support and coordinate movements, campaigns, and investment plans to mobilise financial resources**

ICO is well resourced, in spite of declining ODA to the country, due to a strong resource mobilisation function, and in particular, its engagement with private sector corporations. ICO has significant ‘unutilised’ funds that can be deployed for programme needs as and when required.  

Fluctuations in HIV programme budgets and expenditures have corresponded with:

- the requirements of NACO and MoHFW, which were more intensive leading up to the adoption of Option B in 2012;
- the integration of HIV within the RCH programme component in 2012, following which staff costs decreased;
- a large DFID-funded primary prevention programme that ended in 2012.  

The general trend in total ICO expenditure. We understand that the decline in ICO total expenditure between 2010 and 2013 was due to: (a) an increase in GOI expenditure on public services, and a reduced requirement for external resources; and (b) a reduction in donor resources, linked to the aftermath of the global financial crisis and the decision of a number of donors to reduce support to India.

**SD6: Engage with donors, governments and country stakeholders to leverage additional global and domestic resources, and support countries to access external resources**

Resources for successive NACPs have increased dramatically over time. This has been driven in particular by increased resources from GOI, with domestic funds accounting for 85% of total resources for NACP IV – UNICEF’s advocacy efforts are felt to have contributed to this increase and have boosted the outlook for the financial sustainability of the programme. External resources initially increased and then declined.  

GOI has reported that resource needs for NACP IV are being met. However, there is a need for greater programme expansion and systems strengthening in order to achieve universal testing of the 28 million annual pregnancies in the country each year, in order to push for e-MTCT.  

UNICEF has played a limited in leveraging partner resources for PPTCT and paediatric HIV, with the exception of the valuable role in supporting the development of successive Global Fund funding applications, particularly around the prioritisation and costing of activities.  

UNICEF’s role in negotiating and managing the supply of commodities has also been highly valued by partners.  

UNICEF’s significant contribution to capacity building has worked to improve prospects for programmatic sustainability. UNICEF has also supported a number of new and/or innovative approaches in India that have continued to be implemented and supported by the MoHFW, NACO, NIMHANS and partners – these include a system to track HIV-positive pregnant women and their children for follow-up, EID follow up processes, engagement of the private sector in the provision PPTCT and paediatric HIV services using a PPP model, and a telemedicine initiative that allows for video-linked delivery of expert services to underserved areas on paediatric ART.

**Assumptions related to resource mobilisation**

**Flows of total ODA, and ODA for health and HIV/AIDS specifically, remain stable or grow over time**

As noted above, there is strong capacity within the MoHFW to plan, budget and manage the HIV programme for children. The growth in ODA for HIV/AIDS was solely attributable to increases in funding from Global Fund and International Development Association. Funding from all other donors fell over the period.
**Economic growth and growth in government expenditures takes place in countries where UNICEF is active to support HIV responses**
The Indian economy has grown quickly over the evaluation period, between 5–10% p.a., with the exception of in 2008 when growth was 3.8%. This is thought to be due to the global financial crisis.
GOI resources for HIV/AIDS increased from US$30m for NACP II (4% of total) to US$636m for NACP III (25% of total), and US$2.6bn for NACP IV (85% of total).

**A minimum level of capacity at country level exists to plan and budget for HIV in children**
As noted above, there is strong capacity within the MoHFW to plan, budget and manage the HIV programme for children.

### Strategic information (SI), knowledge generation and dissemination

**SD7: Generate, collate and disseminate high-quality global and national data for scaling up effective approaches to address HIV among children**
UNICEF has played a key role in conducting operational research and analysis to support national decision making for programme design. In particular, UNICEF has supported the initial piloting of PPTCT and new regimens in a few states, and used this evidence and experience to advocate for their wider roll-out. UNICEF has also sought to analyse bottlenecks, quality of services and resource needs for further improvement and scale-up of services.

**SD8: Provide support for governments and country partners to generate and collate SI and knowledge**
UNICEF’s role in the generation, analysis and dissemination of SI has evolved over time. In earlier years, UNICEF played an active role in supporting WHO and GOI in the design of M&E and surveillance systems, and in monitoring of SI to check the quality of reporting. UNICEF’s field presence gave it a particular added value in this regard. Over time, as systems have become embedded and the capacity of NACO and MoHFW has been strengthened, UNICEF has not been required to play a significant role at the national level in the generation, analysis and dissemination of SI.

UNICEF staff and consultants have worked to build the capacity of SACS staff and district field officers in surveillance, field monitoring, M&E, data analysis, follow-up processes and programme reviews at the state level.

**SD9: Support global- and country-level interpretation and translation of SI and evidence into sound policies, strategies and programmes**
UNICEF participates in various TRGs and provides technical support for the development of national strategies and policies (e.g. the 2007 Policy Framework for Children and AIDS, 2013 National Strategic Plan for PPTCT), as well as guidelines. In particular, UNICEF, as the only UN agency with state offices and a field presence, is felt to add considerable value to these processes by ensuring that the outputs of these national forums are practical and actionable in the field.

### Assumptions:

- **A minimum level of capacity at country level exists to generate and use SI and knowledge**
  - There is strong national capacity for the generation, analysis and dissemination of SI. This capacity has grown over the evaluation period.

- **Support from technical partners is sustained for generating SI and knowledge**
  - Earlier support from technical partners has been sustained, as demonstrated by the government now taking responsibility for this function.

### UNICEF’s organisational structure

**SD 14: UNICEF as an organisation responds to changes in the external environment and leverages its comparative advantage in PMTCT and paediatric HIV care and**
UNICEF ICO staff are technically competent, committed and well regarded by MoHFW with state-level consultants valued for their responsiveness and flexibility. The ICO field office structures enable UNICEF to support state-level implementation in a practical and meaningful manner. ICO is appropriately supported by ROSA and HQ.
Integration of HIV functions across other programme components in 2012 reduced the number of staff positions focusing on PPTCT and paediatric HIV, requiring closer internal management and collaboration between teams. Internal planning and management processes reflect the change in...
### Cross-cutting issues

| SD10: Work to ensure that effective interventions are adequately integrated within humanitarian responses | There was little evidence on this from India. The country experienced the Tsunami in 2004 on the east coast of India, the Gujarat earthquake in 2006 and various floods in Orissa and other states during the period 2005–15. However, there is no evidence of UNICEF having a visible role in relation to PMTCT and paediatric HIV specifically in emergencies. |
| SD11: Advocate for and support gender-equitable policies, budgeting and resource allocations, and gender-sensitive approaches to HIV programming and monitoring | UNICEF’s mandate and its articulation of a gender-sensitive approach is well recognised by partners, but there is more work to do in promoting gender in integrated HIV programming. UNICEF has been a strong voice in ensuring the availability of health information systems data and research to improve targeted programming and the focus on gender, equity and rights. External stakeholders note UNICEF’s voice in TRGs has led to better inclusion of gender and rights issues in national policies and strategic plans over time and has influenced guidelines and the provision of services to better recognise the needs of women and children. |
| SD12: Ensure that human rights and child rights are protected, promoted and fulfilled in HIV policies and programmes, and build related accountability mechanisms | UNICEF has focused on children’s rights to HIV treatment and care through its advocacy and support to PPTCT and paediatric HIV programmes. UNICEF’s takes a child rights approach to its programming though its focus on women and children which is well recognised by partners, with more work to do in promoting rights in integrated HIV programming. UNICEF focused on legal and policy frameworks for the rights of HIV-positive children, supporting work to update the Juvenile Justice Act and support to NACP III, to better reflect their needs. |
| SD13: Promote an equity focus in HIV services for children, and build related accountability mechanisms | UNICEF has advocated for a greater focus on equity, helping to push NACO and MoHFW to focus on treatment for pregnant women and children. UNICEF’s approach to equity is focused on achieving universal access to quality care with a geographical focus on priority states. UNICEF’s field structure of offices has allowed it to have a strong presence in many of the country’s priority states having high HIV prevalence. UNICEF recognised the importance of engaging civil society networks to mobilise communities to reach universal access targets in the PPTCT roll-out phase, paediatric treatment and care. There is need for UNICEF to focus beyond geography and UA and embrace an equity approach focused on coverage of the most hard-to-reach women and their children who have limited access to services. |

### Assumptions related to cross-cutting issues

| There is no convergence of unmanageable numbers of crises simultaneously | This assumption has held in India. |
| Functional coordination systems exist in emergencies | There is little evidence of this from India. |
| Political support for working towards gender equality in HIV/AIDS programming remains strong | There is evidence from interviews with government and partners that there is a commitment to gender equity, with challenges at the operational level. |
| Political support for rights-based approaches and funding remains strong | There is evidence from interviews with government and partners that there is a commitment to rights-based programming, with challenges at the operational level. |
Political support for addressing inequity remains strong
There is evidence from interviews with government and partners that there is a commitment to addressing inequity, with challenges at the operational level.

Intermediate outcomes

<table>
<thead>
<tr>
<th>Strategies, policies and implementation plans are aligned and coherent across partners at global, regional and country levels</th>
<th>The strong role of the government in leading the development of strategies, policies and implementation plans, including through the multi-stakeholder TRGs, ensure that partner plans are well coordinated. UNICEF’s engagement through the UN Development Assistance Framework also ensures that it is closely aligned with other UN agencies (e.g. WHO and UNAIDS) and global priorities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levels of political commitment and capacity of governments and other global, regional and national stakeholders to plan for and support scale-up of HIV services for children are increased</td>
<td>There has been a significant increase in political commitment to HIV/AIDS in India over the evaluation period, as witnessed by the dramatic increase in financial resources and adoption of ambitious programme goals and targets.</td>
</tr>
<tr>
<td>Resource needs for PMTCT and paediatric HIV care and treatment are met in a predictable and sustainable manner</td>
<td>GOI has reported that resource needs for NACP IV are being met, with 85% of resources sourced from the government budget. However, there is a need for greater programme expansion in order to achieve universal testing of the 28 million annual pregnancies in the country each year, in order to push for e-MTCT.</td>
</tr>
<tr>
<td>Mechanisms to ensure accountability for provision and scale-up of PPTCT and paediatric HIV care and treatment are strengthened at all levels</td>
<td>Accountability mechanisms for provision and scale-up of PPTCT and paediatric HIV care and treatment exist through the National AIDS Control Programme</td>
</tr>
<tr>
<td>Strategies, policies and approaches to implementation are informed by evidence on what does and does not work and why in relation to PMTCT and paediatric HIV care and treatment</td>
<td>Although there has been some delay in the adoption of new treatment regimens, particularly for Option B which was not adopted until 2012, it is felt that strategies, policies and approaches to implementation are now appropriate and informed by global best practices, as well as national evidence on what does and does not work. UNICEF has played a particularly important role on the latter, bringing field expertise to national strategy and policy setting forums.</td>
</tr>
<tr>
<td>HIV policies and programmes are resourced and implemented in a gender-sensitive, equitable and human rights-based manner (including in humanitarian situations)</td>
<td>Gender, human rights and equity issues all feature as a part of the response to PMTCT and paediatric HIV in India with more work to do in promoting gender and rights in integrated HIV programming. There has been an increased GOI commitment over time for universal testing and access to treatment. Children’s access to HIV treatment occurred later than adults yet is now universally available. Legal and policy frameworks are more inclusive of the rights of HIV-positive children and health information systems have improved enabling some targeted programming. Families with HIV-positive children are more easily able to access social protection schemes. However, with India’s diversity, complexity and social structures there is variation between states.</td>
</tr>
</tbody>
</table>
Annex VII: Bibliography


CBHI, MoHFW. 2015. National Health Profile.


GOI. 2013. India Report for UN High Level Meeting, Government of India.


MoHFW India. 2015. National Health profile 2015, CBHI.


Acknowledgements

The Itad team is very grateful for the support provided by the South Africa Country Office during, and in the lead up to, the country visit. We would also like to acknowledge the constructive engagement and responsiveness of all those who were consulted during the course of this case study. Their expert knowledge and reflective insights have made valuable contributions to the report.

The findings within this document, however, are entirely the responsibility of the evaluation team.
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## Acronyms

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>BRICS</td>
<td>Brazil, Russia, India, China and South Africa</td>
</tr>
<tr>
<td>CO</td>
<td>Country Office</td>
</tr>
<tr>
<td>CPD</td>
<td>Country Programme Document</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DREAMS</td>
<td>Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe</td>
</tr>
<tr>
<td>ECD</td>
<td>Early Child Development</td>
</tr>
<tr>
<td>EID</td>
<td>Early Infant Diagnosis</td>
</tr>
<tr>
<td>e-MTCT</td>
<td>Elimination of Mother-to-Child Transmission</td>
</tr>
<tr>
<td>ESARO</td>
<td>Eastern and Southern Africa Regional Office</td>
</tr>
<tr>
<td>GARP</td>
<td>Global AIDS Response Progress</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>INK</td>
<td>Instituut Nederlandse Kwaliteit</td>
</tr>
<tr>
<td>KZN</td>
<td>KwaZulu-Natal</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
</tr>
<tr>
<td>MNCWH</td>
<td>Maternal, Newborn, Children and Women’s Health</td>
</tr>
<tr>
<td>MRC</td>
<td>Medical Research Council</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother-to-Child Transmission</td>
</tr>
<tr>
<td>NDoH</td>
<td>National Department of Health</td>
</tr>
<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
</tr>
<tr>
<td>RO</td>
<td>Regional Office</td>
</tr>
<tr>
<td>ODA</td>
<td>Official Development Assistance</td>
</tr>
<tr>
<td>OR</td>
<td>Other Resources</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
</tr>
<tr>
<td>RDP</td>
<td>Reconstruction and Development Programme</td>
</tr>
<tr>
<td>RO</td>
<td>Regional Office</td>
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<tr>
<td>SA</td>
<td>South Africa</td>
</tr>
</tbody>
</table>
SACU  Southern African Customs Union
SADC  Southern African Development Community
SAG   South African Government
SANAC South African National AIDS Council
SI    Strategic Information
STI   Sexually Transmitted Infection
TB    Tuberculosis
ToR   Terms of Reference
TWG   Technical Working Group
UNAIDS Joint United Nations Programme on HIV/AIDS
UNDAF United Nations Development Assistance Framework
UNFPA United Nations Population Fund
UNICEF United Nations Children’s Fund
USAID United States Agency for International Development
WCARO West and Central Africa Regional Office
WHO   World Health Organization
Executive summary

Introduction

UNICEF has commissioned an evaluation of its activity in the area of prevention of mother-to-child transmission (PMTCT) of HIV and paediatric HIV care and treatment during the period 2005–15. The purpose of the evaluation is to support accountability and learning in relation to UNICEF’s efforts to support the scale-up of these programmes, and will examine four dimensions of its engagement:
1. Leadership, advocacy, coordination and partnerships
2. Resource mobilisation
3. Strategic information, knowledge generation and dissemination
4. Key aspects of UNICEF’s organisation

This report summarises the findings of the South Africa case study, which is one of the four in-depth case studies being undertaken as part of the evaluation. The case study was conducted during May 2016 and included a documentation review and interviews or group discussions with 25 stakeholders (including UNICEF staff, government, development partners and civil society). Semi-structured interview guides were used to elicit perspectives on the four key dimensions of the evaluation, as well as the three cross-cutting issues of gender, equity and human rights.

Summary of findings

Some of the key findings of the case study are as follows:

- **UNICEF is perceived as a trusted technical partner by national stakeholders on a broad range of issues related to children and HIV.** Its support to critical steps in the rapid scale-up of the PMTCT and paediatric HIV care and treatment programme is widely recognised and appreciated. In particular, UNICEF is credited for taking the lead in introducing and implementing data-driven approaches to programme scale-up and in launching critical innovations, for instance for early infant diagnosis (EID) among HIV-exposed infants or the follow-up of HIV-positive pregnant women and mothers.

- **UNICEF is recognised as the driver of data-informed, decentralised approaches to programme planning, implementation and tracking.** These approaches were widely cited by stakeholders for their significant contribution to programme performance improvements throughout the country – since 2011 for PMTCT and more recently for paediatric HIV care and treatment – and have now been adopted in a number of related programmes.

- **UNICEF has also made appreciated investments over the years to build and share critical knowledge on HIV and children acquired through research, assessments, evaluations and programme reviews.**

- **UNICEF’s financial contribution to programme activities is very small** in comparison with the resources allocated by the government or provided by some key partners, particularly the President’s Emergency Plan for AIDS Relief (PEPFAR). Its team working on health and HIV issues has remained limited in numbers over the last several years. Yet UNICEF has managed to keep its strong presence in critical forums for policy development and to make important contributions to the design and implementation of key components of the very large and dynamic South African HIV programme.

- **UNICEF staff are committed to develop programme linkages and integration across programmes and sectors.** They have not yet, however, fully tapped the potential for doing so, beyond the support to the South African government (SAG) to integrate HIV services into the maternal, newborn and child health (MNCH) platform.

- **There is scope for positioning UNICEF more integrally in the dialogue around the complex dimensions of equity.** UNICEF articulates a focus on equity internally, but has less prominence externally with regards to some of the key equity challenges for the HIV response in South Africa (for example, rural/urban, public/private, reaching the most marginalised,
and reducing disparities in the quality of services).

- There is also scope for UNICEF to move beyond a programme focus on women, and to identify more innovative models to address key gender challenges in South Africa (e.g. male involvement; gender-based violence; female empowerment).

Implications

Going forward, UNICEF may wish to consider the following suggestions:

- **Keep the focus of UNICEF investments on reaching out to vulnerable populations and underserved districts in the country** ("leave no-one behind").

- **Work to develop stronger linkages between PMTCT/paediatric HIV care and treatment programme efforts with initiatives to step up HIV prevention and care among adolescents**, as a key contribution to reducing HIV prevalence among young women (thereby "closing the tap") and building a continuum of care for HIV-infected children from birth through to adulthood.

- **Increase the programme focus, as necessary, on paediatric HIV case findings and early treatment**, making sure that children’s needs are fully taken into account in the scale-up of the antiretroviral therapy (ART) programme (within the ‘90-90-90’ initiative).

- **Drive towards integration** – internally and externally – of HIV issues within other child-focused programmes and sectors, thereby "connecting the dots". This will require an even greater effort within the South Africa Country Office (SACO) for joint programming with shared accountabilities.

- **Seize opportunities to innovate and build on comparative advantages**, including UNICEF’s unique roles in advocacy and social mobilisation around equity issues and its global experience with gender-transformative and rights-based approaches to programming, within the formal health system, but also increasingly at the community level.

- **Maintain a strong presence at the policy level** to ensure that the needs of children affected by HIV are fully considered in the development of key policies and strategies, as well as evolving agendas (such as planning for the National Health Insurance).

- **Step up efforts to document best practices and innovative approaches to addressing HIV in children**, making the most of South Africa’s tremendous advances and position as a thought leader for the whole continent.
1 Objectives and scope of the evaluation

1.1 Purpose of the evaluation

UNICEF has commissioned an evaluation of its activity in the area of prevention of mother-to-child transmission of HIV and paediatric HIV care and treatment. The purpose of the evaluation is to support accountability and learning in relation to UNICEF’s efforts to support the scale-up of these programmes:

- to contribute to improving the organisation’s accountability for performance by defining and documenting key achievements as well as missed opportunities in UNICEF’s engagement with partners and countries in support of improved PMTCT and paediatric HIV care and treatment outcomes between 2005 and 2015.

- to generate evidence and learning to enhance the understanding of the organisation and other stakeholders on how UNICEF’s strategies and programmes related to PMTCT and paediatric HIV care and treatment have evolved, what has worked, has not worked, and why, and make recommendations for UNICEF’s future engagement in these programme areas.

The evaluation will look at four key dimensions of UNICEF’s work in this area:

1. Leadership, advocacy, coordination and partnerships: the ability to foster or to be effective within partnerships by leveraging corporate knowledge and assets to become a trusted advisor for donors, national governments and other global and national stakeholders; and the ability to influence global, regional, national PMTCT and paediatric HIV care and treatment agendas over time.

2. Resource mobilisation: the ability to generate the required funds for PMTCT and paediatric HIV care and treatment programmes and projects that UNICEF supports across levels; the ability to leverage major funders’ resources to achieve UNICEF’s strategic priorities; to be an effective support to governments attempting to access funds for these programmes; and helping foster an adequate global resource base for them.

3. Strategic information, knowledge generation, and dissemination: the contribution to global and national policies and strategies through evidence generated by UNICEF- and partner-supported research and programming, as well as through its global data, estimation and progress reporting; and the translation of global policies and evidence into national plans, operational guidance and tools.

4. Key aspects of UNICEF’s organisation: to include establishing an effective presence at the global, regional and country levels, the proper employment of UNICEF’s comparative advantages (e.g. its ability to play a convening role, its procurement functions); the ability of the organisation to adapt based on new scientific and operational information; and the extent to which UNICEF’s structures in relation to HIV have been fit for purpose over time.

The evaluation is also focusing on three cross-cutting issues, namely: gender, human/child rights and equity. While not a focus of this case study, it will also examine how the response to PMTCT and paediatric HIV is integrated within a humanitarian response.

1.2 Focus of the country case studies

Data collection is being undertaken in seven countries as part of this evaluation – four involving country visits (in-depth studies)\(^1\) and three conducted through remote desk reviews and telephone interviews (light-touch studies).\(^2,3\)

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\(^1\) Zimbabwe, Cameroon, India and South Africa.
The key purpose of the country case studies is to record how UNICEF’s engagement in PMTCT and paediatric HIV/AIDS has played out at country level during the period 2005–15, and help test and validate the theory of change for UNICEF’s strategic approaches in these programme areas, which was developed to guide the evaluation. It is important to note the following:

- Each case study has been selected because of the learning opportunity offered to the evaluation.
- The approach to each is focused on recording experiences rather than measuring or assessing individual country performance.

This report on the South Africa experience presents the findings of one of the four in-depth case studies.

2 Approach and methodology

2.1 Approach to data collection and analysis

The full methodology for the evaluation is set out in the Evaluation Inception Report produced as part of the initial phase of the evaluation. Figure 1 below summarises the process through which this in-depth country study was implemented.

Figure 1: Process for conducting country studies

2.2 South Africa visit schedule

The visit was carried out over the course of a week in May 2016, and included interviews or group discussions with 23 stakeholders. Following the visit, the team also conducted two additional remote interviews with stakeholders who were not available during the team’s time in South Africa. Semi-structured interview guides were used to elicit perspectives on the four key dimensions of the evaluation (see above), as well as the cross-cutting issues. Interviewees included UNICEF staff (from the HIV section and others), government representatives, development partners and civil society organisations. The full agenda and the list of stakeholders interviewed are included in Annexes II and III respectively. The country visit was also used as an opportunity to source additional documents from the South Africa Country Office (SACO).

On the last day of the visit, the team presented its preliminary observations to the UNICEF team for their early reflection and response.

The final step in the country case study process has involved a more comprehensive analysis of interviews and documents, to produce this Country Report. The report is presented in six parts:

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2 Cambodia, Haiti and Ukraine.
3 Country case studies are one component of the data collection process. The evaluation also includes interviews with key stakeholders at a global and regional level, an online survey to UNICEF and partners, and an extensive document review.
4 Further details are included in the Inception Report for this evaluation.
5 It should be noted that one remote interview is still outstanding due to lack of availability of the respondent.
1. **Objectives and scope of the evaluation** – describes the aim of the evaluation.

2. **Approach and methodology** – explains the approach to the case studies.

3. **Overview of UNICEF’s Country Programme in South Africa** – provides an introduction to the South Africa context and UNICEF’s work in PMTCT/paediatric HIV.

4. **Findings** – details findings against the four key dimensions of the evaluation, as well as the cross-cutting issues.

5. **Achievements and challenges** – details some of the key achievements and challenges for UNICEF and South Africa during the evaluation time period.

6. **Implications for UNICEF** – reflects on lessons learned to present some areas for UNICEF’s consideration moving forward.

Further information is presented in the Annexes to this report, including a summary of the evidence against the theory of change, which is presented in Annex VI.

3  **Overview of UNICEF’s Country Programme in South Africa**

3.1 **South Africa context**

South Africa has the highest number of people living with HIV in the world. An estimated 6.3 million people were living with HIV in 2013, representing 18% of all people with HIV worldwide. About 12% of South Africa’s population, including 19% of adults aged 15–49, were living with HIV in 2012, with significant regional variations. Women and adolescent girls face disproportionate risks of HIV, as shown in Figure 2. Overall, HIV prevalence is increasing, in association with the increased life expectancy of people receiving antiretroviral therapy (ART).

![Figure 2: HIV prevalence by sex and age](image)

HIV incidence and prevalence have declined sharply among children in recent years, but the numbers of affected children remain high. HIV prevalence among children aged 2–14 fell from 5.6% in 2002 to 2.4% in 2012 and the number of new infections among children declined by 79% from an

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8 Ibid.
estimated 78,000 infections in 2004 to 16,000 infections in 2013 due to the rapid expansion of services to prevent MTCT.\(^\text{11}\) However, levels of exposure of newborns to HIV have not declined, as HIV prevalence among women attending antenatal clinics has remained steady, and was estimated at 29.7% in 2013.\(^\text{12}\) In 2012, an estimated 410,000 children aged 0–14 years were living with HIV in South Africa (SA).\(^\text{13}\) HIV was one of the leading causes of death among mothers and children in SA during the period under review. In 2011, an estimated 70% of maternal deaths were associated with HIV,\(^\text{14}\) as were half of all deaths in children under 5 years of age.\(^\text{15}\)

The national response to HIV/AIDS has been stepped up in recent years, guided by a number of ambitious plans and frameworks launched since 2007. The national PMTCT programme and the national ART programme, known as the Comprehensive HIV and AIDS Care, Management, Treatment and Support (CCMTS) Plan, were started in 2002 and 2003 respectively and gradually expanded in the first few years. Then, in 2007 the South African Cabinet adopted the National Strategic Plan (NSP) for HIV and AIDS and Sexually Transmitted Infections (STIs) 2007–11, committing the government to implement the most comprehensive ARV-based prevention and treatment programme in the world.\(^\text{16}\) The post-2008 period saw unprecedented momentum in the scale-up of ART services and the strengthening of health systems for their effective delivery. That year the Minister of Health launched the national PMTCT Accelerated Plan (A-Plan), which aimed to reduce early (6-week) MTCT of HIV from 12% in 2008 to less than 5% by 2011, in accordance with the NSP.\(^\text{17}\) The government also initiated a decentralised model of care, in which HIV testing and treatment were integrated in antenatal care, and the capacity of primary health care staff – notably nurses – to initiate ART was strengthened. By 2010, PMTCT services were being offered at 98% of all health care facilities in the country.\(^\text{18}\) In 2011, the National Elimination of Mother-to-Child Transmission (e-MTCT) Action Framework entitled “No child born with HIV by 2015 and improving the health and well-being of mothers, partners and babies in SA” was developed in response to the “Global Plan to Prevent New HIV Infections in Children and Keep their Mothers Alive” (the Global Plan) and the “Campaign on the Accelerated Reduction of Maternal and Child Mortality in Africa” (CARMMA). All nine provinces and 52 districts were supported to develop and implement the framework.

Since 2005, the South African government (SAG) has revised national PMTCT guidelines several times to keep pace with the WHO’s regularly updated recommendations. These recommendations made more women eligible for treatment, helping to expand mothers and children’s access to more effective and longer-term treatment regimens and protocols. In 2013, new guidelines were issued for the provision of ART to all HIV-positive pregnant and breastfeeding mothers regardless of their CD4 count until the end of the breastfeeding period, with lifelong ART for those having a CD4 count of 350 or under (Option B). Guidelines for lifelong ART for all HIV-positive pregnant women and breastfeeding mothers, regardless of their CD4 count (Option B+) were issued in January 2015.

The first edition of guidelines for the management of HIV infections in children was approved in 2005, the second edition in 2008, and more changes were introduced in 2010 and 2013, including the expansion and then elimination of eligibility criteria for starting ART in children less than five years of age. The second edition in 2008–10: Fifth report on confidential enquiries into maternal deaths in South Africa.


\(^{16}\) The NSP committed the SAG to providing ART to 80% of those eligible.


age. The Blueprint for Action (2012–16) “Keeping Children Alive and Healthy in South Africa” was developed on the basis of a review of data and a national rapid assessment. It provides a road map to work towards keeping children aged 0–19 years alive and healthy and improving the health and wellbeing of children and adolescents, with a focus on ART and tuberculosis (TB) screening and management in this age group. Integration of HIV and AIDS, TB and MNCWH and nutrition programmes is promoted to ensure a continuum of prevention, care, treatment and support for children and adolescents.

The scale-up of PMTCT and treatment programmes has been dramatic in recent years. By 2013, 2.4 million South Africans living with HIV were on ART, that is an estimated 42% of eligible adults and 44% of eligible children, and exceptional progress has been made in increasing PMTCT coverage and reducing the MTCT rate. PMTCT services are now fully integrated within the MNCWH platform in South Africa. In 2005, slightly less than 50% of pregnant women were tested for HIV infection; by 2009, HIV testing among pregnant women was almost universal. Progress is evident across all indicators. By 2013, 90% of HIV-positive pregnant women were receiving ARVs and the coverage of EID reached 75%.

There is evidence that the transmission rate at 4–6 weeks post-partum was as low as 2.6% in 2012–13 (when Option A was the recommended regimen for PMTCT). Remaining issues concern: (a) uneven coverage rates across provinces and districts, (b) late antenatal care bookings, and (c) poor postnatal follow up and (d) incomplete implementation of HIV re-testing policies during pregnancy and breastfeeding – leading to missed opportunities for identifying new seroconversions in women and mothers.

A timeline of key milestones in the response to HIV/AIDS in the context of South Africa is included in Annex V.

3.2 UNICEF’s work in HIV in children during 2005–15


The overall goal of the Country Programme has been to support national efforts to accelerate the realisation of children’s rights in South Africa and the achievement of the UN Millennium Development Goals (MDGs), with a focus on bridging the deep-seated inequities and widespread child poverty in the country. During the 2010 Strategic Moment of Reflection, UNICEF identified the need to continue to strengthen national systems and support activities that address implementation bottlenecks, including weaknesses in prioritisation processes and capacity gaps within the public sector. UNICEF therefore maintained its engagement in upstream policy work as well as provided targeted technical support to remove implementation bottlenecks at operational levels, especially in geographic areas of high child deprivation. Currently, SACO focuses on four key programme areas: child survival and development; basic education and adolescent development; child protection; and social policy and advocacy.

Given the large share of childhood mortality attributed to HIV, the UNICEF Country Programme placed a strong focus on scaling up the response to HIV/AIDS, including accelerating access to PMTCT towards

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e-MTCT and access to comprehensive HIV care and treatment services for women and children on the route towards achieving universal access. UNICEF’s work in this area was closely aligned with the country’s NSPs.

Over the period of the evaluation, UNICEF advocated for and contributed to the design and implementation of large-scale HIV/AIDS prevention and care interventions for children and adolescents, with technical and financial support for:

- strategic and operational planning
- partnership-building to advance the agenda
- programme implementation in a number of priority districts
- pilot and rollout of innovative technologies and programme approaches
- capacity-building
- programme monitoring and knowledge generation
- development of evidence-informed policies and guidelines
- resource mobilisation.

UNICEF’s activities were conducted in close collaboration with other partners. The programme’s main counterparts in this area have been the national, provincial and district health authorities, as well as the South African National AIDS Council (SANAC). Overall programme coordination was provided by the technical working groups (TWGs) on PMTCT and on Paediatric and Adolescent HIV and TB, which are convened by the NDoH and bring together key partners, including the representatives from the President’s Emergency Plan for AIDS Relief (PEPFAR), UNICEF, the World Health Organization (WHO), research and academic institutions, civil society and implementing partners. Other important partnerships in which UNICEF has served as the lead on PMTCT and paediatric HIV include the Joint UN Team on HIV. The Joint UN Programme of Support on AIDS is mainstreamed into the UNDAF and aligned with the relevant NSPs.

4 Findings from South Africa

This section provides the team’s detailed findings against the four key dimensions of the evaluation, as well as the cross-cutting issues. A summary of the evidence related to each of the strategic directions underpinning these dimensions and issues, as well as against intermediate outcomes identified in the theory of change guiding the evaluation is presented in Annex VI.

4.1 Thematic leadership, advocacy, partnerships and coordination

Respondents recognise UNICEF as a credible, trusted and reliable player in national efforts to scale up HIV services for children. In the last several years, the SAG has made a clear political commitment at the highest level to eliminating MTCT and to reaching universal access to HIV treatment for adults and children. It plays a strong leadership and stewardship role, working with a range of partners to step up the response. UNICEF is considered a privileged partner for issues related to children. UNICEF has made noted contributions to a range of national strategic planning processes that have laid out bold commitments for children, as outlined in particular in:

- The NSP for HIV and AIDS and STIs 2007–11 and the NSP for HIV, STIs, and TB (2012–16)
- The Blueprint for Action (2012–16) for paediatric and adolescent HIV/ART and TB programmes
- The South Africa HIV and TB Investment Case (2016)
UNICEF has made substantial efforts to provide guidance and build capacity for programme planning and implementation related to PMTCT and paediatric HIV treatment, at the national level as well as in the provinces and districts that it has prioritised for its HIV work. There is a lag between policy and implementation, especially in some high burden and less well-endowed regions and districts, given highly decentralised government structures. Government representatives and partners indicate that UNICEF played a ‘pivotal role’ in bridging this gap, through its contributions to a range of strategic and operational planning, policy development and capacity development activities at all levels. UNICEF is especially commended for its role in supporting national, provincial and district authorities and their partners to develop and implement the e-MTCT Action Framework. UNICEF was instrumental in the rapid development and deployment of data-informed and target-driven frameworks and related implementation plans for e-MTCT in all provinces and districts in 2011, and of systems for the continued tracking of progress towards targets at the local level (see section 4.3).

UNICEF has provided valued support to the National and Provincial Departments of Health (DoH) to decentralise maternal and paediatric HIV care and treatment to the primary health care level. In line with the SA government’s current focus on primary health care (PHC) re-engineering, UNICEF now supports five out of the country’s nine provinces with ‘down-referral’ of maternal and paediatric HIV services. UNICEF is commended for its strong presence at local levels. As noted by a government stakeholder: “UNICEF is in the trenches”. It is currently helping to provide further momentum at field level in support of the Minister of Health’s focus to go from “30,000 to 3 feet”, meaning that policies should be implemented all the way down to facility and community levels (see also section 4.3).

UNICEF has forged strong partnerships with a range of players in programme scale-up. Current SAG leadership and coordination systems are strong at all levels of the decentralised response, ensuring alignment with established roles and responsibilities, and overall complementarity and coherence. The NDH is the main government authority for PMTCT and paediatric HIV care and treatment and works with various partners, including the SANAC, PEPFAR, the UN, research and academic institutions, civil society and implementing partners. UNICEF is an active and appreciated member of national coordination structures, including the PMTCT TWG and the Paediatric and Adolescent HIV and TB TWG, which are convened by the NDH. UNICEF has also participated in other time-limited working groups, for example serving as co-lead on the PMTCT sub-working group, with the NDH, for the development of the South African HIV and TB Investment Case. UNICEF is also maintains informal partnerships with other significant players in PMTCT/paediatric HIV care and treatment, including CDC, USAID and PEPFAR. Finally, UNICEF serves as the lead on PMTCT and paediatric HIV in the Joint UN Team on HIV.

UNICEF has pioneered a number of innovative programme approaches to improve the reach and quality of HIV services for women and children. Stakeholders mentioned, among other efforts:

- UNICEF’s support to the ‘MomConnect’ pilot project in selected sites in KwaZulu-Natal Province from 2011–15. This involved cellphone SMS technology linked with electronic medical records to enable tailored messages, support reminders and track women and their newborns throughout pregnancy and up to 18 months after delivery. Based on this experience, the NDH designed and implemented a national programme which has already reached more than 500,000 women. UNICEF is also supporting the helpdesk as well as design and implementation of the communication and advocacy plan for MomConnect towards improving knowledge and demand creation at community level.

- UNICEF support for the development of a leadership and mentorship package and information for KwaZulu-Natal’s DoH district specialist teams, with a view to national scale-up. The aim was to strengthen clinical governance in health clinics and district hospitals, supervise adherence to treatment guidelines and protocols, mentor clinicians and track health outcomes, including those related to PMTCT.

UNICEF has also worked with civil society organisations, to promote the involvement of women living with HIV in the delivery of services for women and children and the strengthening of systems
to extending these services into the community. For example, UNICEF has worked with the international non-governmental organisation, ‘mothers2mothers’, and the DoH to implement a peer-based psychosocial and health education model in which trained HIV-positive mentor mothers work alongside formal medical staff. UNICEF continues to support the engagement of women living with HIV and the mentor mother programme in selected districts, extending the model into the community to provide peer psychosocial support, counselling and education for PMTCT and infant and young child feeding, strengthening facility – community referral and linkage systems, following mothers and infant pairs, and linking HIV-exposed and HIV-positive children to early treatment, care and support.

Stakeholders reflected that UNICEF is well placed to develop more initiatives to strengthen the engagement of community-based structures in PMTCT and follow-up of affected families. Current approaches to community health systems remain fragmented in South Africa and efforts are under way for the rationalisation and convergence of community-based health initiatives across programme lines. Furthermore, while accountability mechanisms for meeting PMTCT and paediatric HIV care and treatment targets at all levels of the health system are strong, there is limited evidence of the implication of civil society in supporting these mechanisms. UNICEF could support the building of systems for citizen participation in claiming accountability for programme reach, coverage and quality.

UNICEF has provided support to national efforts over the last several years to fully integrate PMTCT and paediatric HIV care and treatment services into the MNCH’s platform. It should be noted, however, that different NDoH departments – that is the Cluster for Maternal, Neonatal and Women’s Health and the Cluster on Child Health – cover PMTCT and paediatric HIV care and treatment respectively, leading to a risk of disjointed efforts. In turn, UNICEF also has different programme sections, and while HIV is integrated within its Child Health and Nutrition section, its efforts to integrate programme activities with those of other sectors such as early childhood development, child protection and education are less visible to stakeholders. Some stakeholders noted that UNICEF’s internal structures and staff interactions did not convey a thrust towards integration at the planning level, leading to the impression that: “UNICEF perpetuates the silos”. Furthermore, UNICEF’s focus on PMTCT has very much been on PMTCT ‘prongs three and four’ which concern ARV-based interventions to prevent vertical transmission and to provide care and treatment to HIV-positive pregnant women, mothers and their children. A government stakeholder expressed the strong wish that UNICEF turn some of their attention to promoting PMTCT ‘prongs one and two’, related to preventing HIV infections and helping reduce unintended pregnancies among young women, which will be necessary to reach e-MTCT targets.

4.2 Resource mobilisation

4.2.1 Internal resource mobilisation functions

UNICEF expenditure on PMTCT and care and treatment of children affected by HIV/AIDS in South Africa totalled US$5.3m between 2012 and 2015. As shown in Figure 3, UNICEF expenditure decreased substantially from US$2m in 2012 to US$0.7m in 2014 and 2015.24 However, it was noted by UNICEF staff that this may not be fully reflective of the resources that are allocated to PMTCT and paediatric HIV. In particular, they noted the shift towards more integrated streams of work and funding from donors in recent years. So, for example, there may be activities linked to PMTCT under MNCH that are not coded as such.

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24 UNICEF’s internal reporting follows the structure of its organisational strategic plans, and as such, the data reflects a change in the coding of expenditures between the 2006–13 Medium-Term Strategic Plan to the 2014–17 Strategic Plan. More specifically, for 2012 and 2013 the figures present expenditure to reduce the number of paediatric HIV infections; increase the proportion of HIV-positive women receiving antiretrovirals (ARVs); and increase the proportion of children receiving treatment for HIV/AIDS. For 2014 and 2015 the figures present expenditure on two programme areas: (a) PMTCT and infant male circumcision; and (b) care and treatment of children affected by HIV/AIDS.
UNICEF PMTCT and paediatric HIV response is heavily dependent on ‘Other Resources (OR)’. As detailed in Figure 3, over the period for which data is available, the vast majority of expenditure was comprised of Other Resources Regular (94%), with the rest comprised of Regular Resources (6%) funds. Both the Chief of the Health and Nutrition section and the PMTCT/paediatric HIV specialist are funded through OR (the structure of the team working in HIV is discussed in more detail in section 4.4 below). This reliance on OR is reflective of a more general pattern within the SACO – there are reported challenges to sourcing regular funding, given that they are an upper-middle-income country. SACO is exploring options for further funding sources. Currently, SACO receives HIV funding from CDC (since 2012), foundations such as MacAIDS and the ELMA Foundation, in addition to some thematic funds for HIV. However, it has also been exploring options for additional funding – for example, taking advantage of the requirement in South Africa for businesses to invest in corporate social responsibility. A fundraising strategy was submitted as part of the 2013–17 CPMP, and while not specific to HIV, the most recent Country Report from South Africa notes the increase in the number of pledge donors and broader partnerships.

### 4.2.2 External resource mobilisation functions

Domestic spending on health and HIV in South Africa has grown rapidly over the period of interest and now over 90% of national health care expenditure, together with the largest proportion of expenditure for the HIV response, are sourced from the national budget. Public allocations for the HIV response have grown dramatically over time from ZAR 966 million in 2004/5 to ZAR 13.6 billion in 2014/15 (representing a 1300% growth in a decade) – another measure of the SAG’s commitment to expand the national response to HIV. The SAG plans to continue to expand its contribution to

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25 Source: Analysis of internal UNICEF data.
26 Regular Resources are those with no restrictions on their use (i.e. core resources). Other Resources include funds earmarked by donors for a specific purpose such as a country, theme, project, sector, emergency or any other category (i.e. non-core/earmarked resources). Other Resources are further classified as: a.) Other Resources Regular (ORR) – funds for specified non-emergency programmes and strategic priorities; b.) Other Resources Thematic (ORT) – contributions that donors earmark to support strategic and pre-defined objectives for countries, regions, UNICEF’s Medium Term Strategic Plan (MTSP) Focus Areas or humanitarian response; or c.) Other Resources Emergency (ORE) – funds specifically provided by donors for UNICEF’s humanitarian actions and post crisis recovery activities.
28 ZAR 10 = USD 0.678635 in June 2016.
identified priority areas, especially HIV and AIDS and TB in the health sector, as laid out in the National Development Plan 2030.

**Additional funds have been sourced from development partners, primarily the US government and the Global Fund, and the private sector.** The split between various sources in 2009/10 was 75% public, 16% development partners, and 8% private sector. According to findings from a NASA expenditure tracking effort, a total of ZAR 17.4 billion was spent in 2011 on the HIV and TB programme, ZAR 19.2 billion in 2012 and ZAR 22.1 billion in 2013. The SAG was the largest contributor over the 3 years, with the SA share increasing from 76% in 2011 to 80% in 2013. The US government provided the second most substantial contribution, with its share decreasing from 22% in 2011 to 17% in 2013 (though still increasing in real terms). The Global Fund’s contribution rose from 1% in 2011 to 3% in 2013. The SA is increasingly meeting resource needs for the whole HIV and TB response, though it still relies quite heavily on PEPFAR support. PMTCT-specific services accounted for 3% of total spending for HIV and TB for the period 2011–13. In 2013, the largest proportion of funding for PMTCT came from the SAG, a little more than 50%. PEPFAR provided the second largest proportion (just over 50%), and the Global Fund provided the remainder.

**UNICEF has provided valuable support for the SAG’s efforts to develop its NSPs and costed plans (such as the e-MTCT plan 2011–15), which are tied to funding commitments from domestic sources and key donors.** UNICEF has also provided technical and financial support to SANAC in the development of applications to the Global Fund. Finally, UNICEF has also provided support (as co-lead of the PMTCT stream) to develop the South African HIV and TB Investment Case, which was completed in 2016. This far-reaching exercise involved an extensive review of the evidence base to identify and cost the key interventions needed to bring the HIV and TB epidemics under control by 2030, with a view to guide the budget decisions of the NDOH and the Treasury. The Investment Case informed the development of a new application for funding from the Global Fund from 2016 to 2019, which will support the implementation of the ‘90-90-90’ strategy.

**It is projected that expenditure on the HIV and TB programme will continue to increase in future years and that the share covered by the SAG will also continue to rise.** However, current projections indicate that these projected increases are unlikely to meet resource needs, and a substantial resource gap is projected for each of the next 5 years. The country thus confronts the need both to identify new sustainable sources of funding and to maximise the strategic impact and efficiency of funding. For the longer-term, work is under way to develop the National Health Insurance Plan, with the aim “to improve access to quality health care services for the whole population and to provide financial risk protection against health-related catastrophic expenditures”. This plan would shape a financing model for funding all health care, including for HIV, while working towards equality and equity, in the face of huge disparities.

### 4.3 Strategic information, knowledge generation and dissemination

**UNICEF has made appreciated investments in national processes to build critical knowledge on women and children, pinpoint bottlenecks to implementation and identify gaps in programme coverage.** Stakeholders particularly commended UNICEF’s guidance on data-driven processes to identify bottlenecks in implementing the e-MTCT framework, which were introduced across all provinces and districts in 2011. UNICEF promoted the use of simple monitoring tools such as visual dashboards, and data for action reports, to identify gaps and track improvements along the PMTCT cascade. These were successfully used to improve local programme performance and scale-up over the following years and are now being replicated for provincial and district-specific monitoring and evaluation.

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30 Ibid.
31 Ibid.
work planning in other programme areas, as an integral part of institutionalised quarterly provincial reviews (with district participation) to monitor the performance of conditional grant business plans. A data quality improvement intervention was also conducted in three districts in KwaZulu-Natal to increase the completeness and accuracy of data used to monitor PMTCT services.  

Currently, UNICEF is providing support to the ‘30,000 to 3 feet’ initiative for the development of tools at facility level to track the achievement of results, complete a bottleneck analysis and identify key actions as well as track their implementation using a dashboard. The key indicators cover the continuum of care for maternal, newborn, child health including HIV and TB. This approach has been adopted by the government for scaling up the 90-90-90 campaign across the country, to reach every district and facility in the country.

UNICEF has also provided technical and financial support for a number of programme assessments and focused programme reviews. For example, UNICEF participated in a high-level UN review of the public health sector’s HIV and AIDS response in 2009, in a joint national review of the HIV, TB and PMTCT programmes in 2013, and in an e-MTCT stocktaking exercise across all provinces and districts in 2014, together with the development of action plans to build momentum towards programme scale-up. UNICEF also supported a situational assessment of the EID service in PHC facilities in 2012 and in an assessment of gaps in paediatric HIV treatment in the same year, which informed the development of the Blueprint for Action by the SAG, with support from PEPFAR, UNICEF and other partners.

UNICEF has also pioneered innovative approaches to monitor programme activities, which have informed national programming efforts. For example, as mentioned in section 4.1 above, UNICEF provided support to the MomConnect pilot project in KwaZulu-Natal (KZN) since 2011 to follow mothers and infants through SMS reminders, with links to client electronic records. UNICEF also invested in further work to explore technological innovations, namely, setting up real-time tracking systems for understanding leaks in the PMTCT cascade as well as ensuring linkages to treatment for HIV-positive infants and mothers. UNICEF also supports the National Health Laboratory Service in linking polymerase chain reaction (PCR) testing reports to service delivery for mothers and infants. Another example of innovation is the digitalisation of the ‘Road to Health’ booklet as an app for mothers and caregivers to access key information about children, customised with the date of birth and linked to milestones and growth monitoring, to be further built upon in 2016.

UNICEF has also leveraged the considerable clinical, epidemiological and social research capacity present in South Africa to generate knowledge related to PMTCT and paediatric HIV care and treatment in support of policy and intervention development at national as well as global levels. Research activities encouraged and supported by UNICEF over the period of interest covered a wide range of topics, of which some examples follow:

- In 2006, The Department of Education and UNICEF commissioned research on the effects of HIV and ART among young children in educational settings.
- Also in 2006, UNICEF provided support to the University of KwaZulu-Natal Nelson Mandela School of Medicine participation in a multi-national PMTCT collaborative study (Kesho Bora) coordinated by the WHO.
- In 2008, UNICEF supported an initiative that documents the experiences of young HIV-infected mothers enrolled in PMTCT programmes in KwaZulu-Natal.
- UNICEF supported the University of Witwatersrand and the National Institute for Communicable Diseases in the development of PCR tests for EID in young infants and promoted their wide use at programme level and in surveys – making South African the site of the first population-based

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35 The Blueprint for Action aims to increase number of sites providing paediatric HIV services and identify best models for providing services to perinatal and behaviourally infected children/ adolescents (PEPFAR South Africa 2014 COP).
UNICEF has also provided technical and financial support to the Medical Research Council for PMTCT impact studies, which document population-level MTCT rates and identify related programme gaps.

UNICEF has been active in the dissemination of the knowledge generated through these various activities. SACO staff have published widely with national counterparts and contributed to a ‘Best Practices’ document on approaches to PMTCT.36 Some stakeholders indicated that they would welcome even greater attention by UNICEF to the dissemination of knowledge in these areas, both within the country and within the region, while acknowledging the small number of technical staff in SACO who need to cover many bases. There is also a sense that the bulk of evidence generated so far relate to the health-facility components of the programme as well as technology-driven innovations, with some stakeholders recommending that UNICEF invest more in building evidence on community-based components of the programme, as well as on ‘prongs one and two’ of the PMTCT framework.

Together with partners, UNICEF has made useful contributions in supporting the NDoH to shift their strategies, policies and guidelines based on global guidelines and country experiences, and build the capacity of health care workers in their use. The NDoH and the SANAC have been attentive to evidence about what works and why in this area and very prompt to respond to changes in international recommendations on a range of issues. Successive national guidelines for PMTCT since 2002 have taken on switches in ARV regimens for prophylactic use while progressively expanding eligibility criteria for ART for pregnant women and mothers, from single-dose nevirapine (in 2002) through dual prophylaxis (2007 and 2008), Option A (2010), Option B (2013), to Option B+ on 1 January 2015. In April 2015, universal HIV PCR testing of all HIV-exposed infants at birth was also adopted.37 UNICEF have also provided valuable technical and financial support for the development of guidelines related to infant and young child feeding, including HIV issues, and related information and training activities over the years. For example, UNICEF has worked with the NDoH to publish and edit informational materials on breastfeeding and child nutrition, together with civil society organisations.38

A few issues remain that would benefit from the close attention of SACO, in close consultation with national, regional and global partners. As in other countries of the region, the estimation of HIV prevalence and incidence in children is challenging and methods vary from year to year, making it difficult to estimate accurately the need for HIV care and treatment and progress in improving ART coverage in children. In addition, at this time, the NDoH is considering certification processes for pre-elimination of MTCT, as it has generally met the pre-elimination criteria. However, it has raised concerns that while PMTCT coverage is very high and the MTCT rate is low, South Africa could take many years, or even decades, before the case rate criterion for elimination is met, given that current HIV exposure levels of newborns remain very high. WHO is charged with the certification process at the global and country levels. UNICEF will need to work very closely with WHO and other partners to consider how best to address this situation in ways that take into account continued high HIV prevalence and incidence, as found in other countries in the sub-region.

39 Annual case rate for paediatric HIV infections <50/100,000 births.
4.4 UNICEF’s organisational structure

4.4.1 Organisational structure

The structure of the team working on HIV in the SACO has remained fairly stable over the time period of the evaluation. The HIV function within SACO sits in the Health and Nutrition section; therefore, it is under the leadership of the Chief of the Health and Nutrition section (at the P5 level) and additionally comprises a dedicated Specialist for PMTCT and paediatric HIV (P4). Given the context in South Africa, experience working in HIV is part of the job description for the Chief of the Health and Nutrition section. The people occupying these positions have changed during the period 2005–15; however, the posts have remained fairly constant. The key shift identified was the transition in 2011 from the PMTCT and paediatric HIV specialist being a temporary position to being a P4 (international position).

There is an external perception that the team working on HIV in SACO is small. The structure and capacity of the SACO is reported by UNICEF staff to be a reflection of the strength of the government and recognition that South Africa is an upper-middle-income country. However, the perception externally is that the team working in HIV is a bit “thin on the ground”, given the burden of HIV in South Africa. Both UNICEF staff and external stakeholders recognise that this has implications for where and how UNICEF can work – for example, it may limit the amount of meetings that can be attended. One partner noted the resultant risk for the pace that they can operate, and particularly for the geographical scale at which they can work, given the number of provinces and districts in South Africa.

The UNICEF Health and Nutrition section has historically made use of consultants and short term contracts with institutions to bolster its capacity. For example, during the early phases of work on the data for action reports, and the bottleneck analyses, UNICEF contracted consultants to support on some of the analytical work.

Having an HIV function that sits within the Health and Nutrition section, rather than as a standalone function, is reported to encourage internal collaboration and integration. UNICEF staff report that there are good internal mechanisms for coordination within the Country Office – for example, programme staff meetings and TWGs around the three office priorities (discussed further below). More informally, having HIV within the Health and Nutrition section allows issues of PMTCT to integrate with MNCH, and paediatric HIV to link with other child health issues; historically, the HIV team has reportedly interfaced with staff working in Child Protection (although there was less evidence of this currently). However, there is some sense that staff turnover may present a challenge to this integration – for example, there have been a number of nutrition specialists in post over the time period of this evaluation, and the MNCH role within the team is currently vacant.

UNICEF is perceived externally as the organisation that can “connect the dots” and support the drive for a more multisectoral response to HIV in South Africa; however, this potential may as yet not be fully tapped. There is a broader push for integration within the HIV response South Africa – for example, the Blue Print for Action stresses a multisectoral approach between the Department of Health, the Department of Basic Education, Department of Social Development and SANAC for addressing paediatric HIV: “it is critical that the above mentioned departments work closely at all level and ensure a multisectoral and integrated approach while involving other stakeholders and partners.” The “action” section of the blueprint also has one of its five components as “improve integrated services for infants and children/adolescents to ensure early identification of HIV and TB infection, treatment, care and support ...”.

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41 Republic of South Africa, DoH. Blue Print for Action: Keeping Children Alive and Healthy in South Africa.
The SAG and partners both recognise that this push for integration will require a shift in ways of working, and a number of external stakeholders felt that UNICEF is well positioned to drive this agenda and start ‘connecting the dots’ given that they are engaged in a number of different areas, including education, nutrition and MNCH. However, there is a perception that this potential is not yet being fully realised – some stakeholders still see UNICEF as being somewhat “siloued”. (This is discussed in further detail in the following sections, in relation to the skills and competencies of the team engaging in HIV issues and the planning systems within the Country Office.)

**The HIV function in SACO can draw on support from the Regional Office (RO).** One UNICEF staff member highlighted the value that the RO can bring, given the proximity to the SACO, describing it as “a huge plus” – and noted examples where they had invited the previous Eastern and Southern Africa Regional Office (ESARO) HIV specialist to attend meetings and provide technical expertise. More formally, the SACO can draw on support from the RO as defined in the Compact that exists between the CO and RO. The Compact highlights the following areas of support in relation to PMTCT and paediatric HIV:

- **Support in relation to the validation of the e-MTCT process and roles and responsibilities at country level.**
- **Technical inputs and feedback into research methodologies, analysis and studies, including documenting lessons learned and best practice.**

### 4.4.2 Skills and competencies

External stakeholders recognise the team working on HIV in SACO to be technically strong and knowledgeable. Key areas of value highlighted by some partners included technical expertise in HIV issues, the ability to operate across the levels of the health system (from the national level to the grassroots), skills in problem solving, and a focus on results. Staff were perceived as technically very competent – indeed one partner flagged a desire among some implementing partners to be able to draw on that expertise more often. In addition to technical expertise, some partners noted their strength in building relationships and working closely with the DoH, as well as their ability to bring the right people together.

However, some stakeholders felt that the UNICEF Health and Nutrition section is overly focused on PMTCT, to the detriment of wider child health issues. This was felt by some individuals interviewed to be a result of the interests and expertise of the UNICEF team leading to efforts being focused in particular areas. However, equally – this may also be a function more recently of vacancies within the Health and Nutrition section and a recognition from one UNICEF staff member that in the context of South Africa, and with a small team, there is a need to focus efforts.

There appears to be scope for increasing the emphasis and understanding of HIV outside of the Health and Nutrition section. The external perception from some government stakeholders was that HIV expertise could be strengthened outside of the team that works directly on HIV to ensure that opportunities for integration are maximised as part of the wider Early Child Development (ECD) response in South Africa (linked to the new ECD policy). For example, one interviewee suggested that if the UNICEF staff working on education had a stronger understanding of HIV issues, they would be better positioned to identify opportunities for integrated activities, such as incorporating HIV testing into school based programmes. Within UNICEF, ECD is one of the three office-wide priorities – led by the education section – that cover the whole spectrum from birth through thrive, survive, including HIV testing and counselling in antenatal care settings and access of pregnant women and mothers to treatment. From within the Health and Nutrition team, there is recognition that team members working in health need to have cross-cutting expertise – for example, in health systems strengthening – in order to be able to leverage opportunities for integration.

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4.4.3 Planning and systems

The SACO Country Programme is designed around four key programme areas. Since 2006, PMTCT and paediatric HIV has been situated within the child survival and development programme area (see table 1). The CPDs are translated into rolling workplans agreed with government and partners.

**Table 1. Country Programme components as articulated in the Country Programme Documents**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>• Social policy for child rights</td>
<td>• Social transformation and</td>
<td>• Social policy and advocacy</td>
</tr>
<tr>
<td>• Basic social services</td>
<td>strategic leveraging</td>
<td>• Child survival and development</td>
</tr>
<tr>
<td>• HIV/AIDS</td>
<td>• Child survival and development</td>
<td>• Basic education and adolescent</td>
</tr>
<tr>
<td>• Communication and community</td>
<td>• Education and adolescent</td>
<td>• Child protection</td>
</tr>
<tr>
<td>participation programme</td>
<td>development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Protection for OVCs</td>
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</tbody>
</table>

Since 2015 there has been a push towards integration within SACO, with three office-wide results defined. Staff recognised that, historically, work within SACO has been somewhat compartmentalised – with each team or section working towards their own results. This led to the definition of three office-wide results during 2015: early child development, results for adolescents, and ending violence against children. This was in response to a recognition from the SACO management that a sectoral approach to programming struggles to address complex challenges. While going forward, there will still be individual accountability at the output level; the higher level results will be cross-sectoral.

While integration is reported to have improved, staff still see room for further work. TWGs are now organised around the three priority areas – convened by the designated leads, and there are two mandatory review meetings per year for each priority where a consolidated report is prepared. Overall, the perception from internal UNICEF staff was that integration was improving but that there was still more work to do to break down the barriers. This view was reflected among some external stakeholders, who felt that UNICEF could be more “child-focused” (government stakeholder). While this is not a challenge that is unique to UNICEF, stakeholders see UNICEF as well positioned to make this shift and not perpetuate the silos that exist in government and some other partners.

4.4.4 Analysis against the INK management model

The Instituut Nederlandse Kwaliteit (INK) Management Model provides a diagnostic framework to explore the extent to which UNICEF as an organisation is set up to leverage its comparative advantage, respond over time to the changing external environment, and deliver on its overall objectives. The INK model focuses on five organisational elements, as shown in Figure 4.43 The table below provides a summary of evidence against the elements observed at SACO and will contribute to a more comprehensive global analysis for the final report.

![INK management model diagram](http://www.toolshero.com/strategy/ink-model/)

43 http://www.toolshero.com/strategy/ink-model/ – it should be noted that the INK Management Model also has additional components, linked to results areas; however, this dimension of the evaluation is focused on the organisational aspects of UNICEF and therefore the focus is on these five areas.
Table 2: Analysis of SACO team working on HIV against elements of the INK management model

<table>
<thead>
<tr>
<th>Focus area</th>
<th>Evident in the SACO team working on HIV</th>
<th>Not so evident in the SACO team working on HIV</th>
</tr>
</thead>
</table>
| **1. Leadership – attitude and behaviour of people with guiding responsibility** | - There is recognition in the SACO management of the importance of integration and cross-sectoral working.  
  - The job description for the Chief of the Health & Nutrition section includes HIV experience as a requirement – suggesting it is afforded priority within the area of health. | - There is an external perception that the interest areas of the team working in HIV translate into a focus on PMTCT rather than broader child health issues.                                                                 |
| **2. Staff management – fully using the potential of knowledge and expertise** | - The team working on HIV are recognised by government and partners as technically strong.  
  - Having the HIV team embedded within the Health and Nutrition section is reported to encourage internal collaboration.  
  - SACO has been able to draw on expertise from the ESARO, given the proximity of the Regional HIV advisor. | - There is a perceived need for development of further HIV expertise outside of the team (e.g. in the education team) to maximise opportunities for synergies.                                                                               |
| **3. Strategy and policy – the way in which strategy is translated into objectives** | - There has been a recent shift (in 2015) to joint results within SACO, to encourage integration.  
  - Output indicators remain individually owned, to promote accountability. | - While integration and cross-sectoral working is reported to have improved, there is more work to do to address the external perception that UNICEF remains somewhat siloed.                                      |
| **4. Management of resources – how resources are handled** | - The HIV team has remained fairly stable over time – funded through OR.  
  - Short term consultants have been used to supplement the capacity of the HIV team. | - There is a perception that the team working on HIV is small.                                                                                                                                                                      |
| **5. Process and systems – how the organisation identifies, designs, manages, improves or innovates systems** | - Planning processes within SACO evolved in 2015 to the use of joint results across sectors.                                                                                                                                              |                                                                                                                                                                                                                                      |

4.5 Cross-cutting issues

4.5.1 Gender

Women are disproportionately affected by HIV in South Africa. There is a higher HIV prevalence in women in almost all age cohorts in South Africa, and in adolescence the difference is particularly stark – 5.6% of young women aged 15–19 were HIV-positive in 2012, compared to 0.7% of young men the same age. More broadly, women face challenges such as high levels of gender-based violence, which

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44 Data cited in the 2016 Investment Case Report.
increases the risk of HIV among women. Reports suggest that 20–25% of new HIV infections in young women in South Africa are as a result of gender-based violence.  

There is a strong policy environment for the reduction of gender inequality in South Africa – for example, country endorses the Universal Declaration of Human Rights, the African Charter on Human Rights and Women’s Rights, the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), and the Constitution has gender rights clearly articulated. However, the challenge is in the translation of policy into practice – the 2014 Global AIDS Response Progress (GARP) report suggests that while the NSP addressed the target of eliminating gender inequalities, the country is not on track to reach the target.  

Stakeholders within and outside of UNICEF recognise the importance of gender issues in the HIV response, and that more needs to be done with both men and women in mind. By its design, PMTCT is a service for women. What is less evident is the involvement of men within PMTCT and maternal and child health (MCH). This was discussed by some interviewees as a challenge and is also highlighted in the 2016 Investment Case as a critical question for exploration in South Africa – “how best may male involvement in MCH services in the South African context be enhanced?”  

Interviewees also recognised the importance of wider social determinants in ensuring that women have access to quality care; for example, they highlighted the need for strengthening community systems for PMTCT and the importance of economic empowerment. The DREAMS\(^4\) Initiative in South Africa is now being implemented in 19 high burden and high transmission subdistricts, targeting adolescent girls aged 10–19 years in and out of school, orphans and vulnerable children aged 10–19, 20–24-year-old young women, and male sexual partners aged 20–49. The initiative aims to supply post-violence care, parenting/caregiver programmes, increase access to cash transfers and education subsidies with in order to address the “the structural drivers that directly and indirectly increase girls’ HIV risk, including poverty, gender inequality, sexual violence, and lack of education”.  

UNICEF lacks a significant profile in relation to gender issues – beyond its focus on pregnant women for PMTCT. In terms of the reporting on gender in recent UNICEF annual reports,\(^5\) much of the focus is on girls’ education and does not have a clear link to HIV. There is a gender focal point within SACO that interacts with the team working on HIV – for example, in checking work plans to ensure gender has been incorporated and there is also reported interactions in relation to work with adolescent girls. However, in relation to PMTCT, the incorporation of wider gender issues (beyond a focus on women) is less evident. For example, links with challenges such as gender-based violence and consideration of models of male involvement in the response. This is recognised by external stakeholders, who do not associate UNICEF with a strong gender focus, beyond its focus on women and girls. Some partners flagged the need for both UNICEF and the broader UN to be more vocal in advocating to the government on some key issues that challenge women in South Africa – in particular, gender-based violence.  

Gender mainstreaming is not a challenge unique to HIV. One staff member noted: “Gender has been mainstreamed almost out of existence. Everybody thinks it is there, but in the absence of additional capacity it has been difficult to identify specific efforts on gender.” A gender review was conducted in SACO in 2015, and one HIV output area was considered.\(^6\) While it was in relation to work with adolescents, and therefore is not directly related to the focus areas of this evaluation, the review reflected on issues of gender mainstreaming within SACO more generally, noting that in 2014 1.6% of

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\(^{45}\) 2014 GARP report.  
\(^{46}\) 2014 GARP report.  
\(^{48}\) Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe.  
\(^{50}\) The evaluation team had access to reports from 2012, 2013 and 2015.  
the budget was spent on programming but that this may not reflect fully the efforts of SACO to work towards gender equality. The review also made some more generally applicable recommendations, including:

- **As SACO Programmes continue to operate at scale, they can strengthen the monitoring of the programmes by disaggregating data by sex and age groups, whenever possible.**
- **Programme staff can also conduct gender bottleneck and barrier analyses during the design phases of their programmes.**
- **In preparation for the development of the upcoming CPD, SACO can develop a gender profile to provide an overview of the status of women and girls in South Africa.**

### 4.5.2 Human rights

The importance of human rights is articulated in a number of key documents that guide the South African response to HIV. According to the latest GARP report,\(^\text{52}\) the “legal framework for respecting, protecting, promoting and fulfilling rights in the context of HIV and TB is largely in place”. The National Strategic Plan on HIV, STIs and TB 2012–16 notes that “South Africa’s response to HIV, STIs and TB is based on the understanding that the public interest is best served when the rights of those living with HIV, STIs and/or TB are respected, protected and promoted”. It articulates two of its goals as to “ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP” and to “reduce self-reported stigma and discrimination related to HIV and TB by 50%”.

A number of stakeholders spoken to as part of this case study also referenced the South African Constitution as a key guiding document in relation to human rights more generally. It protects women and children’s rights to life, health, and freedom from unfair discrimination, including on grounds of gender, age and race. The Constitution was drafted by South Africa’s first democratically elected government, and signalled the shift from apartheid and colonial era policies and practices.

**Progress has been made in relation to human rights and HIV; however, there continue to be challenges in relation to some key issues.** The 2016 Investment Case Report notes a number of improvements in the area of human rights – including a decline in the prevalence of stigmatising attitudes towards people living with HIV, and the upgrading of the South African Human Rights Commission’s system for investigating complaints of human rights violations.\(^\text{53}\)

However, in relation to the rights of the child, stakeholders noted challenges with the implementation of the *Children’s Act 38 of 2008*, which was passed in 2010. It guarantees a child’s rights to participate in health treatment decisions and provides guidance on the age at which children can be tested and who can give consent. However, government and partners highlighted the lack of clarity among both providers and caregivers about consent, and noted that this can be a barrier to testing – for example, if the parent is not the person who accompanies an HIV-exposed baby to an appointment.

More broadly, funding challenges are reported to have weakened the voice of civil society and its ability to keep the pressure on the government, in comparison to the early phases of the HIV response. There was a perspective from one stakeholder that the UN agencies working in South Africa could be more prominent in relation to human rights issues, thus ensuring that the government is held to accountability.

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\(^{52}\) Republic of South Africa GARP Report 2014.  
Child rights are articulated within UNICEF’s Country Programme Documents; however, there is some sense that they could be more vocal with regards to this agenda. As detailed in Box 1, rights have featured in the programme goals for each of the three CPDs that cover the period 2005–15. Although not specific to HIV, the most recent annual reports from SACO also flag the partnerships that UNICEF has with organisations that enhance the child rights agenda, for example the South African Human Rights Commission.  

However, there were mixed views from the stakeholders spoken to about the extent to which UNICEF are strongly articulating a human rights agenda, or even their position on issues related to women’s rights and child rights. For example, while one partner highlighted UNICEF as a voice that reminds partners about issues of human rights, another government stakeholder noted the following:  

*They really are not very vocal as advocates for children. We realise that this is difficult. However, they focus so much on technical support but not enough on advocacy for children. This can be sensitive … but still they should think strategically about how to go about this (government stakeholder).*

### 4.5.3 Equity

In South Africa, PMTCT and paediatric HIV services are designed to be universally accessible; however, equity issues remain. Although the policy is that services should be equitably distributed and freely available to pregnant women and children under 5-years old, inequity persists in a number of dimensions. In particular, interviewees discussed the spectrum of quality of care across public and private providers, inequity between rural and urban areas, and challenges reaching mobile populations and adolescents. These challenges have implications for a number of ongoing areas of work in South Africa – in particular, the transition to ‘universal test-and-treat’ later in the year, and the discussions about National Health Insurance coverage.

UNICEF staff articulate a focus of their programmes on the most disadvantaged, but this is not always prominent externally. When asked about UNICEF’s approach, some stakeholders indicated the limited visibility of an equity focus from UNICEF – one government representative noted that the equity focus had historically been more visible than it is now, and some others could not articulate UNICEF’s approach to equity at all. In contrast, UNICEF staff often highlighted that their work in South Africa is equity based and that the design of interventions is focused on consideration of the most marginalised groups. This suggests that perhaps UNICEF could do more to communicate this agenda externally.

The most visible feature of UNICEF’s equity lens has been the work on bottleneck analyses in relation to working towards universal access. UNICEF has been a key proponent of the use of tools to monitor progress in increasing PMTCT coverage, and define action plans to address barriers – i.e. the

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**Box 1: The goals of the UNICEF Country Programmes 2002–17**

**CPD 2013–17:** The overall goal of the country programme of cooperation is to support national efforts to accelerate the **realisation of children’s rights** … To achieve this goal, the country programme will … (c) assist national institutions with the promotion of social change to support the **acceleration of the realisation of child rights**.

**CPD 2007–10:** The country programme goal is to support the full **realisation of the rights of OVCs**, regardless of the cause of orphanhood or vulnerability … Emphasis is placed on the promotion and protection of girls and women’s rights.

**CPD 2002–06:** The strategy for the 2002–06 country programme responds to the new thrusts and priorities of the country and UNICEF global policies, with the following country programme goals: (a) to contribute to the **fulfilment of children’s and women’s rights**, with an emphasis on the principles of universality and non-discrimination … and (c) to support learning processes and the application of knowledge by all duty-bearers and rights-holders for the **fulfilment of children’s and women’s rights**.

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use of ‘robot’ dashboards for tracking progress at district level. Following the roll out of the Monitoring Results for Equity System in UNICEF, SACO implemented the use of bottleneck analyses starting in 2011, with the aim of improving coverage of PMTCT.55 (This is discussed in more detail in Section 4.3 above). Based on the analyses of the barriers to access, since early last year, UNICEF has been working with mothers2mothers on a project to strengthen community platforms in four under-performing districts to assess whether similar dashboard models can be applied at community level, to link the community with the facility.

UNICEF prioritises women, children and adolescents; however, a focus on other disadvantaged and key populations is less evident. UNICEF funded the MomConnect pilot programme in KZN, and reportedly focused on hard-to-reach women in the design of the intervention. It is also involved in the communications aspect of the South African government’s new campaign on adolescents. However, what is less evident is a focus on other key populations – including those who may be the most marginalised, for example, sex workers and the disabled. Ensuring that key populations have access to quality care – and are involved in the dialogue around the response – was highlighted as a challenge for the South African HIV response.

5 Achievements and challenges

5.1 Achievements

- UNICEF is perceived as a trusted technical partner by national stakeholders on a broad range of issues related to children and HIV. Its support to critical steps in the building of the PMTCT and paediatric HIV care and treatment programme, especially since 2007, is widely recognised and appreciated. In particular, UNICEF is credited for taking the lead in introducing and implementing data-driven approaches to programme scale-up and in launching critical innovations, for instance for EID among HIV-exposed infants or the follow-up of HIV-positive pregnant women and mothers.

- UNICEF is recognised as the driver of data-informed, decentralised approaches to programme planning, implementation and tracking. These approaches were widely cited by stakeholders for their significant contribution to programme performance improvements throughout the country – since 2011 for PMTCT and more recently for paediatric HIV care and treatment – and have now been adopted in a number of related programmes.

- UNICEF has used its limited financial and human resources in strategic ways. UNICEF’s financial contribution to programme activities is very small in comparison with the resources allocated by the government or provided by some key partners, particularly PEPFAR. Its team working on health and HIV issues has remained limited in numbers over the last several years. Yet, UNICEF has managed to keep its strong presence in critical forums for policy development and make critical contributions to the design and implementation of key components of the very large and dynamic South African HIV programme. This is a significant achievement that stakeholders attribute to the strong capability and energy of the UNICEF team working on HIV issues in the SACO since 2005.

5.2 Challenges

5.2.1 Programmatic challenges

- South Africa must develop new tactics to consolidate the gains that it has made so far in preventing new HIV infections in children. South Africa has reached very high levels of coverage with PMTCT interventions among women and children and reduced transmission rates to very low levels at the national level. The country has met the criteria for ‘pre-elimination’ of new HIV

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55 UNICEF. 2015. Pursuing equity in practice – a compendium of country case studies on the application of the Monitoring Results for Equity System (MoRES).
infections in children. Some further progress can be made to reach vulnerable populations (such as young women who book late for antenatal care) and to increase programme performance in some remaining underserved facilities and districts. At the same time, attention needs to shift to reducing HIV prevalence among pregnant women, and therefore exposure levels of newborns. ND officials recognise that the further decrease of the case rate among children depends on significant progress being made for ‘prongs one and two’ of the PMTCT framework. Until then, the country cannot meet current criteria for the elimination of HIV infections in children, and the number of affected children will remain high.

- **South Africa must also keep up its efforts to close the paediatric ART gap.** The size of this gap is unclear, while the new (2015) HIV estimates in children are being finalised. However, it is widely recognised that EID is providing diminishing returns as the transmission rate decreases and that case finding of HIV-positive children through other means and in other venues must be intensified, so ART can be initiated among children in need as early as possible.

- **In the context of the 90-90-90 initiative, an increased focus is required on building community health systems** to boost HIV testing levels, as well as ART uptake and long-term adherence levels among all in need (women, men and children). As shown in the Investment Case, increasing ART coverage will in the longer-term reduce the need for initiating ARV-based PMTCT interventions during pregnancy, as most HIV-infected women will be on treatment before becoming pregnant. A key issue, however, is maintaining high adherence levels with treatment – for life.

### 5.2.2 Challenges for UNICEF

- **UNICEF will need to support South Africa in addressing the above key programme challenges.** The coming year is a critical time for reviewing and shifting strategic approaches for UNICEF’s support to South Africa, across its health and HIV portfolio, as the country develops its new NSP and UNICEF works on its new CPD. UNICEF needs to carve a niche for its inputs in a complex environment marked by a number of new initiatives, such as the 90-90-90 initiative, and a thrust to prevent HIV among adolescents, especially adolescent girls.

- **Careful prioritisation of work is required** in view of SACO’s limited resources and small staff numbers for HIV work. Given the limited HIV resources available to SACO at this time it may be difficult to be effective both upstream at the policy and planning levels, as well as downstream at the implementation level. Upstream work should be protected, as far as possible while support for small-scale projects on service delivery issues may need to be reviewed.

- **There are organisational challenges in achieving programme linkages and integration across programmes and sectors,** while maintaining a clear HIV programme focus and efficiency in use of financial and human resources.

- **There is scope for positioning UNICEF more integrally in the dialogue around the complex dimensions of equity** (e.g. rural/urban, public/private, reaching the most marginalised, reducing disparities in the quality of services).

- **There is also scope for UNICEF to move beyond a programme focus on women,** to **identify more innovative models to address key gender challenges in South Africa** (e.g. male involvement; gender-based violence; female empowerment).

### 6 Implications for UNICEF

The evaluation team has identified the following implications for SACO, to support the consolidation of the results achieved so far and the strengthening of its programme for the future.

- **Keep the focus of UNICEF investments on reaching out to vulnerable populations and underserved districts in the country (“leave no-one behind”).**
• Work to develop stronger linkages between PMTCT/paediatric HIV care and treatment programme efforts with initiatives to step up HIV prevention and care among adolescents, as a key contribution to reducing HIV prevalence among young women (thereby “closing the tap”) and building a continuum of care for HIV-infected children from birth through to adulthood.  

• Increase the programme focus, as necessary, on paediatric HIV case finding and early treatment, making sure that children’s needs are fully taken into account in the scale-up of the ART programme (within the 90-90-90 initiative).

• Drive towards integration – internally and externally – of HIV issues within other child-focused programmes and sectors. UNICEF is uniquely placed to demonstrate approaches to linking or as useful integrating services for children and adolescents across programmes and sectors (HIV, MNCWH, nutrition, child protection and education), thereby “connecting the dots”. This will require an even greater effort within SACO for joint programming, with shared accountabilities.

• Seize opportunities to innovate and build on comparative advantages, including UNICEF’s unique roles in advocacy and social mobilisation around equity issues and its global experience with gender-transformative and rights-based approaches to programming, within the formal health system, but also increasingly at the community level.

• Maintain a strong presence upstream, at the policy level to ensure that the needs of children affected by HIV are fully considered in the development of key policies and strategies, as well as evolving agendas (such as planning for the National Health Insurance).

• Step up efforts to document best practices and innovative approaches to addressing HIV in children, making the most of South Africa’s tremendous advances and position as a thought leader for the whole continent. This will require more investment in targeted documentation and information dissemination activities.

Implications for the evaluation
The South Africa case study has been a useful exercise and has met the purposes laid out in the evaluation design. In particular, the process has allowed for UNICEF’s role and contributions in PMTCT and paediatric HIV care and treatment to be explored in some detail over the evaluation period (2005–15), as well as providing inputs for the testing and validation of the theory of change that will guide the evaluation (see Annex VI). However, as previously noted, the NDoH and SANAC have played a very strong role in: leading and coordinating the PMTCT and paediatric HIV care and treatment programme over time; mobilising and leveraging national and partner resources; in defining programme guidelines and policies; and in the generation, analysis and dissemination of strategic information. As such, UNICEF’s contributions in these areas have been less critical than in other countries.

56 This implies that the HIV prevention, care and treatment activities among adolescent girls and boys take into account a full range of sexual and reproductive health issues, including dual protection against pregnancy, HIV and other sexually transmitted infections, and access as required to PMTCT services. In particular, the specific sexual and reproductive health needs of children who have grown up with HIV should be adequately addressed. Some joint activities among UNICEF staff working on the first and second decade respectively would be of great value toward this end.

57 Further details are included in the Inception Report for this evaluation.
Annex I: Terms of reference for in-depth country studies

Overview of the evaluation
Itad is a UK-based consultancy company that has been commissioned by UNICEF to undertake an evaluation of its activity in the PMTCT and paediatric HIV treatment, care and support. The purpose of this evaluation is to support accountability and learning in relation to UNICEF’s efforts to scale up PMTCT and paediatric care and treatment programmes and to document its contribution towards elimination of mother-to-child HIV transmission and an AIDS-free generation for children. By looking over the past 10 years of UNICEF’s PMTCT and paediatric HIV engagement, the evaluation will provide evidence and lessons learned to enhance the understanding of the organisation and other stakeholders on how strategies and programmes have evolved, what has worked, has not worked, and why.

The evaluation will assess four particular aspects of PMTCT and paediatric HIV treatment programming, namely:

1. Thematic leadership, advocacy and partnership
2. Resource mobilisation
3. Strategic information, knowledge generation and dissemination, and
4. Key aspects of UNICEF’s organisation.

It will also consider the cross-cutting issues of gender, equity, and human rights. The findings will be used to guide (a) effective action towards the achievement of the UNICEF Strategic Plan HIV outcome and (b) UNICEF positioning in the post–2015 HIV agenda as guided by the UNAIDS 2016–21 Strategy.

As part of the data collection for this evaluation, Itad is undertaking case studies in a total of seven countries – four involving country visits and three conducted remotely through a desk review and phone interviews. The findings from country level are being supplemented with a structured document review, an online survey, and interviews with key stakeholders at global and regional levels.

This document details the process for the country visits in ESARO and WCARO, to be undertaken during the period of April–May 2016.

Purpose of the country case studies
The evaluation is taking as its starting point the theory of change for UNICEF’s work in PMTCT and paediatric HIV over the period of 2005–15. The purpose of the case studies is to record how UNICEF’s engagement in this area has played out at country level, and help test and validate the theory of change. It is important to note the following:

- Each case study has been selected because of the learning opportunity offered to the evaluation.
- The approach to each is focused on recording experiences rather than measuring or assessing individual country performance.

Approach to data collection and analysis
Each mission will last seven working days (over a period of two weeks). Each team will arrive in-country with a clear case study terms of reference (ToR), detailed draft agenda, and having already performed a remote desk study and stakeholder listing to ensure that the time the evaluators spend in-country can be used as effectively and efficiently as possible. Figure 1 below summarises the proposed process through which each of the country studies will be implemented. However, the first country case study visit will be used as an opportunity to refine the process. This will be attended by four members of the core team to gain consensus and maximise consistency of approach.
Step 1: Prior to the visit, a desk review phase will focus on enabling the team to gain a comprehensive understanding of the background to PMTCT/Paediatric HIV/AIDS programme activities in each case study country, and extracting available secondary evidence – for example on key events.

Step 2: During this stage, an agenda for the country case study will be agreed, based on a stakeholder mapping exercise undertaken by the evaluation team and UNICEF Country Office (CO). The evaluation team will contact the CO to discuss this agenda including possible stakeholder interviews.

Step 3: Each mission will start in-country with a brief kick-off meeting with UNICEF staff to orientate the team to the national context, provide background to the UNICEF office, and to enable an initial exploration of issues arising from remote desk review.

Step 4: Following this workshop, the evaluation team will then conduct semi-structured interviews (and where appropriate, small group discussions) with key in-country stakeholders – including UNICEF staff, government, and partners. These interviews will be designed to elicit further information on the thematic areas of interest.

Step 5: At the end of the country visit, the evaluation team will share debriefing notes of observations and preliminary findings through a slide set with the UNICEF CO, and hold a feedback discussion.

Step 6: Subsequently, a case study report will be written up for each country and shared with the CO for comments (approximately two weeks after the end of the country visit).

The team

The country case studies will be conducted by a team of two consultants belonging to the core evaluation team, over a total input period of seven working days in the field per country. This team will be complemented by a national expert who will be normally resident in-country and can support on collation of documents and identification and contacting of stakeholders, and will bring in-depth understanding of the country context. One consultant will act as lead consultant in order to ensure that responsibility for delivery of the report is clearly located.

Guidance to case study country offices

The agenda should ideally be agreed between the CO and the evaluation team at least a week before the visit to allow sufficient time for in-country preparation. In order to appropriately support the case study visit, the team suggest that the CO:

1. Confirm suitability of suggested dates as soon as possible.
2. Identify someone to act as a point of contact to organise the schedule proposed below.
3. Share the ToRs with those who might be consulted during the visit.
4. Identify documents/create a list of key documents that would be useful to share with the evaluation team.
5. Consider which staff members it would be useful for the evaluation team to meet and whether this is most appropriate on a one-to-one basis or in a focus group (or both). Ideally, this should include current staff members as well as staff who were involved during the period.
of interest for the evaluation (2005–15). If necessary, interviews can be conducted remotely over Skype.

6. **Consider which external stakeholders** the evaluation team should meet. This should include representatives from all key development partners working in HIV/AIDS at country level, as well as relevant government stakeholders. Ideally, this should include stakeholders who were involved during the period of interest for the evaluation (2005–15), as well as those who are currently in post.

7. **Feedback on preliminary findings**: Please consider which staff members should be included in the meeting to discuss preliminary findings.

The schedule for the visit is projected to look like this:

| Day   | Monday | AM: Meeting with UNICEF CO  
| Day 2 | Tuesday | PM: Stakeholder interviews (UNICEF staff) |
| Day 3 | Wednesday | Stakeholder interviews (UNICEF staff) |
| Day 4 | Thursday | Stakeholder interviews (external – government and partners) |
| Day 5 | Friday  | Stakeholder interviews (external – government and partners) |
| Day 6 | Saturday | Stakeholder interviews (as required) and internal team working |
| Day 7 | Monday  | Presentation of initial findings to CO (plus additional interviews as required) |
## Annex II: South Africa country visit agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Person/group</th>
<th>Participants</th>
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</thead>
<tbody>
<tr>
<td><strong>Wednesday, 25 May</strong></td>
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<tr>
<td>9:00–10:00</td>
<td>Meeting with SACO management</td>
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<td>10:00–11:00</td>
<td>UNDSS Security Briefing</td>
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<td>11:30–12:30</td>
<td>Regional interview</td>
<td>UNICEF Regional Office, Nairobi (Skype)</td>
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<td>12:30–13:00</td>
<td>Evaluation Team – Schedule and logistics update with Health and Nutrition section team</td>
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<tr>
<td>14:00–15:00</td>
<td>Stakeholder interviews (external partner)</td>
<td>Dr Nancy Knight, Coordinator, CDC</td>
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<tr>
<td>15:30–16:30</td>
<td>Stakeholder interviews (UNICEF staff)</td>
<td>Dr Kondwani N’goma, HIV/AIDS Specialist</td>
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<tr>
<td><strong>Thursday, 26 May</strong></td>
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<tr>
<td>09:00–10:00</td>
<td>Stakeholder interviews (UNICEF staff)</td>
<td>Dr Yulia Privalova Krieger, Deputy Representative</td>
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<tr>
<td>10:00–11:00</td>
<td>Stakeholder interviews (UNICEF staff)</td>
<td>Ms Zodwa Mthethwa, M&amp;E Specialist</td>
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<td>10:00–11:00</td>
<td>Stakeholder interviews (UNICEF staff)</td>
<td>Mr Rory Williams, Budget Officer</td>
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<td>11:00–12:00</td>
<td>Stakeholder interviews (external partner)</td>
<td>Prof. Jerry Coovadia, MATCH</td>
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<td>14:30–15:30</td>
<td>Stakeholder interviews (UNICEF staff)</td>
<td>Ms Sebenzile Mabena, HR Specialist</td>
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<tr>
<td><strong>Friday, 27 May</strong></td>
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<tr>
<td>9:00–10:00</td>
<td>Stakeholder interviews (government partner)</td>
<td>Dr Lesley Bamford, Ms Mazibuko, Ms Lebo Madisha, NDoH Child Health Cluster</td>
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<tr>
<td>9:00–10:00</td>
<td>Stakeholder interviews (WHO)</td>
<td>Dr Sandra Barber, WHO Representative</td>
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<td><strong>Monday, 30 May</strong></td>
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<tr>
<td>8:30–9:30</td>
<td>Stakeholder interviews (UNICEF Staff)</td>
<td>Dr Sanjana Bhardwaj, Chief of Health and Nutrition Section</td>
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<tr>
<td>11:00–12:00</td>
<td>Stakeholder interviews (external partner)</td>
<td>Dr Erasmus Morah, UNAIDS Country Director</td>
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<tr>
<td>12:00–13:00</td>
<td>Stakeholder interviews (external partner)</td>
<td>Dr Peter Barron, Technical Advisor PMTCT, National Department of Health</td>
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<tr>
<td>15:00–16:00</td>
<td>Stakeholder interviews (external partner)</td>
<td>Dr Margot Uys, Head: Integrated Health Systems Strengthening, Technical Assistance Department, Foundation for Professional Development</td>
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<tr>
<td>16:30–17:30</td>
<td>Stakeholder interviews (external partner)</td>
<td>Dr Shungu Gwarinda, Country Director M2M – South Africa</td>
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<tr>
<td><strong>Tuesday, 31 May</strong></td>
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<tr>
<td>8:45–9:45</td>
<td>Regional interviews</td>
<td>UNFPA, Johannesburg</td>
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<tr>
<td>10:00–11:00</td>
<td>Regional interviews</td>
<td>UNAIDS, Johannesburg</td>
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<tr>
<td>11:00–12:00</td>
<td>Regional interviews</td>
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<tr>
<td>12:00–13:00</td>
<td>Stakeholder interviews (external partner)</td>
<td>Dr Ameena Goga, Senior Specialist Scientist: Health Systems Research Unit, South African Medical Research Council</td>
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<tr>
<td>14:30–15:30</td>
<td>Stakeholder interviews</td>
<td>Mr Mark Heywood, Executive Director, Section 27</td>
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<tr>
<td>15:30–16:30</td>
<td>Regional interviews</td>
<td>UNICEF, Johannesburg</td>
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<tr>
<td>16:30–17:30</td>
<td>Stakeholder interviews (external partner)</td>
<td>Dr Gayle Sherman, Associate Professor Department of Paediatrics and Child Health, University of the Witwatersrand Centre for HIV &amp; STI, National Institute for Communicable Diseases</td>
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<tr>
<td>19:00–00</td>
<td>Stakeholder interviews (external partner)</td>
<td>Precious Robinson, Right to Care</td>
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**Wednesday, 1 June**

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<thead>
<tr>
<th>Time</th>
<th>Person/group</th>
<th>Participants</th>
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<tr>
<td>10:30–11:00</td>
<td>Stakeholder interviews (government partner)</td>
<td>Dr Pearl Holele, Chief Director: Maternal, Neotal and Women’s Health, NDoH</td>
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<tr>
<td>11:00–13:00</td>
<td>Presentation of initial findings to the Country Office</td>
<td>Dr Sanjana Bhardwaj, Dr Kondwani N’goma</td>
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</table>

**DEPARTURE**

Follow up Skype interviews
- Ms Nokuthula Prusent
- Yogan Pillay
### Annex III: Stakeholder list

<table>
<thead>
<tr>
<th>Name of person</th>
<th>Title</th>
<th>Organisation</th>
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</thead>
<tbody>
<tr>
<td>Dr Lesley Bamford</td>
<td>Technical Advisor, Child health cluster</td>
<td>NDoH Child Health Cluster</td>
</tr>
<tr>
<td>Dr Sandra Barber</td>
<td>WHO Representative</td>
<td>WHO</td>
</tr>
<tr>
<td>Dr Peter Barron</td>
<td>Technical Advisor PMTCT</td>
<td>NDoH</td>
</tr>
<tr>
<td>Dr Sanjana Bhardwaj</td>
<td>Chief of Health and Nutrition section</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Prof. Jerry Coovadia</td>
<td></td>
<td>MATCH</td>
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<tr>
<td>Dr Ameena Goga</td>
<td>Senior Specialist Scientist: Health Systems Research Unit</td>
<td>South African Medical Research Council</td>
</tr>
<tr>
<td>Dr Shungu Gwarinda</td>
<td>Country Director</td>
<td>mothers2mothers</td>
</tr>
<tr>
<td>Mr Mark Heywood</td>
<td>Executive Director</td>
<td>Section 27</td>
</tr>
<tr>
<td>Dr Pearl Holele</td>
<td>Chief Director: Maternal, Neotal and Women’s Health</td>
<td>NDoH</td>
</tr>
<tr>
<td>Dr Gulprit Kindra</td>
<td>Public Health Specialist Care and Treatment Branch</td>
<td>CDC</td>
</tr>
<tr>
<td>Dr Nancy Knight</td>
<td>Coordinator</td>
<td>CDC</td>
</tr>
<tr>
<td>Dr Yulia Privalova Krieger</td>
<td>Deputy Representative</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Ms Sebenzile Mabena</td>
<td>HR Specialist</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Ms Lebo Madisha</td>
<td>Deputy Director, and programme manager for paediatric HIV</td>
<td>NDoH Child Health Cluster</td>
</tr>
<tr>
<td>Ms Mazibuko</td>
<td>Director, Child health cluster</td>
<td>NDoH Child Health Cluster</td>
</tr>
<tr>
<td>Dr Mary Mogaswa</td>
<td>Chief, Care and Treatment Branch</td>
<td>CDC</td>
</tr>
<tr>
<td>Dr Erasmus Morah</td>
<td>Country Director</td>
<td>UNAIDS</td>
</tr>
<tr>
<td>Ms Zodwa Mthethwa</td>
<td>M&amp;E Specialist</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Dr Kondwani N’goma</td>
<td>HIV/AIDS Specialist</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Yogan Pillay</td>
<td>Deputy DG/HIV, TB and MCH/South Africa, and global policy advisor</td>
<td>NDoH</td>
</tr>
<tr>
<td>Ms Nokuthula Prusent</td>
<td>Adolescent and Youth Specialist</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Precious Robinson</td>
<td>MNCWH and PMTCT Programme Lead</td>
<td>Right to Care</td>
</tr>
<tr>
<td>Dr Gayle Sherman</td>
<td>Associate Professor Department of Paediatrics and Child Health</td>
<td>University of the Witwatersrand Centre for HIV &amp; STI</td>
</tr>
<tr>
<td>Dr Margot Uys</td>
<td>Head: Integrated Health Systems Strengthening, Technical Assistance Department</td>
<td>Foundation for Professional Development</td>
</tr>
<tr>
<td>Mr Rory Williams</td>
<td>Budget Officer</td>
<td>UNICEF</td>
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Annex IV: An overview of the country context to South Africa’s PMTCT and paediatric HIV and AIDS programme

Geography and population

South Africa (SA) occupies the most southern part of Africa. Its land area comprises slightly more than 1.2 million square kilometres, much of which is bordered by approximately 2,500 kilometres of coastline. The country shares borders to the north with Namibia, Botswana and Zimbabwe. Mozambique and Swaziland are on the east. SA also borders Lesotho, a small mountainous kingdom that it completely surrounds.

Administratively, the country is divided into nine provinces, each varying in climate and topography. Four of these are coastal provinces, namely the Eastern Cape, KwaZulu-Natal (KZN), Northern Cape and the Western Cape. The landlocked provinces are the Free State, Gauteng, Limpopo, Mpumalanga and North West. Gauteng is the smallest province in terms of land area, but the most densely populated. It is home to SA’s largest city, Johannesburg, and also to Pretoria, the country’s administrative capital. Bloemfontein, the capital city of the Free State, is the country’s judicial capital, and Cape Town in the Western Cape, the second most populated city after Johannesburg, is SA’s legislative centre.

In geopolitical terms, the country’s spatial boundaries reflect its three tiers of government, namely national, provincial, and local government. Provinces, each with its own legislature, executive council, and executive authority (the Premier) are, for instance, further demarcated into local government areas known as municipalities. There are three categories of municipality, namely metropolitan, district, and local municipalities. Of the 278 municipalities, eight are classified as metropolitan, 44 as district, and 226 as local.58

As of July 2015, SA’s population was estimated at just over 54.9 million. Females comprise 51%. A significant proportion of the total population is under 15 years, 30.2%; of these, almost 44% are split between Gauteng and KZN. Those over 60 years account for 8% of the population, with more than a quarter concentrated in Gauteng. Disaggregated by race, black Africans make up 80.5% of the total population, coloureds 8.8%, whites 8.3% and Indians 2.5%. Overall, Gauteng has the largest share of the population, 24%, and KZN, the second largest, 19.9%. Migration is a factor shaping demographic distributions. Gauteng and the Western Cape, which have the largest cities, experience the greatest inflows; the Eastern Cape, the Free State, and Limpopo have the largest outflows. Recent estimates put the proportion of the total urban population at 60%; since 1994, there has been a drop in the proportion living in rural areas, by around 10 percentage points.59

Economy

SA is one of the most naturally mineral-rich countries in the world and historically, commercial mining has fuelled the growth of the country’s economy. For instance, prior to 2007, the country was the leading producer of gold in the world, and the mining industry contributed significantly to gross domestic product (GDP).60 However, though still a major industry, mining no longer occupies the same status that it once did in the SA economy. Some of the reasons for this are shifts towards secondary and tertiary industries and knock on effects of the 2008/9 financial crisis.

In terms of economic sectors driving SA’s growth in the post-apartheid period, the financial services sector and manufacturing sector have been among the largest contributors, occupying a 41% share of


the country’s economy for 2012. The financial services sector’s strong performance continued into 2015, by the third quarter contributing the largest proportion to GDP, 20.7%. The government services sector was the second highest contributor for this year, 17.6%, with manufacturing third, 13.3%. SA’s diversified economy also includes other major sectors. These are agriculture, mining, construction, personal services, trade, transport; and electricity, gas and water supply. Gauteng, KZN and the Western Cape contribute in excess of 60% of GDP, making them key economic centres.

In recent years, economic growth in SA has been sluggish with GDP at a low 1.5% in 2014 and 1.3% in 2015, and the country is now the second biggest economy on the continent after Nigeria. Foreign direct investment has declined – by 31.2% between 2013 and 2014 – and in 2015, the international market for exports is subdued, and the country’s credit ratings were downgraded.

That said, SA’s position within the BRICS partnership, brings international trade opportunities. Also, through membership of the Southern African Development Community (SADC) and the Southern African Customs Union (SACU), as well as through bilateral investment agreements with a number of African countries, prospects remain for tapping into opportunities resulting from regional integration.

**Socio-economic and political context**

SA’s human rights-based Constitution guarantees equality for all before the law. To this end, its Bill of Rights protects rights to life, health, and freedom from unfair discrimination on various grounds, including gender, race, age, and sexual orientation. Drafted by the country’s first democratically elected government, such protections signalled a shift from pre-1994 apartheid and colonial era policies and practices. They also provide the legal and theoretical frame guiding SA’s post-apartheid period of transformation. This is a frame that foregrounds the necessity of intervening in the structural inequities that apartheid had left behind.

These inequities manifest in myriad ways in contemporary SA. High unemployment and poverty rates, both of which have a racial and gender bias, are key among them. Apropos, combatting the triple threat of poverty, unemployment, and inequality is a critical component of South Africa’s democratic project. This is made clear in number of policy frameworks that have guided and continue to guide the country’s development. For instance, the 1994 Reconstruction and Development Programme (RDP) states: “no political democracy can survive and flourish if the mass of our people remain in poverty, without land, without tangible prospects for a better life...attacking poverty and deprivation must therefore be the first priority of a democratic government”. The elimination of poverty and the reduction of inequality are also key objectives of the most recent framework, the National Development Plan 2030 (NDP).

The Gini coefficient, a measure of economic equality, shows that SA represents one of the most unequal societies in the world, with the measure recorded in 2006 only slightly improved in 2011. This inequality is unlikely to shift significantly unless there is a corresponding shift in the socio-economic circumstances of black African South Africans who comprise the majority population, approximately 80%. This is especially pertinent given that poverty – on both an individual and a household level – continues to have a racial and gender bias. This is unsurprising given that black
Africans, and especially black African women, comprise historically marginalised populations. Poverty trends since the mid-2000s are instructive.

Referencing the relationship between race and poverty, data for the period 2006 to 2011 shows that although poverty decreased overall, black African households continued to constitute the vast majority of all poor households; around 93% since 2006. That black Africans start from a low economic base relative to those privileged by the apartheid system is also indicated by data on income growth in households. Although 2006 to 2011 showed a 16.7% real increase in household income growth, contributing to decreasing poverty levels during this period, the disparity in income between black African-headed households and white-headed households remained large. This is despite black African-headed households experiencing the most income growth during this time – a 34.5% increase compared to 0.4% increase in white-headed households. On an individual level, more than half of black Africans live in poverty, 54%.68

Poverty trends also draw attention to the intersections between poverty and gender. Female-headed households are more likely to be poorer than those headed by males; females head more than half of all poor households. On an individual level, they are also likely to be hardest hit by poverty. In terms of poverty share, they make up the largest proportion of the country’s poor, with more females than males living below the poverty line. This status has remained relatively unchanged since 2006.69

The long-term effects of apartheid era land policies, and the rural urban dynamics that they underscored, are also important when considering poverty. Rural areas are still disproportionately affected by poverty; poverty trends for 2006–11 show that more than half of all rural households are poor. In 2011, poverty was twice as high in rural as compared to urban areas; also more than half the country’s poor were living in rural areas.70 That in 2012 the urban poverty rate for females was 38.7%, and the non-urban rate was 76.8%, provides some insight into the gendered dimensions of the rural urban divide in SA.71

What the gendered and racial dimensions of poverty mean for the livelihoods and well-being of children, not least black children, 71.1% of whom live in low-income households, is a vital consideration. This is especially in light of the fact that more than two thirds of all children (17 years and under) were living in poverty in 2006, with more than half remaining impoverished by 2011. Children’s share of poverty is also concerning – in 2011, children comprised 37.6% of the total population but almost half of all poor people.72

Unemployment:

By the third quarter of 2015, the unemployment rate in South Africa was 25.5%.73 This corresponds with the average unemployment rate from around the year 2000.74 Unemployment as an indicator of inequity on the basis of race is indicated by the fact that black Africans are over-represented among the unemployed and the not economically active population – in 2014 this was 85.7% and 83.3% respectively. Unemployment figures also highlight women’s vulnerability in the South African labour
market. In 2014, women accounted for more than half of those in long-term unemployment. This is in line with trends for the period 2008–14.75

The strong relationship between education and poverty is highlighted by data showing that poor households are likely to be headed by people with low education levels. This relationship is also evident at the individual level. In 2011, more than two thirds of adults without a formal education were poor, of those with a post matric qualification, only 5.5% were poor. 76 Employment data for 2015 expands on this link between education, historical disadvantage on the basis of race, and access to economic opportunities that reduce poverty and inequality.

**Initiatives to reduce inequity:**

In a bid to mediate the legacy of inequality left by SA’s colonial and apartheid past, all of SA’s socio-economic blueprints since 1994, from the RDP to the Growth, Employment and Redistribution Plan to the NDP 2030, have prioritised poverty and unemployment as key development concerns. The nationwide Expanded Public Works Programme, the Community Rural Development Programme, the Kha ri Gude mass literacy campaign, and the creation of the Ministry of Small Business Development in 2014, are some of the government initiatives that have focused on addressing these concerns. Government’s Broad-Based Black Economic Empowerment (B-BBEE) Act, 2003, along with various revisions to the Code of Good Practice that informs its implementation, has also been a key initiative.77

With close to 60% of government spending allocated to the ‘social wage’, this too has been a key aspect of the government’s efforts to mitigate the threats of poverty, unemployment and inequality.78 Social wages in South Africa include social grants, free primary health care, free basic education (no fee paying schools) and RDP housing. The MDG Country Report 2013 notes that expenditure on social wages more than doubled in real terms over the past decade; over this period, per capita health spending increased, 1.5 million free homes were constructed, and free basic education was provided to the poorest 60% of learners.79

With respect to social protections, SA’s social welfare system has also played an instrumental role, especially to those living below the poverty line. Since 2000, social grants have increased, from around 3 million grants to 15 million by 2011.80 This growth has been largely driven by an expansion in coverage of child support grants. The growth has continued since 2011 with government spending on social protection increasing by 39% over a 5-year period, from about R87 billion in 2010/11 to about R121 billion in 2014/15.81

**Inequality, poverty, gender and sexual violence:**

The history of the majority of South Africa’s women references the political economy of exclusion that characterised the country’s colonial and apartheid period. South African women were usually reliant on the remittances that came from men’s participation as cheap unskilled labour in the migrant labour system, especially in the mining sector, and were subject to unregulated labour conditions in the former Bantustans. The women were on the margins of employment opportunities and a living wage

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77 BBEE was intended to produce market conditions that would remedy the effects that historical exclusion from the economy has on black South Africans. It was thus designed to intervene in historically institutionalized ways of doing business that had promoted such exclusion (see Andrews, 2008; Chabane et al., 2006, among others).
in the formal economy, and prejudiced in terms of equal access to formal education.\textsuperscript{82} In the post-apartheid period, this history, and the structural inequities that underscored it, remains apparent in women’s heightened vulnerability to poverty and unemployment. It also remains apparent in gender norms, including norms that drive South Africa’s high rates of gender-based and sexual violence (SA’s rate of reported rape of women/girls is the highest worldwide), as well as in women’s particular vulnerability to HIV infection.\textsuperscript{83} How these knit together to shape high HIV prevalence rates for pregnant women, high maternal mortality rates, unplanned pregnancy and children’s associated risks of HIV exposure is a question requiring further research. This is especially in light of the fact that despite high coverage of the national PMTCT programme, HIV prevalence has remained high among pregnant women, and maternal mortality – frequently related to preventable diseases, and especially AIDS – is unacceptably high.

Health

The health care system in SA is pluralistic. At an institutional level, the system is two-pronged, comprising a large under-resourced public sector and a smaller well-funded private sector. These are the two main health care providers. Other alternatives, in particular African traditional medicine and healing, are also available. This plurality not only reflects the cultural diversity of the country’s population, it also reflects the legacy of social and economic inequality that SA’s history of colonial and apartheid rule has left behind. The private health care sector, ranked among the top four in the world, is, for example, unaffordable for the vast majority of South Africans.\textsuperscript{84} Those who are able to access private health care are usually those who can afford private medical aid schemes; a minority of around 16%.\textsuperscript{85}

Public health sector:

As part of the transformation project in the period after 1994, the newly elected democratic government focused on building a national health care system that would provide cost-effective and equitable health care to all citizens. This was aligned with the Constitution’s framing of health as a human right, a framing that among other things advanced the right of health care services, the right of every child to basic health care services, and the right of everyone “to an environment that is not harmful to health or wellbeing.”\textsuperscript{86}

This focus on equitable health care access resulted in a process of restructuring that prioritised a primary health care (PHC) approach. Notably this is an approach promoting the widespread reach of free health care services, especially into under-serviced and poor communities. Through PHC clinics, implemented within the framework of a district health system, the government has thus been able to decentralise health care in a way that puts the health district and its management structure at the centre of the public health system.\textsuperscript{87}

The structure of the public health model is as follows:

- Primary health care (clinics)
- District hospitals
- Tertiary and central academic hospitals


\textsuperscript{85} See Rowe and Moodley, 2013. ‘Patients as consumers of health care in South Africa: The ethical and legal implications’. BMC Medical Ethics.

\textsuperscript{86} As stated in articles 27, 28, and 24 of the Bill of Rights.

\textsuperscript{87} See McCoy and Engelbrecht, 1999. ‘Establishing the district health system’. Health Systems Trust, 1999.
PHC facilities are the foundation of SA’s public health system. They provide entry-level access to those requiring basic health care services. This includes free services to children under six, pregnant women, the disabled and indigent. Although these facilities have improved health care access at community level, concerns about the quality of services have been raised. For instance, findings from a survey of 3,356 clinics indicated that 21% did not have facility managers, nearly half had no visiting doctors (47%), 84% had no assistance from a pharmaceutical support, 11% had no lay counsellors, 57% had no administration support, and 79% had no information management staff.  

District hospitals are the second line of access, with patients usually being referred by PHC staff for more advanced and specialised levels of health care support. At the tertiary and regional level are the academic hospitals that train medical students and health care professionals. These institutions also serve as centres for health-related research and innovation, and undertake advanced diagnostic and clinical procedures and treatments.

**Progress and challenges:**

Since 1994, in excess of 1,500 public health facilities have been built or upgraded, and figures from the National Health Facilities Baseline Audit 2013 indicate that there are 3,901 public health facilities in South Africa (this figure includes the 21 PHC facilities in the Western Cape that were not audited). Despite this increase, for 2.5 million South Africans, the nearest clinic is, however, more than 5 kilometres away from home. Transport may well be a barrier to timely health care access.

On average, each facility provides services to 13,718 people; this is more than the 10,000 per clinic recommended by the WHO guidelines. The strain under which public health care operates is also indicated by the doctor patient ratio; there is one doctor for every 4,219 patients. Compared to the one doctor to 243 patients in the private sector, this is a marked difference. Indeed, the shortage of staff at various levels of service provision has been one of the main challenges that the public health care sector faces with regard to effective delivery and implementation. This has been especially evident in addressing the health care burdens that have been posed by SA’s HIV and TB epidemics. To some degree, this shortage has been filled by thousands of community health care workers who have provided support in home-based care, treatment monitoring, voluntary counselling and so forth.

**Enabling policies and initiatives:**

Apart from the Constitution, there have been a number of policies that have directed the growth path of SA’s public health system and its ability, albeit with inefficiencies, to serve a population that continues to experience high poverty and unemployment rates, along with high burdens of disease, especially HIV and TB. The National Health Strategic Framework has been key among these policies. Others include the National Health Act, 61 of 2003, a National Health Amendment Bill of 2010, the three National Strategic Plans on HIV and AIDS, TB and STIs. Government’s publishing of a white paper on implementation of the National Health Insurance at the end of December 2015 is the most recent policy development. This proposed implementation holds promise for bringing SA even closer to the goal of equality through universal health coverage.

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89 Ibid. Also cited in Jobson 2015.

90 Ibid.

91 Ibid.

92 Ibid.

93 Ibid.
### Annex V: Timeline of key events during 2005–15

The following pages detail some key events in South Africa during the period of the evaluation.

#### 2005
- Saving Children 2005 Report.
- Saving Mothers 2005 Report.
- The NDoH issues a directive instructing facilities that possession of an ID book is not a prerequisite for accessing treatment. This opened the ART programme to foreign nationals.
- The Children’s Act, No. 38 of 2005 protects the right of the infant to receive protection from acquiring HIV through MTCT.

#### 2006
- South Africa is signatory to the 2006 Political Declaration on Universal Access.
- Saving Children 2006 Report.
- Saving Babies 2006–07 mortality audit.

#### 2007
- Cabinet adopts the final National Strategic Plan (NSP) for HIV and AIDS and STIs (2007–11).

#### 2008
- Mbeki and his health minister resign, setting the scene for a new era in South Africa’s battle with HIV.
- The NDoH updates the PMTCT policy. The 2008 revised guidelines recommend (for all HIV-positive pregnant women) maternal Zidovudine (AZT) prophylaxis from 28 weeks gestation with single-dose maternal nevirapine (sdNVP) in labour or ART (ifCD4<250cells/µl or Stage IV disease). All infants receive sdNVP and seven (or 28) days AZT (NDoH, 2008).
- The Minister of Health launches the national PMTCT Accelerated Plan (A-plan) which aimed to reduce mother-to-child transmission of HIV from 12% in 2008 to less than 5% by 2011, in accordance with the National Strategic Plan 2007–11.
- Saving Mothers Report, 2008.
- Saving Babies 2008–09 mortality audit.
- The National Infant and Young Child Feeding Policy is promulgated.
- From 2008, major changes in professional practice are initiated, including a shift towards nurses initiating and managing the use of ART.

#### 2009
- In May 2009, the newly elected President Jacob Zuma acknowledges HIV as among the most important challenges facing the country.
- President Zuma’s speech on World AIDS Day 2009 outlines changes to be implemented in 2010. He declares World AIDS Day 2009 as “the day on which we start to turn the tide in the battle against AIDS.”
- Minister of Health, Dr Aaron Motsoaledi, begins his tenure by acknowledging that South Africa’s health care system has spent the last 10 years “pedalling backwards”.
- The Minister of Health directs that there should be greater integration between HIV, TB and MCH programmes through a decentralised model of care. And the NDoH develops a set of guidelines on integration of HIV and TB services into PHC services (A Practical Guide to HIV/TB Service Integration at PHC Level).
- SANAC endorses integrated TB/HIV services.
- The Saving Children 2009 Report
### 2010
- Revised Clinical Guidelines for the Management of HIV in Adults and Adolescents recommend that ART should be initiated for anyone meeting the WHO definition of stage 4 clinical condition regardless of CD4 count (Option A). The guidelines also indicate earlier initiation of ART for people living with HIV with TB and pregnant women.
- Guidelines for the Management of HIV in Children are updated to recommend that all HIV-infected children under the age of one should receive ART, irrespective of CD4 count.
- On 26 October 2010, the Minister of Health, Dr Aaron Motsoaledi, together with eight other ministers and the nine provincial Members of the Executive Committees for Health, signs the Negotiated Service Delivery Agreement (NSDA) on behalf of the health sector. Decreasing maternal and child mortality and combating HIV and AIDS and TB over a 5-year period were among the strategic outputs that the NSDA cited.
- The SAG launches the national HIV, Counselling and Testing Campaign in April 2010, with the President being tested publicly.
- First national survey to measure PMTCT effectiveness. Conducted by South African Medical Research Council (MRC) between June and December 2010.
- Saving Children 2010 Report.
- Saving Babies 2010–11 mortality audit.
- Revision of National Guidelines on Infant and Young Child Feeding in the context of HIV.

### 2011
- SANAC launches the National Strategic Plan for HIV, STIs, and TB (2012–2016).
- Second national survey conducted by the MRC to evaluate PMTCT effectiveness.
- South Africa’s infant feeding policy changed to exclusive breastfeeding for six months and continued breastfeeding thereafter, regardless of HIV status.
- The NDoH develops a national action framework for eliminating mother-to-child transmission of HIV, namely: “No child born with HIV by 2015 and improving the health and wellbeing of mothers, partners and babies in South Africa.”
- Between 2011 and 2013, the NDoH develops and implements an intervention using data-driven participatory processes to understand facility-level bottlenecks to optimise PMTCT implementation and to scale up priority PMTCT actions nationally.
- Saving Mothers 2011.
- South Africa signatory to the 2011 UN General Assembly Political Declaration on HIV and AIDS. The Political Declaration sets 10 targets on HIV and TB to be reached by 2015, including: eliminate MTCT of HIV by 2015 and substantially reduce AIDS-related maternal deaths.

### 2012
- South Africa launches the Campaign on the Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA) strategy, setting goals to reduce maternal and neonatal mortality by more than half between 2013/2014 and 2018/19.
- The NDoH produces the National Plan on Maternal, Newborn, Children, and Women’s Health (MNCH) and Nutrition for South Africa, 2012–16.
- Rapid Paediatric Assessment.
- Third national survey measuring early population-level effectiveness of WHO PMTCT Option A, South Africa.
- Saving Children 2012 Report.
- Saving Babies 2012–13 mortality audit.

### 2013
- The 2010 clinical guidelines for PMTCT are updated, recommending a standardised triple-drug regimen to treat HIV-infected pregnant women (regardless of CD4 count) during pregnancy and breastfeeding, with continuation of ART after breastfeeding for women with CD4 counts less than 350 (Option B).
- The Country Coordinating Mechanism, managed by the SANAC, submits its country proposal to the Global Fund at the end of May 2013. The Global Fund Board approves US$307m on 6 September
### 2013.
- Joint National Review of the HIV, TB, and PMTCT programmes.
- National Plan of Action for Children in South Africa (2012–17) is approved by Cabinet.

### 2014
- The NDoH announces expanded access to the fixed dose combination regimen by raising the threshold for initiation of ART to CD4 count ≤500/µl. This is in line with the WHO guidelines published in 2013.
- In July 2014, the Minister of Health announces that from January 2015 the South African PMTCT programme will now adopt the WHO B+ guidelines that were published in 2013. In terms of these revisions, every pregnant and breastfeeding woman is entitled to lifelong ART regardless of CD4 count or clinical staging.
- In December 2014, NDoH publishes revised *National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults*.
- The Minister of Health launches the “30,000 to 3 feet” approach.
- The NDoH launches the 90-90-90 effort.
- The NDoH launches the MomConnect project.

### 2015
- The PEPFAR funded programme: DREAMS is launched in Johannesburg, South Africa on 17 November 2015.
- The NDoH publishes revised *National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults*.
### Annex VI: Summary analysis against the components of the theory of change

<table>
<thead>
<tr>
<th>Component of theory of change</th>
<th>Evidence from country</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic directions</strong></td>
<td></td>
</tr>
<tr>
<td>Thematic leadership, advocacy, coordination and partnership</td>
<td></td>
</tr>
<tr>
<td>SD1: Coordinate programme design, planning and implementation among partners at all levels</td>
<td>National stakeholders recognise UNICEF as a lead player in programming related to HIV in children. UNICEF has played a significant role in supporting national, provincial and district authorities and their partners to develop data-informed and target-driven strategic frameworks and related implementation plans for scaling up PMTCT and paediatric HIV care and support services.</td>
</tr>
<tr>
<td>SD2: Broker partnerships at all levels, including among private sector, civil society and multi-sector stakeholders, and encourage South–South as well as triangular cooperation among partners</td>
<td>UNICEF has forged strong partnerships with a range of players in programme scale-up. Partners include all key players in the South African response to HIV, including government institutions, development partners, civil society, private sector and research centres. UNICEF is also an active member of the technical working groups on PMTCT and paediatric care, which are convened by the NDoH, and other time-limited working groups, such as for the South African HIV and TB Investment Case.</td>
</tr>
<tr>
<td>SD3: Ensure that HIV services for children receive adequate priority in global, regional and national decision making</td>
<td>National stakeholders commend UNICEF for its advocacy for prevention, care, treatment and support services for children affected by HIV. UNICEF was in particular very active in supporting national, provincial and district stakeholders in formulating commitments for e-MTCT and in supporting the development of related strategies and plans. UNICEF has provided support to national efforts over the last several years to fully integrate PMTCT and paediatric HIV care and treatment into the MNCWH’s platform. Its efforts to integrate programme activities with those of other sectors such as early childhood development, child protection and education are less visible to stakeholders however.</td>
</tr>
<tr>
<td>SD4: Support key stakeholders at all levels to plan, resource and implement HIV services for children</td>
<td>UNICEF has made substantial efforts to build capacity for programme planning and implementation related to PMTCT and paediatric HIV care and treatment, at the national level as well as in the provinces and districts that it has prioritised for its HIV work. Many respondents pointed to UNICEF’s strengths in working at the district level. UNICEF has also worked with organisations involving women living with HIV in the delivery of PMTCT services, in health facilities and at the level. More work could be usefully done to strengthen the engagement of community-based structures and to build citizen accountability systems for ensuring that children are adequately addressed in the HIV response.</td>
</tr>
</tbody>
</table>

**Assumptions related to thematic leadership, advocacy, coordination and partnership**
<table>
<thead>
<tr>
<th><strong>Strong global, regional, and national systems of coordination exist that can be leveraged to galvanise action on HIV and children</strong></th>
<th>Current SAG leadership and coordination systems are strong at all levels of the decentralised response. Partner coordination arrangements ensure alignment with established roles and responsibilities, and overall complementarity and coherence.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A wide range of partners at all levels exists that could be engaged on issues related to HIV and children</strong></td>
<td>A wide range of national and international stakeholders already work on issues related to HIV and children in South Africa, and there are many opportunities for additional partners to be engaged.</td>
</tr>
<tr>
<td><strong>A minimum level of capacity among key stakeholders at country level exists that can be supported</strong></td>
<td>The technical and managerial capacity levels among stakeholders in South Africa are very strong.</td>
</tr>
</tbody>
</table>

### Resource mobilisation

<table>
<thead>
<tr>
<th>SD5: Initiate, support and coordinate movements, campaigns, and investment plans to mobilise financial resources</th>
<th><strong>UNICEF SACO</strong> is heavily reliant on “Other Resources” and therefore has explored additional avenues of resourcing. During 2012–15, 94% of SACO’s funding for PMTCT and paediatric HIV was from Other Resources Regular. Both the Chief of the Health and Nutrition section and the PMTCT and paediatric HIV specialist are funded through OR. SACO receives HIV funding from CDC (and has done since 2010), foundations such as MacAIDS and the ELMA Foundation, in addition to some thematic funds for HIV. However, it has also been exploring options for additional funding – for example, taking advantage of the requirement in South Africa for countries to invest in corporate social responsibility. A fundraising strategy was submitted as part of the 2013–17 CPMP, and while not specific to HIV, the most recent Country Report from South Africa notes the increase in the number of pledge donors and broader partnerships.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SD6: Engage with donors, governments and country stakeholders to leverage additional global and domestic resources, and support countries to access external resources</td>
<td><strong>UNICEF</strong> has supported South Africa to develop budgets for use in securing financial commitments for PMTCT/ paediatric HIV care and treatment, through its engagement in the preparation of costed plans (such as the e-MTCT plan 2011–15), the PMTCT component of the Investment Case and applications to the Global Fund. The share of the HIV budget taken up by the SAG has grown rapidly over recent years and now accounts for about 80%.</td>
</tr>
</tbody>
</table>

### Assumptions related to resource mobilisation

| Flows of total ODA, and ODA for health and HIV/AIDS specifically, remain stable or grow | Official development assistance for HIV/AIDS has grown between 2005 and 2014. This has largely been driven by an increase in funding from the United States. |
Evaluation of UNICEF’s PMTCT/Paediatric AIDS Programme: South Africa Case Study

<table>
<thead>
<tr>
<th>Economic growth and growth in government expenditures takes place in countries where UNICEF is active to support HIV responses</th>
<th>Overall, economic growth has continued during this period and government expenditures on the response have increased rapidly.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A minimum level of capacity at country level exists to plan and budget for HIV in children</td>
<td>Capacity to plan and budget for HIV in children is very strong in South Africa.</td>
</tr>
<tr>
<td><strong>Strategic information, knowledge generation and dissemination</strong></td>
<td><strong>SD7: Generate, collate and disseminate high-quality global and national data for scaling up effective approaches to address HIV among children</strong> UNICEF has made appreciated investments in national processes to build critical knowledge on women and children, track progress in HIV programme scale-up at all levels of the health system, pinpoint bottlenecks to implementation and identify gaps in programme coverage. In particular, it has provided technical and financial support to focused reviews, evaluations and studies. It has also pioneered the application of innovative tools to identify problems and solutions, such as real-time monitoring of PMTCT.</td>
</tr>
<tr>
<td></td>
<td><strong>SD8: Provide support for governments and country partners to generate and collate strategic information (SI) and knowledge</strong> UNICEF has provided critical support for programme data collation and validation processes for tracking progress in programme implementation at national, provincial and district levels. Its role in promoting the dashboards to track improvements along the PMTCT cascade is widely appreciated and is now being replicated in other programme areas.</td>
</tr>
<tr>
<td></td>
<td><strong>SD9: Support global- and country-level interpretation and translation of SI and evidence into sound policies, strategies and programmes</strong> Together with partners, UNICEF has made useful contributions in supporting the NDoH to shift their strategies, policies and guidelines based on global guidelines and country experiences.</td>
</tr>
<tr>
<td><strong>Assumptions related to strategic information (SI), knowledge generation and dissemination</strong></td>
<td><strong>A minimum level of capacity at country level exists to generate and use SI and knowledge</strong> Capacity at the country level to generate SI related to PMTCT and paediatric HIV care and treatment is excellent. South Africa also boasts of world class centres for clinical, epidemiological and social research on health and HIV.</td>
</tr>
<tr>
<td></td>
<td><strong>Support from technical partners is sustained for generating SI and knowledge</strong> A number of partners contribute to this area, including US government supported partners, UNAIDS and WHO, working with the NDoH.</td>
</tr>
</tbody>
</table>
### Cross-cutting issues

<table>
<thead>
<tr>
<th>SD10: Work to ensure that effective interventions are adequately integrated within humanitarian responses</th>
<th>There was no evidence of this from the South Africa Case Study.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SD11: Advocate for and support gender-equitable policies, budgeting and resource allocations, and gender-sensitive approaches to HIV programming and monitoring</td>
<td>UNICEF has a focus on women and children; however, it has a less significant profile in relation to broader gender issues. UNICEF is recognised externally as having a focus on women and children, through its work on PMTCT. However, there is less evidence of engagement with wider gender issues linked to HIV – including linkages between gender-based violence and HIV, and models of male involvement. Stakeholders (internally and externally) recognise these as critical issues affecting South Africa – for example, optimising male involvement was highlighted in the 2016 Investment Case as an important question for South Africa going forward. There is a perception that UNICEF, as well as the broader UN system, could be more vocal on gender issues.</td>
</tr>
<tr>
<td>SD12: Ensure that human rights and child rights are protected, promoted and fulfilled in HIV policies and programmes, and build related accountability mechanisms</td>
<td>Child rights feature prominently in the goals of the South Africa Country Programme; however, there is an external perception that UNICEF could be more vocal on advocating for the rights of women and children. Rights are at the centre of the programme goals for each of the three CPDs that cover the period 2005–15. However, there were mixed views from the stakeholders spoken to about the extent to which UNICEF are strongly articulating a human rights agenda, or even their position on issues related to women’s rights and child rights. For example, while one partner highlighted UNICEF as a voice that reminds partners about issues of human rights, other disagreed.</td>
</tr>
<tr>
<td>SD13: Promote an equity focus in HIV services for children, and build related accountability mechanisms</td>
<td>UNICEF staff articulate a focus of their programmes on the most disadvantaged, but this is not always prominent externally. When asked about UNICEF’s approach, some stakeholders had little visibility on an equity focus from UNICEF. In contrast, UNICEF staff often highlighted that their work in South Africa is equity based and that the design of interventions is focused on consideration of the most marginalised groups. The most visible feature of UNICEF’s equity lens has been its work on increasing coverage of PMTCT through identification of the bottlenecks to universal access. UNICEF has been a key proponent of the use of tools such as ‘robot’ dashboards to monitor progress in increasing PMTCT coverage, and define action plans to address barriers in poorly performing districts.</td>
</tr>
</tbody>
</table>

### Assumptions related to cross-cutting issues

<table>
<thead>
<tr>
<th>Assumptions</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no convergence of unmanageable numbers of crises simultaneously</td>
<td>There was no evidence of this from the South Africa case study.</td>
</tr>
<tr>
<td>Functional coordination systems exist in emergencies</td>
<td>There was no evidence of this from the South Africa case study.</td>
</tr>
<tr>
<td>Political support for working</td>
<td>The government will be launching a campaign on adolescent girls later in 2016 to try and address some of the broader issues that</td>
</tr>
<tr>
<td>Evaluation of UNICEF’s PMTCT/Pediatric AIDS Programme: South Africa Case Study</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>towards gender equality in HIV/AIDS programming remains strong</strong></td>
<td>Challenge adolescent girls; however, there is a perceived need for more work on tackling issues such as gender-based violence. There is a strong policy environment for the reduction of gender inequality in South Africa – for example, country endorses the Universal Declaration of Human Rights, the African Charter on Human Rights and Women’s Rights, the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW); and the Constitution has gender rights clearly articulated. However, the challenges are reported to be in the translation of policy into practice.</td>
</tr>
<tr>
<td><strong>Political support for rights-based approaches and funding remains strong</strong></td>
<td>The importance of human rights is articulated in a number of key documents that guide the South African response to HIV (including the NSP on HIV, STIs, and TB 2012–16) and the Constitution is also an important guiding document for South Africa.</td>
</tr>
<tr>
<td><strong>Political support for addressing inequity remains strong</strong></td>
<td>In South Africa, PMTCT and pediatric HIV services are designed to be universally accessible, and South Africa will transition to ‘universal test-and-treat’ later in 2016. There are also discussions ongoing about National Health Insurance coverage.</td>
</tr>
</tbody>
</table>
| **UNICEF’s organisational structure** | The team working on HIV has remained stable over the period of the evaluation. In recognition of the need for integration within the context of South Africa, the HIV function sits under the Health and Nutrition section in SACO. The team working on HIV consists primarily of one PMTCT and pediatric HIV specialist, plus contributions from the Chief of the Health and Nutrition section who continues to play a significant policy and technical role.  

**UNICEF is well respected technically, although is perceived to be “thin on the ground”.** UNICEF staff are perceived as technically strong in a number of areas; however, stakeholders do note that there are small numbers of staff working on HIV. Perhaps as a result of the need to focus efforts, the staff are perceived as focusing more on PMTCT, over and above broader child health issues.  

**UNICEF has demonstrated its willingness to evolve ways of working.** For example, in recognition of the importance of cross-sectoral collaboration in dealing with complex challenges and the increasing prominence of integration in South Africa, SACO shifted to the use of three joint results areas in 2015. This is reportedly improving integration within the office although there is scope for further integration to maximise synergies. |
<p>| <strong>Intermediate outcomes</strong> | There is evidence that strategies and policies are closely aligned across partners and coherent with national and global priorities. |
| <strong>Strategies, policies and implementation plans are aligned and coherent across partners at global, regional and country levels</strong> | The political commitment of the SAG to e-MTCT and Universal Access to pediatric HIV care and treatment is very strong, and bold measures have been taken for programme scale-up since 2007. There is a lag between policy and implementation, however, especially in some high burden and less well-endowed regions and districts. |</p>
<table>
<thead>
<tr>
<th>Stakeholders to plan for and support scale-up of HIV services for children are increased</th>
<th>The SAG is increasingly meeting resource needs for the whole HIV (and TB) response, though it still relies quite heavily on PEPFAR support. For the longer-term, discussions are under way to develop the National Health Insurance Plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource needs for PMTCT and paediatric HIV care and treatment are met in a predictable and sustainable manner</td>
<td>Accountability mechanisms for meeting targets at all levels of the health system are strong. There is, however, limited evidence of the implication of civil society in supporting these mechanisms, except through SANAC mechanisms at national level.</td>
</tr>
<tr>
<td>Mechanisms to ensure accountability for provision and scale-up of PMTCT and paediatric HIV care and treatment are strengthened at all levels</td>
<td>The Ministry of Public Health and the National AIDS Coordinating Committee have been attentive to evidence about what works and why in this area and quick to respond to changes in international guidelines.</td>
</tr>
<tr>
<td>Strategies, policies and approaches to implementation are informed by evidence on what does and does not work and why in relation to PMTCT and paediatric HIV care and treatment</td>
<td>There is evidence of a focus on rights, equity and gender in a number of key documents that guide the South African response to HIV, but challenges remain in the translation of policy into practice – in particular in relation to key gender issues such as gender-based violence.</td>
</tr>
</tbody>
</table>
Annex VII: Bibliography


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EVALUATION OF UNICEF’S
PMTCT/PAEDIATRIC AIDS PROGRAMME
ZIMBABWE CASE STUDY REPORT

May 2016
Acknowledgements

The Itad team is very grateful for the support provided by the Zimbabwe Country Office during, and in the lead up to, the country visit. We would also like to acknowledge the constructive engagement and responsiveness of all those who were consulted during the course of this case study. Their expert knowledge and reflective insights have made valuable contributions to the report.

The findings within this document, however, are entirely the responsibility of the evaluation team.
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Acronyms

AMP  Annual Management Plan  
ART  Antiretroviral Treatment  
ARV  Antiretroviral (Drugs)  
CBO  Community-Based Organisation  
CCM  Country Coordinating Mechanism  
CCORE  Collaborating Centre for Operational Research and Evaluation  
CIFF  Children’s Investment Fund Foundation  
CO  Country Office  
CPAP  Country Programme Action Plan  
CPD  Country Programme Document  
DFID  UK’s Department for International Development  
EGPAF  Elizabeth Glaser Pediatric AIDS Foundation  
e-MTCT  Elimination of Mother-to-Child Transmission  
ESP  Expanded Support Programme  
GoZ  Government of Zimbabwe  
HDF  Health Development Fund  
HTF  Health Transition Fund  
IATT  Inter-Agency Task Team  
ICASA  Independent Communication Authority of South Africa  
IMNCI  Integrated Management of Neonatal and Childhood Illnesses  
INK  Instituut Nederlandse Kwaliteit  
M&E  Monitoring and Evaluation  
MDG  Millennium Development Goal  
MICS  Multiple Indicator Cluster Survey  
MNCH  Maternal, Newborn and Child Health  
MoHCC  Ministry of Health and Child Care  
MoHCW  Ministry of Health and Child Welfare  
MoRES  Monitoring Results for Equity System  
MTCT  Mother-to-Child Transmission  
NAC  National AIDS Council  
NGO  Non-Governmental Organisation  
NMRL  National Microbiology Reference Laboratory  
ODA  Official Development Assistance  
PEPFAR  President’s Emergency Plan for AIDS Relief
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
</tr>
<tr>
<td>PMU</td>
<td>Project Management Unit</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>RO</td>
<td>Regional Office</td>
</tr>
<tr>
<td>SI</td>
<td>Strategic Information</td>
</tr>
<tr>
<td>SIDA</td>
<td>Swedish International Development Corporation</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>ToR</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>ZCO</td>
<td>Zimbabwe Country Office</td>
</tr>
<tr>
<td>ZDHS</td>
<td>Zimbabwe Demographic and Health Surveys</td>
</tr>
<tr>
<td>ZimASSET</td>
<td>Zimbabwe Agenda for Sustainable Socio-Economic Transformation</td>
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<tr>
<td>ZUNDAF</td>
<td>Zimbabwe United Nations Development Assistance Framework</td>
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Executive summary

Introduction

UNICEF has commissioned an evaluation of its activity in the area of prevention of mother-to-child transmission (PMTCT) of HIV and paediatric HIV care and treatment during the period 2005–15. The purpose of the evaluation is to support accountability and learning in relation to UNICEF’s efforts to support the scale-up of these programmes, and will examine four dimensions of its engagement:

1. Leadership, advocacy, coordination, and partnerships
2. Resource mobilisation
3. Strategic information, knowledge generation, and dissemination
4. Key aspects of UNICEF’s organisation

This report summarises the findings of the Zimbabwe case study, which is one of the four in-depth case studies being undertaken as part of the evaluation. The case study was conducted during April 2016, and included a documentation review and interviews or group discussions with over 40 stakeholders (including UNICEF staff, government, development partners and civil society). Semi-structured interview guides were used to elicit perspectives on four key dimensions of the evaluation, as well as the three cross-cutting issues of gender, equity and human rights.

Summary of findings

Some of the key findings of the case study are as follows:

UNICEF has made many critical contributions to supporting Zimbabwe in the massive scale-up of HIV services for women and children since 2005, through its broad-based support for health systems that serve women and children, its targeted advocacy for children affected by AIDS and their families, and its support to policy development, programme planning and implementation, and knowledge-building activities.

UNICEF has also made use of its position in key country-level partnership forums and financial arrangements, such as the Country Coordinating Mechanism (CCM) and the Expanded Support Programme (ESP), Health Transition Fund (HTF) and the Health Development Fund (HDF), to leverage resources for programme scale-up from donors. The Global Plan served as a game changer in this regard, in opening opportunities for new international funding for the elimination of MTCT (e-MTCT) and the acceleration of treatment scale-up for children.

UNICEF has contributed to ensuring that the country has been able to procure medicines and commodities, including paediatric antiretrovirals (ARVs), for programme needs. UNICEF stepped in during times of economic crisis when hyperinflation and a lack of foreign currency prevented the National AIDS Council (NAC) from procuring commodities directly. It also successfully advocated for the inclusion of paediatric ARVs in future Global Fund budgets.

There is scope for UNICEF to promote greater engagement of civil society and private sector stakeholders in the response. As the programme matures, there will be a need for a shift in focus and tactics to achieve elimination of mother-to-child transmission of HIV and universal care and treatment coverage for all – including leveraging community-based systems to improve uptake and adherence levels.

UNICEF is recognised as supporting an equity focus. In particular, UNICEF has been a strong advocate for prioritisation of the most disadvantaged districts. This has supported an increase in partner alignment to address some key challenges. The use of bottleneck analysis was spearheaded by UNICEF in 2012 and has since been repeated annually, and replicated at district level. This has served to ensure that strategies are geographically targeted and are informed by data on specific challenges.

However, there is scope for greater prominence to be given to gender-transformative approaches, human rights and equity as part of a holistic response to HIV in children. While partners recognise that gender, human rights and equity are components of UNICEF’s response to HIV, it is not perceived as a thought leader in relation to these issues.

UNICEF has recruited a staff team in Zimbabwe with broad knowledge, experience and programme management skills. It is valued by Government and partners for its responsiveness.
and flexibility. The organisational culture is hands-on and solution focused with strong connections with the field.

Internally, UNICEF faces organisational challenges in achieving programme linkages and integration while ensuring that the HIV function has adequate leverage and influence across programme areas.

**Implications**

In the way forward, UNICEF may wish to consider the following suggestions:

- **Muster all available resources and work closely with partners to ‘finish the job’** in supporting Zimbabwe to achieve the elimination of MTCT and universal coverage of children with HIV care and treatment services. Zimbabwe’s trajectory to date has been exemplary and it would be unfortunate indeed to lose all gains achieved to date through a downturn in commitment and resources.

- **Seize opportunities to innovate and build on comparative advantages**, including UNICEF’s unique roles in advocacy and social mobilisation around equity issues and its global experience with gender-transformative, rights-based and family-centred approaches to programming.

- **Strengthen linkages across programmes and sectors at every level and, as appropriate, promote integrated services at the point of service delivery**, with a strong focus on HIV, health and nutrition services for women and children. Efforts to Integrate HIV and social protection interventions should also be expanded. This implies that UNICEF should make a greater effort to identify opportunities for critical linkages and foster joint planning, financing and reporting approaches, within its own office and with key stakeholders. Bold measures are required to work around current financing mechanisms and government structures. UNICEF could be doing more to model multisectoral and integrated programming and implementation.

- **Seek to increase the Zimbabwe Country Office (ZCO) resource base and use available resources as strategically and efficiently as possible to more fully explore innovative programme solutions**, with a particular focus on the change in tactics required to cover the ‘last mile’.

- **Continue to support the Government of Zimbabwe (GoZ) in the identification of resource gaps in the national programme, and sources of funding to fill these gaps.** In particular, work with the Government, UNAIDS and the World Bank to analyse other domestic financing opportunities. This might include financing through public private partnerships, such as those piloted by UNAIDS in the South African Development Community region, and broadening the tax base to ensure the informal sector contributes to the AIDS Levy.
1 Objectives and scope of the evaluation

1.1 Purpose of the evaluation

UNICEF has commissioned an evaluation of its activity in the area of prevention of mother-to-child transmission (PMTCT) of HIV and paediatric HIV care and treatment. The purpose of the evaluation is to support accountability and learning in relation to UNICEF’s efforts to support the scale-up of these programmes:

- **to contribute to improving the organisation’s accountability** for performance by defining and documenting key achievements as well as missed opportunities in UNICEF’s engagement with partners and countries in support of improved PMTCT and paediatric HIV care and treatment outcomes between 2005 and 2015.

- **to generate evidence and learning** to enhance the understanding of the organisation and other stakeholders on how UNICEF’s strategies and programmes related to PMTCT and paediatric HIV care and treatment have evolved, what has worked, has not worked, and why, and make recommendations for UNICEF’s future engagement in these programme areas.

The evaluation will look at four key dimensions of UNICEF’s work in this area:

1. **Leadership, advocacy, coordination, and partnerships:** the ability to foster or to be effective within partnerships by leveraging corporate knowledge and assets to become a trusted advisor for donors, national governments and other global and national stakeholders; and the ability to influence global, regional, national PMTCT and paediatric HIV care and treatment agendas over time.

2. **Resource mobilisation:** the ability to generate the required funds for PMTCT and paediatric HIV care and treatment programmes and projects that UNICEF supports across levels; the ability to leverage major funders’ resources to achieve UNICEF’s strategic priorities; to be an effective support to governments attempting to access funds for these programmes; and helping foster an adequate global resource base for them.

3. **Strategic information, knowledge generation, and dissemination:** the contribution to global and national policies and strategies through evidence generated by UNICEF- and partner-supported research and programming, as well as through its global data, estimation and progress reporting; and the translation of global policies and evidence into national plans, operational guidance and tools.

4. **Key aspects of UNICEF’s organisation:** to include establishing an effective presence at the global, regional and country levels, the proper employment of UNICEF’s comparative advantages (e.g. its ability to play a convening role, its procurement functions); the ability of the organisation to adapt based on new scientific and operational information; and the extent to which UNICEF’s structures in relation to HIV have been fit for purpose over time.

The evaluation is also focusing on three **cross-cutting issues**, namely: gender, human/child rights and equity. While not a focus of this case study, it will also examine how the response to PMTCT and paediatric HIV is integrated within a humanitarian response.

1.2 Focus of the country case studies

Data collection is being undertaken in seven countries as part of this evaluation – four involving country visits (in-depth studies)\(^1\) and three conducted through remote desk reviews and telephone interviews (light touch studies)\(^2,3\).

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\(^1\) Zimbabwe, Cameroon, India and South Africa.

\(^2\) Cambodia, Haiti and Ukraine.

\(^3\) Country case studies are one component of the data collection process. The evaluation also includes interviews with key stakeholders at a global and regional level, an online survey to UNICEF and partners, and an extensive document review.
The key purpose of the country case studies is to record how UNICEF’s engagement in PMTCT and paediatric HIV/AIDS has played out at country level during the period 2005–15, and help test and validate the theory of change for UNICEF’s strategic approaches in these programme areas, which was developed to guide the evaluation. It is important to note the following:

- Each case study has been selected because of the learning opportunity offered to the evaluation.
- The approach to each is focused on recording experiences rather than measuring or assessing individual country performance.

This report on the Zimbabwe experience presents the findings of one of the four in-depth case studies.

2 Approach and methodology

2.1 Approach to data collection and analysis

The full methodology for the evaluation is set out in the Evaluation Inception Report produced as part of the initial phase of the evaluation. Figure 1 below summarises the process through which this in-depth country study was implemented.

![Figure 1: Process for conducting country studies](image)

2.2 Zimbabwe visit schedule

The visit included interviews or group discussions with over 40 stakeholders and was conducted over a five-day period during April 2016. Semi-structured interview guides were used to elicit perspectives on the four key dimensions of the evaluation (see above), as well as the cross-cutting issues. Interviewees included UNICEF staff (current and former, from HIV section and others), government representatives, development partners and civil society organisations. The full agenda and the list of stakeholders interviewed are included in Annex II and III respectively. The country visit was also used as an opportunity to source additional documents from the Zimbabwe Country Office (ZCO).

On the last day of the visit, the team presented its preliminary observations to the UNICEF team for their early reflection and response. The team then presented and discussed these findings with representatives from the Ministry of Health and Child Care (MoHCC) and the National AIDS Council (NAC) of Zimbabwe.

The final step in the country case study process has involved a more comprehensive analysis of interviews and documents, to produce this country report. The report is presented in six parts:

1. **Objectives and scope of the evaluation** – describes the aim of the evaluation.
2. **Approach and methodology** – explains the approach to the case studies.
3. **Overview of UNICEF’s Country Programme in Zimbabwe** – provides an introduction to the Zimbabwe context and UNICEF’s work in PMTCT/paediatric HIV.
4. **Findings** – details findings against the four key dimensions of the evaluation, as well as the cross-cutting issues.

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4 Further details are included in the Inception Report for this evaluation.
5. **Achievements and challenges** – details some of the key achievements and challenges for UNICEF and Zimbabwe during the evaluation time period.

6. **Implications for UNICEF** – reflects on lessons learned to present some areas for UNICEF’s consideration moving forward.

Further information is presented in the Annexes to this report, including a summary of the evidence against the theory of change, which is presented in Annex VI.

3. **Overview of UNICEF’s country programme in Zimbabwe**

3.1. **Zimbabwe context**

Between 2000 and 2008, Zimbabwe faced major economic challenges, with a contraction of the Zimbabwean economy of more than 50%. As a result, almost two thirds of the population was living below the poverty line by 2003. Concomitantly, a rapid, measurable and visible deterioration was observed in major development indicators, including maternal and child mortality, with increases in the under-five mortality rate and the maternal mortality ratio between 1990 and 2015. The major drivers of increased mortality were believed to be HIV and the decline in the primary health care system. Up to 21% of under-five deaths and 26% of maternal deaths were associated with HIV and AIDS. Major outbreaks of infectious diseases and declining food security underscored the challenges faced in providing basic social services and the lack of remaining coping mechanisms for the population, especially the poorest segments.

As a result, the major focus of United Nations agencies and partners over the last decade has been on stemming the reversal in key indicators. Relative stability followed the signing of the Global Political Agreement in September 2008 and the advent of the inclusive Government in early 2009. Recent fiscal policy decisions, such as the introduction of multiple currencies and cash-based budgeting, have controlled inflation and brought some economic growth.

**Despite significant declines, the burden of HIV and AIDS remains high.** The epidemic reached its peak in 1997, followed by a sharp decline in HIV prevalence till 2007, and a gradual decline after that. HIV prevalence among adults age 15–49 years declined from about 30% in 1997 to 17% in 2014 and may now be increasing in line with greater access to antiretroviral treatment (ART). The burden remains high, however, with an estimated 1,191,423 adults (15 years and over) (of which 59% were female), and another 147,000 children (0–14 years) living with HIV in 2014. As such, Zimbabwe is one of the 22 countries prioritised in the Global Plan towards the Elimination of New HIV Infections among Children by 2015, and Keeping their Mothers Alive (‘the Global Plan’) that was launched in 2011.

**ART coverage among adults has increased rapidly over the years.** Coverage rose from 5% of eligible adults in 2004 to 84% of eligible adults (and 46% of all persons living with HIV) in 2013. Due to changes in eligibility criteria, ART coverage was 63% of eligible people in 2014 (representing 52% of all people living with HIV).

**Similarly, coverage with PMTCT interventions has increased rapidly.** A pilot project was initiated in three sites in 1999, followed by phased scale-up into what rapidly became a fully-fledged national programme. The GoZ has made a strong commitment to the elimination of new HIV infections in children and keeping...
mothers and families alive,\textsuperscript{12} in line with the Global Plan. The PMTCT coverage rate increased from 38% in 2008 to 79% in 2014, with phased adoption of more efficacious regimens and increasing numbers of women already on treatment before pregnancy.\textsuperscript{13} The transmission rate and the number of new child infections due to MTCT are estimated to have dropped dramatically over the last years, signalling excellent progress towards achieving elimination targets.\textsuperscript{14} The 2015 estimates are currently undergoing review and validation, following significant changes in assumptions made in the Spectrum model for estimating MTCT rates.

**Paediatric HIV care and treatment coverage is now picking up, after a slow start.** Paediatric HIV care and treatment interventions started in 2006, when it was estimated that about 165,000 children were living with HIV in the country. The early infant diagnosis initiative began as a pilot venture in 2007, and was scaled up all over the country on basis of lessons learned from that phase. Rapid progress has been made since then, facilitated by the introduction of paediatric antiretroviral (ARV) formulations, and ART coverage among HIV+ children aged 0–14 years has increased from 9% in 2008 to 39% in 2014.\textsuperscript{15} However, many HIV-exposed children are lost to follow-up along the continuum of care and geographical coverage across the country is very uneven.\textsuperscript{16,17}

**Funding for HIV/AIDS has grown markedly since 2009,** driven by increases in both domestic and external sources. Domestic resources, which comprised around 15% of total resources, are principally sourced through the National AIDS Trust Fund, commonly known as the AIDS Levy. The largest providers of official development assistance (ODA) for HIV/AIDS have been the Global Fund, the United States and United Kingdom, with smaller contributions from Germany, Sweden, Canada, Japan and Ireland.

The vast majority of resources for PMTCT have been sourced from three donors – the United States, Children’s Investment Fund Foundation (CIFF), and UK’s Department for International Development (DFID). These three donors accounted for over 80% of funding between 2012 and 2014. Other sources of finance have included the Global Fund, CIDA, UNICEF, WHO, and others. Further details are included in Annex IV.

The majority of expenditure for paediatric ARVs has been covered by DFID up until now, although the Global Fund will assume these costs from 2016. Domestic resources (primarily sourced through the AIDS Levy) have covered around 30% of this expenditure.

3.2 UNICEF’s work in HIV in children during 2005–15

UNICEF’s country programme priorities during 2005–15 are outlined in the country programme documents (CPDs) that cover this period (CPD 2007–11 and CPD 2012–15). The focus was on progress towards the Millennium Development Goals (MDGs) and the goals of the Plan of Action for *A World Fit for Children*, in line with UNICEF’s Medium-term Strategic Plan 2005–13, its Strategic Plan 2014–17 and the UNICEF Regional Leadership Agenda. An overview of some key events in the Zimbabwe context is included in Annex V.

The UNICEF country programme thus placed a strong focus on scaling up the response to HIV/AIDS, including accelerating access to PMTCT and comprehensive HIV care and treatment services for women and children, towards achieving universal access by 2015. UNICEF’s work was positioned as a key contribution to the Zimbabwe United Nations Development Assistance Framework (ZUNDAF) outcomes.

\begin{itemize}
\item \textsuperscript{13} National AIDS and Tuberculosis Unit, Ministry of Health and Child Care, 2015. Zimbabwe National and Sub-national HIV/AIDS Estimates 2014.
\item \textsuperscript{17} Ministry of Health and Child Care. 2014. The National Strategic Plan for Eliminating New HIV Infections in Children and Keeping Mothers and Families Alive: 2014–18.
\end{itemize}
and was closely aligned with the three national priorities (fighting HIV and AIDS, promoting gender equality and women’s empowerment, and reducing poverty).

Over the period of the evaluation, UNICEF supported the design and implementation of large-scale HIV/AIDS prevention and care interventions within the context of United Nations joint programming, as well as the leveraging of resources; the dissemination of new knowledge and documentation of best practices and lessons learned; improved national tracking systems and critical epidemiological analysis; and capacity building for effective programme coordination and implementation. Most of these activities were conducted in close collaboration with other partners, within and without the United Nations system. The programme’s main counterparts in this programme area have been the Ministry of Health and Child Welfare (MoHCW) (now the Ministry of Health and Child Care – MoHCC) and the NAC. UNICEF also played an important role in procurement, such as medicines (including ARV drugs) and commodities (such as HIV diagnostics).

UNICEF participates in a number of partnership arrangements. The Health Sector Coordination Group has served as the main partnership forum. It brings together the MoHCC; United Nations agencies, including the World Health Organization (WHO), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Development Programme (UNDP); World Bank; non-governmental organisations (NGOs); and donors. Other important partnership frameworks in which UNICEF has been the lead on PMTCT and paediatric HIV include the joint UN Team on HIV and the H4+ for maternal and child survival. UNICEF is also, with UNAIDS, a permanent executive member of the Country Coordinating Mechanism (CCM) for the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and a member of its subcommittee for HIV/AIDS. Finally, UNICEF is an active member of the PMTCT Partnership Forum and of a range of other working groups, such as the Technical Working Group on Paediatric HIV.

Of note is UNICEF’s unique role throughout this period in supporting mechanisms for health financing, through the ESP, the Health Transition Fund (HTF) and now the Health Development Fund (HDF). UNICEF played a lead role in both the HTF and HF (see Annex IV). These were focused on reviving the collapsed health system during the crisis and enabling the delivery of critical MNCH critical services to women and children.

4 Findings from Zimbabwe

This section provides the team’s detailed findings against the four key dimensions of the evaluation, as well as the cross-cutting issues. A summary of the evidence related to each of the strategic directions underpinning these dimensions and issues, as well as against intermediate outcomes identified in the theory of change guiding the evaluation is presented in Annex VI.

4.1 Thematic leadership, advocacy, partnerships and coordination

UNICEF is recognised as a persuasive advocate for scaling up HIV services for children in Zimbabwe. UNICEF’s initial focus was on introducing PMTCT services to reduce the burden of HIV among children in six priority districts and expanded over time to promote and support nationwide scale-up of PMTCT services. UNICEF subsequently drew attention to the treatment gap in children, as the national ART programme took off and ART coverage grew rapidly among adults, but not among children. Throughout the period, UNICEF has played an important role in ensuring that the national HIV/AIDS response places adequate priority on PMTCT and HIV care and treatment of young children and in supporting the development of relevant strategies and plans, such as the 2014 accelerating Children’s HIV/AIDS Treatment Initiative, which received support from the Global Fund, the President’s Emergency Plan for AIDS Relief (PEPFAR), CIFF and the United Nations.

MoHCC and NAC respondents noted that the Global Plan served as a ‘game changer’ in helping to set ambitious national elimination of mother-to-child transmission (e-MTCT) goals and mobilise support for the national programme. The inclusion of Zimbabwe in the 22 priority countries for the Global Plan attracted critical financial and technical support to the country and provided an impetus for programme
scale-up. UNICEF contributed by supporting Zimbabwe’s participation in several planning and coordination meetings in the region. In particular, UNICEF co-hosted (with Global Fund, UNAIDS, the UNFPA and WHO) a regional workshop held in Nairobi in 2010 to review strategies for scaling up country programmes. MoHCC respondents also indicated that UNICEF’s support to the Inter-Agency Task Team (IATT) activities at the global and regional levels were useful in providing a South-to-South learning platform and in securing technical assistance (for instance for programme design and costings).

UNICEF has wielded influence due to its clear commitment to children and its strong presence in a range of partnership forums and health financing mechanisms. UNICEF’s activities across many sectors, such as health, HIV/AIDS, nutrition, education and social protection, and its procurement functions, have increased its reach and leverage. As a member of the Global Fund CCM and its subcommittee on HIV/AIDS, UNICEF has garnered specific support for HIV and children (see section 4.2.2). In particular, it played an important role in supporting the reprogramming of Global Fund resources towards paediatric ARVs from 2016 onwards. More recently, as a partner in the HDF, it played a major role in the change in policy to use HDF resources to support paediatric HIV services. Some respondents mentioned that the launch of UNICEF’s Double Dividend initiative at ICASA in Durban in 2013 spurred high-level commitment to accelerate action towards ending paediatric HIV and AIDS while improving child survival, helping to address silos in programming and funding approaches.

UNICEF is widely appreciated as a credible, trusted and reliable partner. The GoZ has maintained its strong leadership of the HIV/AIDS response, through its support to major partnership mechanisms such as the HTF/HDF and the PMTCT Partnership Forum. The MoHCC AIDS and TB Unit also organises weekly planning and coordination meetings with UNICEF and other key partners. UNICEF engages with many stakeholders, including PEPFAR and its implementing partners (OPHID, FHI360, ITAL, KAPNEK) and EGGAF (the implementing partner for the CIFF ACT), through a range of coordinating bodies or technical working groups. It is widely recognised as a committed, active and helpful partner in these forums, contributing time, technical expertise and as required, flexible funding to support critical activities.

UNICEF has contributed to aligning strategies, policies and implementation plans across partners and ensuring their coherence with national priorities. UNICEF’s own country programme is closely aligned to national and sectoral strategies and plans, such as The Zimbabwe Maternal and Neonatal Health Road Map 2007–15 and the National HIV/AIDS Strategic Framework 2006–11. It is also able to provide financial support directly to the Government, unlike most bilateral development agencies working in the HIV/AIDS sector. At the same time UNICEF remains a privileged partner of the diverse multilateral and bilateral agencies and international organisations working on issues related to children and HIV in the country. UNICEF thus serves as an important player in the harmonisation and alignment of the response related to children and HIV in Zimbabwe, and is able to extend its influence well beyond the activities that it is able to fund directly.

There is scope, however, for UNICEF to promote greater engagement of civil society and private sector stakeholders in the response. The health and development approaches favoured by international partners over the last several years have supported the health system through a major economic upheaval. However, they have had the unintended consequence of weakening the contribution of civil society to the HIV response. The registration process for community-based organisations (CBOs) and small NGOs is also reported to be cumbersome, the context is not favourable, and most are unable to compete for the pooled health and development funds. In addition, Zimbabwe is under additional safeguard measures from the Global Fund, whereby UNDP was selected as the Principal Recipient for all grants in consultation between Global Fund and the CCM, and as a result, the principle of dual-track financing to civil society does not apply. UNICEF has provided valuable support to NGOs and CSOs, with an emphasis on seed funding, capacity-building and technical support for delivering care and support services at the community level. UNICEF could play an even more active role – with an emphasis on strengthening community mobilisation and accountability mechanisms in support of eliminating MTCT and improving access to treatment for all. Community engagement and strengthened community systems are also vital for combating stigma and discrimination, ensuring quality of services and supporting adherence. Furthermore, there is little evidence of UNICEF reaching out to the private sector, including private health institutions and practitioners, which are poised to play a significant role in the delivery of HIV services.
UNICEF has been actively engaged in a range of activities in support of programme implementation and service delivery at all levels of the formal health system. There is evidence of UNICEF’s contributions to a range of operational planning, implementation and capacity development activities. Partners particularly value UNICEF’s flexibility, responsiveness and ‘hands-on’ approach to programming, down to the district level. For example, UNICEF supported partners to develop action plans to address bottlenecks to paediatric treatment programming in poorly performing districts. It has also provided financial and technical support for commodities, supply chain management, information systems, training, meetings, workshops and other capacity-building activities such as supportive supervision and mentoring of MoHCC staff. Its support, especially in the earlier years, for hiring or seconding people to a range of government institutions was valued, as all Government posts have been frozen for more than a decade. However, some respondents commented that UNICEF’s engagement tends to be too broad-based, and could be more strategic and streamlined. While UNICEF’s willingness to ‘fill gaps’ in the implementation of partner activities is appreciated, they suggested that it should invest more in testing innovative solutions to programme scale-up.

UNICEF has also worked to strengthen the MNCH platform for the delivery of HIV services for women and children, through its broad-based health system strengthening work and by protecting access to MNCH services. Through its strong focus on the MDGs and its support to the HTF and HDF, UNICEF has taken a lead to ensure that health system strengthening approaches prioritise the delivery of MNCH services. This has included training of nurses and midwives, contributing to the health retention scheme for health care workers, and procuring and distributing health commodities to health centres. UNICEF helped to ensure that user fees were not imposed for MNCH services during the crisis, by drawing attention to the brake this would place on access to services (including HIV services) for women and children and contributing support for staff and supplies.

There is some evidence that UNICEF is now also building linkages between HIV and health programmes and also with other sectors and programmes, such as child protection. This is a promising avenue for future work. Many respondents, both within and without UNICEF, acknowledge that vertical approaches to HIV programming may have been useful in the early years to ensure that the HIV response was appropriately prioritised. However, they spoke forcefully about the need for UNICEF to more actively spearhead intersectoral linkages, particularly with health, nutrition and social protection.

4.2 Resource mobilisation

4.2.1 Internal resource mobilisation functions

The annual budget for PMTCT and paediatric HIV care and treatment has remained relatively constant between 2007 and 2014. As shown in Figure 2, the ZCO’s annual budget for PMTCT and paediatric HIV care and treatment has remained relatively constant at around US$1.7m between 2007 and 2014, falling to US$1.5m in 2015. This has accounted for a decreasing proportion of its total budget for HIV/AIDS, from 94% in 2007 to 68% in 2015 due to increased budgets for issues related to adolescents. Between 2012 and 2015, expenditure on PMTCT and care and treatment of children affected by HIV/AIDS in Zimbabwe totalled US$5.8m, increasing from US$1.2m in 2012 to US$1.9m in 2015. This did not meet UNICEF’s annual budget in 2012, 2013 or 2014, but exceeded the budget in 2015, partly due to some funds rolled over from earlier years. Over the period, the vast majority of expenditure was comprised of ‘Other Resources Regular’ (around 90% each year), with the rest being ‘Regular Resources’.

18 We do however note that some budgeted funds for adolescents may actually be targeted at PMTCT and paediatric HIV care and treatment. As such, the figures should be interpreted with caution.

19 Data on UNICEF expenditures is only available from 2012 onwards. The data also reflects a change in the coding of expenditures between the 2006–13 Medium Term Strategic Plan to the 2014–17 Strategic Plan. For 2012 and 2013 the figures present expenditure to reduce the number of paediatric HIV infections; increase the proportion of HIV-positive women receiving ARVs; and increase the proportion of children receiving treatment for HIV/AIDS. For 2014 and 2015 the figures present expenditure on: (a) PMTCT and infant male circumcision; and (b) care and treatment of children affected by HIV/AIDS.
UNICEF has been able to raise resources to flexibly support the Government in a difficult fundraising environment. The resources raised have allowed UNICEF to flexibly support the Government in planning, budgeting and managing the PMTCT and paediatric HIV programme, as well as in filling some programme funding gaps. However, UNICEF has found fundraising for HIV/AIDS in Zimbabwe reasonably difficult due to the overall donor landscape where the United States government and Global Fund are the principal donors for HIV/AIDS, and in response, other donors have been less willing to support this area.

Other Resources have been sourced through a mix of targeted grants, flexible funding for the CO, and UNICEF global thematic funds. In spite of the fundraising environment, UNICEF has been able to source funds through a series of donor grants targeted at PMTCT and paediatric HIV, as well as grants for other thematic areas where HIV/AIDS issues are relevant – these are classified as Other Resources. Of particular importance has been a multi-year grant from SIDA used flexibly between UNICEF’s thematic areas, including HIV/AIDS – as shown in Figure 3, accounting for 35% of total expenditure on HIV/AIDS between 2012 and 2015. This funding has been combined with UNICEF’s global thematic resources for HIV/AIDS to ‘top up’ the country programme. However, SIDA’s grant expires this year and we understand that the next grant will not be available for flexible programming. As such, there is likely to be increased reliance on global thematic funds for HIV/AIDS and/or Regular Resources going forward.

![UNICEF budget and expenditure for PMTCT and paediatric HIV](image)

**Figure 2: UNICEF budget and expenditure for PMTCT and paediatric HIV**

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20 Source: CPAPs for 2007–11 and 2012–15; and analysis of internal UNICEF data.
21 It is noted however that there is considerable variation, both in the value of UNICEF’s budgets between CPAPs and sectoral/thematic reports, and in the value of expenditure between UNICEF’s central database, sectoral/thematic reports, and the Country Office records.
22 The other main donors in Zimbabwe are the EU, UK, Canada, Ireland, Norway and Sweden, who have prioritised MNCH by pooling funds through the HDF.
23 Examples of grants for issues related to PMTCT and paediatric HIV have included: grants through the H4+ Initiative and Canada targeted at improving the integration of HIV/AIDS services with MNCH and nutrition programmes; a grant from USAID to support the management and coordination of the Global Fund CCM Secretariat; a grant from UNITAID to support and coordinate testing and evaluation of POC early infant diagnosis technology, alongside CHAI; a grant from the French National Committee to improve CD4 cell testing for HIV positive pregnant women in rural areas; and a grant from UNDP grant for the procurement of commodities to support the treatment and care component of the ESP.
UNICEF has put in place processes to improve the targeting and efficiency of its fundraising efforts. The CO Resource Mobilisation Working Group was established in 2011 to improve the efficiency of fundraising efforts by adopting a more coordinated and targeted approach. This has included sharing simple concept notes with potential donors to gauge their interest before developing resource intensive full funding applications. These concept notes are short and require less time to develop, and as such, mean that potential new donors can be scoped at low cost.

Some external partners raised concerns about UNICEF’s systems and processes. Comments were made about the application of UN rules and regulations leading to delays in the release of funds to implementing partners, and resulting in temporary resource gaps. One development partner also suggested that in the past, UNICEF’s reporting has been untimely – we do however note that UNICEF has maintained a 100% compliance rate on donor reporting timelines over the last few years. Nonetheless, a few respondents held the view that UNICEF is “not seen as an ideal partner for implementation”. However, it is not clear whether this has impacted on UNICEF’s ability to engage in programmatic issues or fundraise.

Additional grants might have allowed UNICEF to more fully explore innovative programme solutions. As indicated above (in Section 4.1) respondents felt that UNICEF could play an even stronger role in supporting the identification, testing and evaluation of innovative solutions to programme issues. Most of the resources available to UNICEF during this period were dedicated to bolstering critical health system functions and its in testing new diagnostic technologies and approaches has typically been tied to specific grants for this purpose. As such, it is felt that sourcing additional flexible funding would have allowed UNICEF to explore other types of programme innovations.

4.2.2 External resource mobilisation functions

The national PMTCT and paediatric HIV care and treatment programme has been reasonably well resourced, although there have been some funding gaps. While some stakeholders reflected that the country PMTCT and paediatric HIV care and treatment has been generally well resourced, other stakeholders (supported by limited available data – see figures in Annex IV for more details) suggest that there have been funding gaps. This has included gaps for procuring ARVs (e.g. in 2009 and 2010), and training/supervision at the district level (e.g. in 2011).

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24 Source: Analysis of Country Office internal UNICEF data.
25 The Group tracks donor partnerships (including the nature and timing of discussions), analyses gaps in funding, and discusses issues and areas for partnerships with other donors. The group meets quarterly and is comprised of the Country Representative, Deputy Representative, all section heads, the Chief of Operations, Reports Office, Budget Office, and a private sector specialist.
Resources are highly concentrated among a few donors. In recent years at least, the vast majority of resources for PMTCT and paediatric HIV have been sourced from three donors: the United States Government, CIFF and DFID. These three donors for PMTCT accounted for over 80% of funding between 2012 and 2014. UNICEF’s funding (US$2.6m) have accounted for 3% of total resources for PMTCT between 2012 and 2014 (see Annex IV for more details).

UNICEF has played an important role in leveraging donor financial resources for the country programme. Stakeholders recognised UNICEF’s important contributions in supporting the country to leverage and access partner financial resources, including through:

- Enabling the development and prioritisation of the actions in the Global Plan at the country level. In particular, UNICEF co-hosted with Global Fund, UNAIDS, UNFPA and WHO a regional workshop held in Nairobi in 2010 where gaps in the country programme were highlighted. UNICEF also supported the development of country situational analyses and implementation plans that fed into the country’s response to the Global Plan, and subsequently led to increased resources for PMTCT.26

- Advocating for and financially supporting consultants to conduct a national review of PMTCT that served as a baseline for future programming.

- Playing a role in identifying resource gaps for the PMTCT and paediatric HIV programme and working with the MoHCC to identify sources of finance to fill them.

- Support in developing funding applications to donors. This has included support in the prioritisation and costing of activities for a proposal to CIFF, and in the development of successive Global Fund applications through membership of the CCM and the HIV subcommittee, and through the provision of management and coordination support to the CCM Secretariat. In particular, UNICEF provided valuable technical assistance for the 2013 Concept Note that led to a dramatic increase in resources for HIV/AIDS. This included playing a major role in successfully advocating for Global Fund support to include paediatric ARVs – this will be provided from 2016 using reprogrammed funds from earlier programme savings, and then ‘incentive’ funding financed by CIFF.

- Advocating for the inclusion of paediatric ARVs in the HDF budget from 2017 onwards. UNICEF’s role in shaping and leading the HTF and HDF, as well as through its procurement function in the ESP, gave the agency considerable influence in the allocation of resources, and allowed for the leveraging of funds for HIV/AIDS, which had previously been considered outside of the HDF’s remit.

UNICEF is an active advocate for increasing domestic spending on PMTCT and paediatric HIV, although this has not yet yielded significant results. UNICEF is currently discussing with the NAC the potential to increase the provision of funding generated through the AIDS Levy for the procurement of health commodities for paediatric HIV. There is, however, some debate as to whether: (a) this funding is required, as funding needs are already broadly being met by partners; and (b) splitting funds between adult and child formulations may reduce purchasing power and economies of scale.

UNICEF has been an important partner for the procurement of commodities, particularly during times of economic crisis. UNICEF’s procurement function is highly valued in the country. In particular, UNICEF has played (and continues to play) a critical role in supporting NAC in the procurement of AIDS Levy commodities, including paediatric ARVs. This has been particularly important during times of economic crisis when hyperinflation and a lack of foreign currency prevented NAC from procuring commodities. Specifically, in 2005 UNICEF and WHO agreed with NAC to provide US$0.9m each month for the procurement of HIV/AIDS commodities in return for the equivalent in Zimbabwean dollars.27 Without this arrangement, it is likely that the country would not have been able to procure these commodities in the quantities required.

There are encouraging signs for the programmatic sustainability of the PMTCT and paediatric HIV programme. The MoHCC demonstrates strong capacity to plan, budget and manage the PMTCT and paediatric HIV programme. UNICEF, as part of the broader donor group, has supported these processes

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26 The workshop included the following presentation – Luo, C (2010): ”Key Components of PMTCT: Overview of global progress and scale-up – Challenges, opportunities with the Global Fund to achieve scale-up targets by 2015″.

in a number of ways. This has included attending weekly meetings with the MoHCC and other donors to assist in the coordination, planning and resourcing of programme activities; and supporting the identification of knowledge and skills gaps, and building the capacity of health staff. As such, there is felt to be strong potential for programmatic sustainability (i.e. where activities can be maintained and improved following UNICEF’s support).

Strong dependency on a few donors to finance the programme raises critical concerns for financial sustainability. As pointed out above, domestic expenditure accounted for just over 1% of total resources for PMTCT between 2012 and 2014, and less than 30% of funding for paediatric HIV. As such, there is a very strong dependency on donors to finance the programme. Given that domestic resources for HIV/AIDS are largely sourced through the AIDS Levy, the potential for increasing domestic financing is closely tied to economic performance, and is largely outside the influence of health sector stakeholders. While we note UNICEF’s discussions with NAC to increase the provision of AIDS Levy funding for the procurement of paediatric HIV commodities, there is some debate as to whether this should be changed, and any reallocation of funding towards paediatric HIV would presumably negatively impact domestic provision for adult commodities. These issues raise critical concerns for the financial sustainability of the programme, and are particularly pertinent at a time when the country has made great strides in improving programme performance but requires additional resources to attain the goals of eliminating new HIV infections among children, and reaching universal coverage of paediatric ART. We understand that the World Bank is supporting the Government in analysing other domestic financing options.

4.3 Strategic information, knowledge generation and dissemination

UNICEF is actively engaged in national processes that build critical knowledge on women and children in Zimbabwe. For example, UNICEF has provided technical and financial support to the Zimbabwe National Statistics Agency (ZIMSTAT) for key demographic and health surveys, including the Zimbabwe Demographic and Health Surveys (ZDHS) of 2005–06, 2010–11 and 2015–16. UNICEF also provided critical support to ZIMSTAT for the recent Zimbabwe Multiple Indicator Cluster Survey (MICS), which was conducted in 2014. The MICS enabled the estimation of key indicators at various levels of the country to support final MDG reporting in 2015, and provided a useful and up-to-date source of information on HIV for the preparation of the Concept Note to the Global Fund and the last Global AIDS Progress Report. UNICEF has conducted sub-analyses of this database, for example to identify populations who are not accessing health services, for social, religious or other reasons. UNICEF has also supported a range of other relevant survey and surveillance activities, for example HIV sero-surveillance among antenatal care attendees.

Over the years, UNICEF has also made important contributions – with other development partners – to strengthen routine health information systems, including information on HIV service delivery and uptake. At the beginning of the period of the evaluation, information to guide HIV/AIDS programming and resource allocations in Zimbabwe was inadequate. Good progress has been made, particularly following the introduction of web-based systems, such as the District Health Information Software version 1.4 (DHIS1), which was rolled out in 2011 and 2012, and the more efficient DHIS2, which was rolled out in 2013. DHIS2 is linked to the Frontline SMS mobile-phone-based system that is used to relay HIV early infant diagnosis information between health facilities and the Zimbabwe’s National Microbiology Reference Laboratory (NMRL). UNICEF is also active in related activities, for example, it is part of the national quantification group on supply chain management.

More recently, UNICEF has become part of the working group led by the MoHCC to develop national and subnational HIV/AIDS estimates (including estimates of new HIV infections in children), together with the NAC, UNAIDS, WHO, CDC and others. UNICEF is perceived to bring useful knowledge concerning the dynamics of HIV infection in children and adolescents to the process of developing these estimates. This process will gain in importance as Zimbabwe moves closer to its e-MTCT and universal access goals.

UNICEF is also an active member of the MoHCC’s Monitoring, Evaluation and Research Advisory Committee, as well as of the Monitoring and Evaluation Subcommittee that is tasked with the review of HIV/AIDS programme performance and research results and with the consideration of approaches to investigate emerging issues. A number of respondents mentioned UNICEF’s success in bringing about
tighter age/sex-disaggregation of national programme data. MoHCC respondents also mentioned their appreciation of UNICEF’s technical and financial support in streamlining and integrating monitoring and evaluation (M&E) activities across the various HIV/AIDS and tuberculosis control programme streams. Currently the only exception is the PMTCT Stocktaking Report, as this will be useful in preparing for elimination validation.

A number of respondents commended UNICEF’s focus on the use of evidence to guide priority-setting and programming. An example that was highlighted was UNICEF’s role in advocating for the reprogramming of the Global Fund grant to cover paediatric ARVs, based on a thorough review of relevant evidence. Another example is the bottleneck analysis spearheaded by UNICEF in 2012 and 2014 to identify programme gaps and develop remedial action plans at the local level. Other useful programme monitoring tools associated with UNICEF include dashboards and scorecards to track performance against targets at subnational level. UNICEF has also played a role in building capacity of MoHCC to use the DHIS data for programme improvement at national and provincial levels. Support is now provided towards district level capacity building. Finally, UNICEF provides support for the training of newly recruited M&E officers, for M&E capacity building at the district level, for supportive supervision and for meetings and workshops.

UNICEF has also made significant investments in focused reviews, evaluations and operational research in support of policy-making and programme design. Topics in recent years have included the use of point-of-care PIMA CD4 cell count machines in MNCH settings, the feasibility of primary school-linked HIV counselling and testing, approaches to integrate early infant diagnosis in immunisation programmes and the involvement of men in promoting PMTCT. Some respondents felt that UNICEF should build on these experiences and strengthen its role in knowledge generation and the testing of innovative solutions of programme issues at the national level. This function used to sit in the Collaborating Centre for Operational Research and Evaluation (CCORE) in the ZCO and now lies with Social Policy section, working closely with programme units.

UNICEF has played a critical role, with other development partners, in supporting the translation of global evidence into national standards, guidelines and protocols. The programme scale-up process had to undergo a number of adjustments in response to global policy and guideline shifts. These affected both approaches to PMTCT and to the identification, care and treatment of HIV-exposed infants and children. In particular, WHO-recommended eligibility criteria for ARVs and ARV regimens underwent significant changes, leading to greater programme complexity and growing proportions of HIV-infected pregnant women and children requiring ARVs. The national programme has developed its capacity to adapt to these changes and continue the steady expansion of the numbers of women and children reached. UNICEF has actively supported the guideline adaptation and adoption process at all levels of the health system. UNICEF participates, along with WHO and other partners, in two Government-run standing committees, and provides technical and financial support for the guideline adaptation and roll-out process, including the required procurement, capacity-building and evaluation activities. For example, it provided guidance and support to the MoHCC for the early switch from single-dose nevirapine to more efficacious ARV regimens for PMTCT. It subsequently supported the 2010 switch to an even more efficacious regimen for PMTCT (Option A), and the provision of ART to all HIV-infected children under the age of 2 years regardless of the CD4 cell count, following the release of revised WHO guidelines earlier that year. It also supported the national adoption of the strategy for provision of lifelong ART to all pregnant and breastfeeding women living with HIV regardless of CD4 count or clinical stage (Option B+), in 2013. The global IATT facilitated critical technical support for the transition to Option B+, through the development of a transition plan and related costings, and UNICEF supported the field costs of a subsequent review.

UNICEF’s efforts to share knowledge with national stakeholders are welcomed. UNICEF regularly supports stocktaking and consultative meetings on a range of topics. A number of respondents particularly appreciated the monthly ‘brown bag’ meetings organised by the ZCO to share and discuss new information as it becomes available. UNICEF has also played a valued role in sharing and

disseminating key products from the IATT with stakeholders through different channels, and in pointing out, as useful, their relevance to the national programme. Some respondents suggested that UNICEF could play an even more active role as a knowledge hub on PMTCT/paediatric HIV issues, by collating and serving as a repository for information as it builds up across the various partners, who may not have the same mandate and credibility in relation to information dissemination. More systematic sharing of research findings and knowledge gained in scaling up the national programme with stakeholders at regional and global level would also be valuable. To date, the IATT, regular regional consultations and International AIDS Society meetings have provided the key mechanisms for sharing Zimbabwe’s experiences with stakeholders outside the country.

4.4 UNICEF organisational structure

4.4.1 Skills and competencies

UNICEF staff are experienced, technically competent, responsive and well regarded by partners. Their broad knowledge, experience and programme management skills confer strong credibility for UNICEF in Zimbabwe. They are valued by Government and partners for their responsiveness and flexibility and in particular for providing advice, guidance and strategic direction within short time frames. They actively participate in various forums, thereby building of trusted relationships with both government and partners. The mix of national and international staff is valued, as it brings external experience and national-level knowledge.

Staff are considered by stakeholders as both technically strong and ‘all rounders’, capable of covering a number of different areas. However, some areas were mentioned where more specialist skills would be useful, for example, to optimise contributions to strategic information (SI) and in strategic thinking around areas such as health systems strengthening (HSS) and community linkages as a foundation for e-MTCT. A hallmark of UNICEF’s staff recruitment and deployment is its generalist approach compared to the specialist approach of some agencies.

4.4.2 Organisational structure

Externally there is a perception that the HIV team is small, considering the recognised effort in supporting the scale-up of PMTCT and paediatric HIV care and treatment (as well as prevention and care interventions for adolescents) across the country and given the diversity of activities the team needs to engage in at national and subnational level. The number of filled HIV positions has increased from one post (L4), for the period 2005 to 2011, to three (one L4 and two NO3) and will increase to four (an additional NO2) during 2016.30 In addition, an HIV Specialist (Education) position (NO3) has been part of the Education team since its creation in 2012.

From 2005 to 2010 the country office has struggled to fill authorised HIV positions promptly. One authorised HIV post (NO3) was vacant for the entire period from 2005 (when created) to 2011 and a second (also NO3) from 2011 (when created) to 2013.

Between 2005 and 2015 there were a number of structural changes in relation to where HIV sits in the organisation, in response to the need for alignment and linkages with other programme areas and the need for influence and leverage. Initially, the HIV function was carried out by a small team scattered across various parts of the organisation. A separate HIV team existed for a short period between 2007 and 2009.31 Subsequently, it was moved to sit in the Health and Nutrition section, with a separate HIV advisor (working on higher level policy issues) reporting directly to the Deputy Representative. As part of the 2015 planning process, a standalone HIV section has been recreated. The HIV Education post has remained separate since its creation in 2012, reporting to the Education section.

For planning purposes HIV was part of the Young Child Survival Development Programme, one of UNICEF’s four programme pillars. The aim of situating two of the three HIV positions within the Health

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30 UNICEF Zimbabwe, Position Authorisation tables – 2005–16
31 Zimbabwe CO staffing charts for HIV 2005-16
and Nutrition section was reported to be to stimulate closer integration with health functions, especially with MNCH and child nutrition. There are mixed views on the success of this move. It is reported that HIV work in general became less visible during this period. Some respondents suggest that the HIV function lacked overall leadership and focus as a result of being spread across the organisation, at a time when mainstreaming of HIV/AIDS was an organisational priority. One positive result was HIV being written into all protocols generated from across the health team; however, programme areas outside of health, such as child protection, suffered from inadequate engagement with the HIV section.

With the move back to a stand-alone function as part of the 2015 planning process with linkages through HIV focal points to CP, Education and Communications, and the creation of a new SI position within the team, the HIV function is now considered by UNICEF respondents to have greater visibility, leverage, strategic positioning and influence across the organisation, as the team works to support the government and other partners in Zimbabwe’s push to elimination. It must be noted, that this change comes at a time when others, for example UNFPA, are mainstreaming their HIV function across teams to enable them to work more closely on integrated programming.

Over all, the advantage of situating HIV within Health and Nutrition prioritised health at a time when MDGs 4 and 5 were slipping. This worked for those who were in health, improving integration of HIV into health programming, but decreasing the visibility of HIV and making it more difficult to build linkages with other sections. The opposite happened when HIV was a dedicated team. The current move is to reinforce the visibility and strategic positioning of the HIV function across the office.

**Various approaches have been attempted to foster coordination between HIV and other programmes.** Staff, across functions, are aware that in moving towards elimination of paediatric HIV organisational ‘silos’ and stand-alone programmes needs to be avoided. This has presented an ongoing challenge for staff – “sometimes coordination between departments is a struggle in UNICEF”. Partner organisations noted that “where we’ve had funding from different departments, we’ve had to force the co-ordination”. As mentioned above, coordination between HIV, health and nutrition staff was facilitated when they were placed in the same department - but remained challenging with staff in other departments. Without a formalised matrix management system the ZCO has relied heavily on collaboration across teams, which is variable and reported to be heavily dependent on personalities. A positive example of collaboration is the consultant currently looking at mainstreaming HIV in CP while being managed by the Chief of HIV, with strong collaboration with Health and CP.

**UNICEF has well-developed systems for translating strategy into objectives and work-plans; however, these systems are less adept at reflecting team interdependencies.** While global and regional HIV priorities are mirrored in country-level planning and at various stages joint planning processes consider the potential for convergence, there is little evidence of these processes having led to shared targets and accountabilities between sections over the period of interest. Feedback suggest that systems have tended to incentivise staff to ‘chase targets’ at the expense of integration. One staff member noted that during the period of scale-up “I had the thankless task of reviewing work-plans that were already drawn up elsewhere and I was not part of the process until late in the game ... the working environment was not conducive to collaboration during the period of scale-up ... staff can be unduly focused on their own programmes success at the expense of other areas, impacting negatively on integration”. There are now some good examples of joint planning, for example, between child protection, nutrition and child health, and HIV focal points ensuring that relevant work-plans include HIV. One example in the 2012 Annual Management Plan (AMP) is for PMTCT, Result Area 3 where four staff are listed as responsible for an outcome – Chief YCSD, HIV Manager, HIV Specialist and Supply and Logistics.

**Roles and responsibilities between UNICEF CO, regional office and headquarters are clear, although there is some duplication.** While most issues are escalated first to regional office, on other issues the CO works directly with HQ, for example, on the Global Plan. The role of the regional office is valued, for example when it reviewed the ToR for a recent point-of-care evaluation and helped to provide quality assurance for its implementation and when it participated in the county programme strategic reflection process. Sometimes there are ‘direct lines’ of communication with HQ. When a quick response is needed,

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the CO might correspond directly with HQ, otherwise the protocol is to go through the regional office. Staff are not always clear when to engage the global level for advice and guidance, sometimes leading to “awkward” situations and duplication of effort. Improvements could be made, “however they trust us to just get on with our work”.

4.4.3 Organisational culture

UNICEF’s organisational culture is hands-on and solution focused with strong connections with the field. Staff describe a culture that is results orientated, productive and professional, where results are measured and all sections know what is expected and how to deliver on the strategy and work plan according to key performance indicators. Staff have a responsive and flexible attitude contributing to positive relationships with government and partners. The country office is considered as agile and effective. ZCO focuses on staff learning and development, linking personal learning objectives to CPDs and ensuring high completion rates for the personal evaluation reviews.

4.4.4 Analysis against the INK management model

The Instituut Nederlandse Kwaliteit (INK) Management Model provides a diagnostic framework to explore the extent to which UNICEF as an organisation is set up to leverage its comparative advantage, respond over time to the changing external environment, and deliver on its overall objectives. The INK model focuses on five organisational elements, as shown in Figure 4. The table below provides a summary of evidence against the elements observed at ZCO and will contribute to a more comprehensive global analysis for the final report.

<table>
<thead>
<tr>
<th>Focus area</th>
<th>Evident in the ZCO HIV section</th>
<th>Not so evident in the ZCO HIV section</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leadership – attitude and behaviour of people with guiding responsibility</td>
<td>Staff from all levels of the ZCO are recognized for their strong engagement, commitment to HIV issues, and collaborative approaches with partners</td>
<td>The internal influence of HIV staff is said to have varied over time, in relation to HIV staff numbers and their placement and roles across the ZCO.</td>
</tr>
<tr>
<td>2. Staff management – fully using the potential of knowledge and expertise</td>
<td>Programme management and specialist skills exist across the ZCO and are highly valued</td>
<td>There was a long delay in filling key authorised posts in the period 2005 – 2012</td>
</tr>
<tr>
<td></td>
<td>Systems for staff learning and development are strong and systematically applied</td>
<td>Specialist skills of HIV staff could be strengthened in the areas of SI, HSS and community engagement</td>
</tr>
<tr>
<td></td>
<td>Roles of CO, RO, and HQ are generally clear with strong technical support and feedback systems</td>
<td>Cross team working and integrated outputs were somewhat constrained in the absence of a more formal matrix management system</td>
</tr>
<tr>
<td>3. Strategy and policy – the way in which strategy is translated into objectives</td>
<td>The ZCO organisational structure has changed over time to adapt to external changes</td>
<td>Child-centred approaches to programming rather than vertical approaches could be more evident</td>
</tr>
<tr>
<td></td>
<td>ZCO has strengthened its planning and accountability processes over</td>
<td>A focus on programme integration is only apparent in recent years</td>
</tr>
</tbody>
</table>

Figure 4: Organisational areas of the INK management model

http://www.toolshero.com/strategy/ink-model/ – it should be noted that the INK Management Model also has additional components, linked to results areas; however, this dimension of the evaluation is focused on the organisational aspects of UNICEF and therefore the focus is on these five areas.
4.5 Cross-cutting issues

4.5.1 Gender

By the nature of its work and its mandate, UNICEF's work in Zimbabwe takes a gender focus. This is well recognised by external stakeholders who note the ‘special place’ that UNICEF has for women and children and its work in ensuring gender-equitable access to treatment.

UNICEF has played an important role in ensuring that data are disaggregated by age and sex in order to inform Zimbabwe’s response to PMTCT and paediatric HIV. This is well recognised by partners – for example, during the study period there have been two MICS that have generated demographic and health related information on women and children. UNICEF also note their work in advocating with the Government to have DHS data disaggregated by sex. Within UNICEF, the Situational Analyses undertaken to inform CPD development to ensure that sex-disaggregated data is considered part of the design of the internal response.35

Stakeholders within and outside of UNICEF recognise the need for further work in relation to the involvement of men and boys in PMTCT and paediatric HIV programming. UNICEF has been engaging in this area through its funding to some projects involving men through NGO partners, including as champions of PMTCT in rural communities36 and a ‘best practice’ campaign.37 Looking forward, UNICEF and the MoHCC are currently planning a study to examine the effectiveness of male mobilisers; however, the evidence suggests that, to date, these projects have not moved beyond pilots to wider scale-up.38

Gender mainstreaming presents an ongoing challenge for partners in Zimbabwe. While gender issues have featured as part of the six key outcomes of the three most recent Zimbabwe United Nations Development Assistance Frameworks (ZUNDAFs),39 an evaluation of the 2012–15 ZUNDAF found that

<table>
<thead>
<tr>
<th>Focus area</th>
<th>Evident in the ZCO HIV section</th>
<th>Not so evident in the ZCO HIV section</th>
</tr>
</thead>
</table>
| 4. Management of resources – how resources are handled | • Robust systems exist for managing financial and human resources | • Resources for staffing and programme sustainability remain a challenge for the future  
• UNICEF systems for grant application and reporting are perceived as burdensome by some NGO partners |
| 5. Process and systems – how the organisation identifies, designs, manages, improves or innovates systems | • Planning, budgeting and review processes are transparent and effective | • There is limited evidence of shared targets and accountabilities among ZCO staff34 which could aid internal planning for horizontal/integrated programming |

34 ZCO Country Management Plans 2011-2015 only show shared accountability in 2011 and 2012, for increased PMTCT services
38 No documents are currently available; however, UNICEF and MOHCC note that they are currently developing training materials for the male mobilisers, and will be looking at the effect on indicators such as couple testing uptake. There is currently a gap in relation to the post-training support.
39 ZUNDAF 2007–11: Outcome 4 – Reduced negative social, economic, political, cultural and religious practices that sustain gender disparity; ZUNDAF 2012–15: Outcome 7.1 – Laws, policies and frameworks established and implemented to ensure gender equality and empowerment of women and girls; ZUNDAF 2016–20: Gender Equality: Outcome 1 – Key institutions strengthened to formulate, review, implement and monitor laws and policies to ensure gender equality and women’s rights. Outcome 2 – Women and girls are empowered to effectively participate in social, economic and political spheres and to utilise gender based violence services.
although MDG 3 (women’s empowerment) and gender featured in the outcome areas, the mainstreaming of gender could be improved.  

There is also scope for greater prominence of gender within UNICEF’s internal approach to HIV. Some external stakeholders do not feel that gender issues are a focus in their discussions with UNICEF, and there is a perception that UNICEF could take a more holistic approach in the strategic integration of different programme areas and the social determinants of health to ensure that opportunities for synergy are fully maximised – for example, capitalising on links between gender-based violence and HIV. One stakeholder suggested that this could be promoted through an increased presence of the HIV team in forums that are focused on gender, not just those that are HIV-specific.

There is a sense that more could be done to mainstream gender structurally within UNICEF’s work in PMTCT and paediatric HIV. This appears to be a broader issue within the CO, which commissioned a Gender Review in 2014. The review found that, although the CPD 2012–16 was informed by sex-disaggregated data and assessment of the situation of women and children, it “lacks an in-depth gender analysis.” It noted that there was more to be done in a number of programme areas to achieve gender mainstreaming – for example, in relation to involvement of men and boys in the HIV response in general and PMTCT in particular.

The latest CPD (2016–20) has split out the Basic Education and Gender Equality component, so that Education stands alone and Gender sits under the cross-sectoral programme area – 41 it makes reference to “gender analysis and mainstreaming” as a key intervention. Although yet to be assessed, there is some perception that this is likely to increase the prominence given to gender issues. However, one internal stakeholder felt that considerations of gender might still be somewhat ‘tokenistic’. There is a felt need for UNICEF to consider how best to integrate gender within the response – taking it beyond working with both men and women and both boys and girls, to be more fully mainstreamed.

4.5.2 Human rights

The scale-up of services for the PMTCT of HIV has been highlighted as a human rights success in Zimbabwe. The GoZ is a party to UN and African Union child rights treaties and participate in the UN Human Rights Commission’s Universal Periodic Review process.42 This is upcoming in summer 2016, and interviewees suggested that achievements in PMTCT might be showcased as a success story. In the most recent report to the Commission of the Rights of the Child, the scale-up of facilities offering PMTCT and the increased coverage of services for pregnant women were highlighted as important achievements for Zimbabwe during the period under review.43

There are some good examples of where the rights of the child are put at the centre of programme approaches in Zimbabwe. For example, the National Case Management approach is being supported by UNICEF and implemented through partners such as World Education and Childline. UNICEF is supporting the training of cadres of community workers (reported to be 150 across 10 districts) that are responsible for identifying child protection cases. Following recognition that a number of the cases were linked to HIV issues (including PMTCT and adherence), workers are now being trained in HIV-sensitive case management in order to strengthen linkages and increase referrals to health services.

UNICEF’s articulation of a human-child rights-based approach to HIV is visible to some, but not all, of its partners. The previous two CPDs (2007–11 and 2012–15) put rights at the centre of the overall goal of the country programme – this is also reflected in the Country Programme Action Plan (CPAP) that accompanies the latest CPD:

CPD 2007–11: to promote every child’s right to equitable access to good quality services, including those in health; water, sanitation and hygiene; basic education and protection.

CPD 2012–15: to enable the equitable and sustained realisation of the rights of every woman and child in Zimbabwe to survival, development and protection.

CPAP 2016–20: to support Zimbabwe’s renewed efforts to accelerate progress towards national compliance with the rights of the child by strengthening the positioning of the needs and priorities of children into the enabling environment, through the building of national and subnational capacities towards reducing gender-based and other inequities and drivers of social exclusion and marginalisation.

Some stakeholders similarly recognise that UNICEF has a ‘clear agenda’ on the rights of the child. However, this not universally the case – a number of interviewees did not feel that UNICEF has been particularly vocal on this issue.

UNICEF could more actively promote the positioning of human/child rights within a holistic HIV response. There was a sense from some stakeholders that a lack of integration at every level is a barrier to the design and implementation of programmes that can address all of the rights of the child – for example, linking PMTCT with infant feeding, and ensuring that child protection issues are fully considered in the design of school-based HIV testing programmes. Integration was recognised by both UNICEF and external stakeholders as a challenge for UNICEF internally, as well as in the broader structures within Zimbabwe.

4.5.3 Equity

UNICEF’s approach to equity is viewed through the lens of universal access to quality care, as well as a special focus on the most disadvantaged districts. This is evident from the results articulated for HIV in the three CPD documents examined, which make reference to “comprehensive services for PMTCT in seven rural convergence districts,”44 “a special focus on the most disadvantaged districts and communities,”45 and “equitable use of proven HIV prevention and treatment interventions.”46

Among external partners, UNICEF is recognised as being a strong advocate for a geographical focus on the most disadvantaged districts – this is felt to have led to an increased focus of government and partners on these areas. In addition, through the H4+, six underperforming districts were selected as priorities in 2010–11 on the basis of poor MNCH performance, and it is reported that good progress has been made in terms of improving coverage of quality care through the efforts of UNICEF and its partners.

Bottleneck analyses are recognised as a critical contribution to improving Zimbabwe’s response. In 2012, Zimbabwe was selected as a pilot country for the accelerated implementation of UNICEF’s Monitoring Results for Equity System (MoRES),47 which aims to improve the equity focus of programmes through identifying barriers and bottlenecks to reaching effective coverage. Elimination of mother-to-child transmission of HIV was one of the strategic results areas for which a national-level bottleneck analysis was undertaken in 2012. Since then, BNA has also been undertaken for paediatric treatment. Following the initial experience, Zimbabwe has expanded on this approach – creating bottleneck analyses and action plans for 20 districts.48 Government and partners felt that the introduction of, and support to, bottleneck analyses had been a critical contribution of UNICEF to the HIV response. In particular, it has driven the development of district implementation plans that are designed to target the specific challenges faced in each area, in contrast to previous approaches to planning which applied generic strategies.

There is a tension between an equity focus and a drive for ‘yield’ in Zimbabwe. Some development partners noted that equity and yield are hard to rationalise – an equity-centred approach may imply priority given to the most disadvantaged and hard-to-reach populations, whereas a focus on reaching targets may drive a focus on entry points that can yield the highest volumes. As an organisation, UNICEF
champions the first approach through the MoRES system, while key partners (and particular, those affiliated with PEPFAR) the second.

**UNICEF has advocated for greater focus on specific populations where progress is slower; however, there is scope for increasing the emphasis given to the most excluded and disadvantaged.** UNICEF’s role in advocating for women and children has manifested itself in different forms over time – for example, the initial focus on scale-up of PMTCT, then an evolving recognition of the need to prioritise paediatric HIV care and treatment, and most recently highlighting the lack of progress among adolescents.

However, as coverage of PMTCT and paediatric ART increases, the GoZ, as well as UNICEF and its partners, will need to strengthen the equity focus to reach the unreached. There is a perception from some partners that, although the most disadvantaged districts are currently prioritised, even in those districts the most hard-to-reach and disadvantaged might be being ‘left behind’. Some stakeholders were very clear that reaching universal coverage will require a change in tactics, and resourcing, to access the poorest and most marginalised.

**The GoZ, as well as some of its partners, recognise the need for greater prioritisation to be given to some key populations.** UNICEF is recognised as supporting the inclusion of key populations in national processes – for example, a recent example of adolescent participation in the All In initiative was highlighted. More generally, there was representation of sex worker groups in processes such as the development of the Concept Note for HIV under the Global Fund’s New Funding Model. However, gaps have also been highlighted – for example, services for family planning and PMTCT among sex workers, ensuring access to care and treatment for disabled children, and working with Apostolic groups. Interviewees highlighted these as potential areas for development for UNICEF’s work, as well as for Zimbabwe more generally.

5 Achievements and challenges

5.1 Achievements

- **UNICEF has made many critical contributions to supporting Zimbabwe in the massive scale-up of HIV services for women and children since 2005**, through its broad-based support for health systems that serve women and children, its targeted advocacy for children affected by AIDS and their families, and its support to policy development, programme planning and implementation, and knowledge-building activities.

- **UNICEF has also made use of its position in key country-level partnership forums and financing arrangements, such as the CCM and the ESP, HTF and the HDF, to leverage resources for programme scale-up from donors**. The Global Plan served as a game changer in this regard, in opening opportunities for new international funding for the elimination of MTCT and the acceleration of treatment scale-up for children.

- **UNICEF has contributed to ensuring that the country has been able to procure medicines and commodities, including paediatric ARVs, for programme needs**. UNICEF stepped in during times of economic crisis when hyperinflation and a lack of foreign currency prevented NAC from procuring commodities directly. It also successfully advocated for the inclusion of paediatric ARVs in future Global Fund and HDF budgets.

- **UNICEF is recognised as supporting an equity focus**. In particular, UNICEF has been a strong advocate for prioritisation of the most disadvantaged districts. This has supported an increase in partner alignment to address some key challenges. The bottleneck analysis spearheaded by UNICEF in 2012, and later replicated at district level, has served to ensure that strategies are geographically targeted and are informed by data on specific challenges.

- **UNICEF has recruited a staff team in Zimbabwe with broad knowledge, experience and programme management skills** that is valued by partners for its responsiveness and flexibility. The organisational culture is hands-on and solution focused with strong connections with the field.
5.2 Challenges

5.2.1 Programmatic challenges

- While the national PMTCT and paediatric HIV care and treatment programme has been reasonably well resourced, there have been some funding gaps. Resources are also highly concentrated among a few donors, raising critical concerns for financial sustainability.
- The division of labour between Government departments and the streams of donor funding present disincentives and barriers to horizontal collaboration.
- As the programme matures, there will be a need for a shift in focus and tactics to achieve e-MTCT of HIV and universal care and treatment coverage for all, including children and their families, to ART. Greater attention needs to be placed on improving service quality and leveraging community-based systems to improve uptake and adherence levels.
- Innovative approaches will be needed to reach underserved populations and to deal with diminishing programme returns (for instance, with regard to the lower yield of early infant diagnosis as transmission rates decrease). ‘Reaching the last mile’ will also require greater and better use of financial resources. There will likely be a need to source these funds from increased domestic contributions, as well as contributions from existing and new donors.

5.2.2 Challenges for UNICEF

- Some of UNICEF’s major grants for HIV/AIDS are coming to a close in 2016, including the joint programme for the H4+ Initiative and a multi-year grant from SIDA that is distributed across UNICEF’s thematic areas, including HIV/AIDS. This will require available financial and human resources to be used very strategically and efficiently going forward.
- While partners recognise that human rights and equity are components of UNICEF’s response to HIV, it is not perceived as a thought leader in relation to these issues. There is scope for greater prominence to be given to human rights and equity as part of a holistic response to HIV in children.
- Gender mainstreaming presents a challenge for both UNICEF and the broader programme in Zimbabwe – there is a need for gender-transformative programming, moving beyond a focus on more gender-specific approaches.
- There are organisational challenges in achieving programme linkages and integration while ensuring that the HIV function has adequate leverage and influence across programme areas. UNICEF’s planning systems needs to reflect programme interdependencies through shared targets and accountabilities.
- UNICEF’s systems and processes are seen to be slow by some donors, and there is some sense that this is hampering fundraising for the ZCO.

6 Implications for UNICEF

Looking ahead, the evaluation team has identified the following implications for ZCO, to support the consolidation of its work to date and the strengthening of the approach for the future.

- Work closely with partners to ‘finish the job’ in making best use of available funds and as necessary leverage additional funds to support Zimbabwe’s effort for e-MTCT and universal coverage of children with HIV care and treatment services. Zimbabwe’s trajectory to date has been exemplary and it would be unfortunate indeed to lose all gains achieved to date through a downturn in commitment and resources.
• **Seize opportunities to innovate and build on comparative advantages**, including UNICEF’s unique roles in advocacy and social mobilisation around equity issues and its global experience with gender-transformative, rights-based and family-centred approaches to programming.

• **Strengthen linkages across programmes and sectors at every level and, as appropriate, promote integrated services at the point of service delivery**, with a strong but not exclusive focus on HIV, health and nutrition services for women and children. This implies that UNICEF should make a greater effort to identify opportunities for critical linkages and foster joint planning, financing and reporting approaches, within its own office and with key stakeholders. Bold measures are required to work around current financing mechanisms and Government structures. UNICEF could be doing more to model multisectoral and integrated programming and implementation.

• **Seek to increase the ZCO resource base and use available resources as strategically and efficiently as possible to more fully explore innovative programme solutions**, with a particular focus on the change in tactics required to cover the ‘last mile’.

• **Continue to support the GoZ in the identification of resource gaps in the national programme, and sources of funding to fill these gaps.** In particular, work with the Government, UNAIDS and the World Bank to analyse other domestic financing opportunities. This might include financing through public private partnerships, such as those piloted by UNAIDS in the South African Development Community region, and broadening the tax base to ensure the informal sector contributes to the AIDS Levy.

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**Implications for the evaluation**

The Zimbabwe case study has served well the two purposes laid out in the evaluation design. It has documented in some detail how UNICEF’s engagement in PMTCT and paediatric HIV/AIDS played out in a particular setting over the period 2005–15, in support of resolute and steady programme advances, despite an unfavourable political and economic context. It has also tested and validated the theory of change developed to guide the evaluation (see Annex VI).

Some caveats are worth mentioning however:

• As previously noted, many of UNICEF’s ZCO contributions to HIV programme scale-up were broad-based. Arguably, it is UNICEF’s efforts, together with that of other partners, to keep the health system functioning and protect access to MNCH services during the country’s economic meltdown that enabled the HIV programme to take hold and build momentum. UNICEF’s HIV-specific activities over the period were undoubtedly important as well. However, its direct financial contribution to the PMTCT/paediatric AIDS programme was limited (in comparison to that of other donors as shown in Annex IV). In addition, most of its activities were conducted in close partnership with other multilateral and bilateral agencies, and its approach was very much to use its limited HIV funding to fill critical programme gaps. It is therefore difficult to tease out UNICEF’s unique contributions to Zimbabwe’s programme successes, except in a broad and informal manner.

• In the last several years at least, the GoZ, particularly through the NAC and the MoHCC, has played a strong leadership and stewardship role, especially in terms of the coordination of the national response. A description of UNICEF’s ‘leadership’ role (examined under the first evaluation theme) was thereby less relevant in the Zimbabwean context.

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49 Further details are included in the Inception Report for this evaluation.
Annex I: Terms of reference for in-depth country studies

Overview of the evaluation

Itad is a UK-based consultancy company that has been commissioned by UNICEF to undertake an evaluation of its activity in the PMTCT and paediatric HIV treatment, care and support. The purpose of this evaluation is to support accountability and learning in relation to UNICEF’s efforts to scale up PMTCT and paediatric care and treatment programmes and to document its contribution towards elimination of mother-to-child HIV transmission and an AIDS-free generation for children. By looking over the past 10 years of UNICEF’s PMTCT and paediatric HIV engagement, the evaluation will provide evidence and lessons learned to enhance the understanding of the organisation and other stakeholders on how strategies and programmes have evolved, what has worked, has not worked, and why.

The evaluation will assess four particular aspects of PMTCT and paediatric HIV treatment programming, namely:

1. Thematic leadership, advocacy and partnership
2. Resource mobilisation
3. Strategic information, knowledge generation and dissemination, and
4. Key aspects of UNICEF’s organisation.

It will also consider the cross-cutting issues of gender, equity, and human rights. The findings will be used to guide (a) effective action towards the achievement of the UNICEF Strategic Plan HIV outcome and (b) UNICEF positioning in the post–2015 HIV agenda as guided by the UNAIDS 2016–21 Strategy.

As part of the data collection for this evaluation, Itad is undertaking case studies in a total of seven countries – four involving country visits and three conducted remotely through a desk review and phone interviews. The findings from country level are being supplemented with a structured document review, an online survey, and interviews with key stakeholders at global and regional levels.

This document details the process for the country visits in ESARO and WCARO, to be undertaken during the period of April–May 2016.

Purpose of the country case studies

The evaluation is taking as its starting point the theory of change for UNICEF’s work in PMTCT and paediatric HIV over the period of 2005–15. The purpose of the case studies is to record how UNICEF’s engagement in this area has played out at country level, and help test and validate the theory of change. It is important to note the following:

- Each case study has been selected because of the learning opportunity offered to the evaluation.
- The approach to each is focused on recording experiences rather than measuring or assessing individual country performance.

Approach to data collection and analysis

Each mission will last seven working days50 (over a period of two weeks). Each team will arrive in-country with a clear case study ToR, detailed draft agenda, and having already performed a remote desk study and stakeholder listing to ensure that the time the evaluators spend in-country can be used as effectively and efficiently as possible. Figure 1 below summarises the proposed process through which each of the country studies will be implemented. However, the first country case study visit will be used as an opportunity to refine the process. This will be attended by four members of the core team to gain consensus and maximise consistency of approach.

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50 In the case of Zimbabwe, in consultation with EO and the Zimbabwe CO, this has now been reduced to five days given that four team members are attending and therefore can cover double the number of interviews.
**Figure I.1 Process for conducting country studies**

**Step 1:** Prior to the visit, a **desk review phase** will focus on enabling the team to gain a comprehensive understanding of the background to PMTCT/Paediatric HIV/AIDS programme activities in each case study country, and extracting available secondary evidence – for example on key events.

**Step 2:** During this stage, an **agenda for the country case study** will be agreed, based on a **stakeholder mapping** exercise undertaken by the evaluation team and UNICEF country office (CO). The evaluation team will contact the CO to discuss this agenda including possible stakeholder interviews.

**Step 3:** Each mission will start in-country with a **brief kick-off meeting** with UNICEF staff to orientate the team to the national context, provide background to the UNICEF office, and to enable an initial exploration of issues arising from remote desk review.

**Step 4:** Following this workshop, the evaluation team will then conduct **semi-structured interviews** (and where appropriate, small group discussions) with key in-country stakeholders – including UNICEF staff, government, and partners. These interviews will be designed to elicit further information on the thematic areas of interest.

**Step 5:** At the end of the country visit, the evaluation team will share debriefing notes of observations and preliminary findings through a **slide set with the UNICEF CO**, and hold a feedback discussion.

**Step 6:** Subsequently, a **case study report** will be written up for each country and shared with the CO for comments (approximately two weeks after the end of the country visit).

**The team**

The country case studies will be conducted by a team of two consultants belonging to the core evaluation team, over a total input period of seven working days in the field per country. This team will be complemented by a national expert who will be normally resident in-country and can support on collation of documents and identification and contacting of stakeholders, and will bring in-depth understanding of the country context. One consultant will act as lead consultant in order to ensure that responsibility for delivery of the report is clearly located.

**Guidance to case study country offices**

The agenda should ideally be agreed between the CO and the evaluation team at least a week before the visit to allow sufficient time for in-country preparation. In order to appropriately support the case study visit, the team suggest that the CO:

1. **Confirm suitability of suggested dates** as soon as possible.
2. **Identify someone to act as a point of contact** to organise the schedule proposed below.
3. **Share the ToRs** with those who might be consulted during the visit.
4. **Identify documents**/create a list of key documents that would be useful to share with the evaluation team.
5. **Consider which staff members** it would be useful for the evaluation team to meet and whether this is most appropriate on a one-to-one basis or in a focus group (or both). Ideally, this should include current staff members as well as staff who were involved during the period of interest for the evaluation (2005–15). If necessary, interviews can be conducted remotely over Skype.
6. **Consider which external stakeholders** the evaluation team should meet. This should include representatives from all key development partners working in HIV/AIDS at country level, as well as relevant government stakeholders. Ideally, this should include stakeholders who were involved during the period of interest for the evaluation (2005–15), as well as those who are currently in post.

7. **Feedback on preliminary findings**: Please consider which staff members should be included in the meeting to discuss preliminary findings.

The schedule for the visit is projected to look like this:

<table>
<thead>
<tr>
<th>Day</th>
<th>Monday</th>
<th>AM: Meeting with UNICEF CO PM: Stakeholder interviews (UNICEF staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2</td>
<td>Tuesday</td>
<td>Stakeholder interviews (UNICEF staff)</td>
</tr>
<tr>
<td>Day 3</td>
<td>Wednesday</td>
<td>Stakeholder interviews (external – government and partners)</td>
</tr>
<tr>
<td>Day 4</td>
<td>Thursday</td>
<td>Stakeholder interviews (external – government and partners)</td>
</tr>
<tr>
<td>Day 5</td>
<td>Friday</td>
<td>Stakeholder interviews (external – government and partners)</td>
</tr>
<tr>
<td>Day 6</td>
<td>Saturday</td>
<td>Stakeholder interviews (as required) and internal team working</td>
</tr>
<tr>
<td></td>
<td>Sunday</td>
<td></td>
</tr>
<tr>
<td>Day 7</td>
<td>Monday</td>
<td>Presentation of initial findings to CO (plus additional interviews as required)</td>
</tr>
</tbody>
</table>
## Annex II: Zimbabwe country visit agenda

### Day 1: 11 April 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:15</td>
<td>Travel from hotel to Office</td>
<td>Hotel</td>
</tr>
<tr>
<td>8:15 – 9:15</td>
<td>Courtesy call to the UNICEF Rep. (Interview the representative and Dep. Rep)</td>
<td>UNICEF</td>
</tr>
<tr>
<td>9:30 – 10:30</td>
<td>Meeting with PMU and HIV sections – review plans for the missions and any other requirements</td>
<td>UNICEF</td>
</tr>
<tr>
<td>10:30 – 12:00</td>
<td>Interviews with HIV team</td>
<td>UNICEF</td>
</tr>
<tr>
<td>12:00 – 13:00</td>
<td>Interviews with the PMU and Social Policy teams</td>
<td>UNICEF</td>
</tr>
<tr>
<td>13:00 – 14:00</td>
<td>Lunch</td>
<td>UNICEF</td>
</tr>
<tr>
<td>14:00 – 15:00</td>
<td>Interview with Nutrition Team</td>
<td>UNICEF</td>
</tr>
<tr>
<td>14:00 – 15:00</td>
<td>Interview with Child protection</td>
<td>UNICEF</td>
</tr>
<tr>
<td>14:00 – 15:00</td>
<td>Interview with HR</td>
<td>UNICEF</td>
</tr>
<tr>
<td>14:00 – 15:00</td>
<td>Interview with Director, Family Health, MoHCC</td>
<td>MoHCC – Kaguvi building</td>
</tr>
<tr>
<td>15:15 – 16:15</td>
<td>Interviews with the Health team</td>
<td>UNICEF</td>
</tr>
<tr>
<td>15:15 – 16:15</td>
<td>Interview with Finance</td>
<td>UNICEF</td>
</tr>
<tr>
<td>15:15 – 16:30</td>
<td>Interview with World Education</td>
<td>Milton Park/UNICEF</td>
</tr>
<tr>
<td>16:30 – 17:00</td>
<td>Travel back to hotel</td>
<td></td>
</tr>
</tbody>
</table>

### Day 2: 12 April, 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:30</td>
<td>Travel from hotel to Office</td>
<td>Hotel</td>
</tr>
<tr>
<td>8:30– 9:30</td>
<td>Interview with UNAIDS</td>
<td>UNAIDS, 1st Floor, Block 9, Arundel Office park</td>
</tr>
<tr>
<td>8:30– 9:30</td>
<td>Interview with UNAIDS</td>
<td>UNAIDS, 1st Floor, Block 9, Arundel Office park</td>
</tr>
<tr>
<td>8:30– 9:30</td>
<td>Interview with UNDP (Global Fund focal point)</td>
<td>UNDP, Ground Floor Building 7, Arundel Office park</td>
</tr>
<tr>
<td>10:30 – 11:30</td>
<td>Interviews with CHAI</td>
<td>CHAI, Block 4 Arundel Office Park</td>
</tr>
<tr>
<td>11:00 – 12:30</td>
<td>Interview with WHO HIV focal point</td>
<td>WHO, Highlands</td>
</tr>
<tr>
<td>13:00 – 14:00</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>14:00 – 15:00</td>
<td>National AIDS council</td>
<td>NAC</td>
</tr>
<tr>
<td>15:30 – 16:30</td>
<td>Interviews with USAID</td>
<td>USAID</td>
</tr>
<tr>
<td>15:30 – 16:30</td>
<td>Interview with ZNNP+ (people living with HIV network)</td>
<td>NAC</td>
</tr>
<tr>
<td>15:30 – 16:30</td>
<td>Interviews with CDC</td>
<td>CDC</td>
</tr>
<tr>
<td>16:30 – 17:00</td>
<td>End of day – Travel back to hotel</td>
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</tr>
</tbody>
</table>

### Day 3: 13 April

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:45 – 8:30</td>
<td>Travel from hotel to Kadoma</td>
<td>Hotel</td>
</tr>
<tr>
<td>8:45 – 9:45</td>
<td>Interview Dr. Mugurungi, Director AIDS and TB</td>
<td>Kadoma</td>
</tr>
<tr>
<td>8:45 – 9:45</td>
<td>Interview with Director Care and treatment</td>
<td>Kadoma</td>
</tr>
<tr>
<td>10:00 – 12:00</td>
<td>Interview Dr. Mushavi, PMTCT and Pediatric ART Coordinator</td>
<td>Kadoma</td>
</tr>
<tr>
<td>10 – 11:00</td>
<td>Interview with EGPAF</td>
<td>EGPAF, Avondale</td>
</tr>
</tbody>
</table>
### Day 4: 14 April 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>7:45 – 08:00</td>
<td>Travel from hotel to Office</td>
<td>Hotel</td>
</tr>
<tr>
<td>08:00 – 09:00</td>
<td>Interview with Coordinator HIV prevention</td>
<td>UNICEF</td>
</tr>
<tr>
<td>08:15 – 09:15</td>
<td>Interview with Former PMTCT Officer UNICEF (2005 – 2007)</td>
<td>UNICEF</td>
</tr>
<tr>
<td>09:00 – 10:00</td>
<td>Interview with Nutrition Deputy Director, MoHCC</td>
<td>MoHCC – Kaguvi building</td>
</tr>
<tr>
<td>10:30 – 12:00</td>
<td>Interview with NMRL (early infant diagnosis)</td>
<td>Southerton, Harare Hospital</td>
</tr>
<tr>
<td>10:00 – 11:00</td>
<td>Interview with UNFPA</td>
<td>UNFPA, Arundel Office park</td>
</tr>
<tr>
<td>11:30 – 12:30</td>
<td>Interview with OPHID Trust</td>
<td>OPHID, Belgravia</td>
</tr>
<tr>
<td>12:30 – 14:00</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>15:30 – 16:30</td>
<td>Skype interview: former UNICEF ZCO staff</td>
<td>Hotel</td>
</tr>
<tr>
<td>15:30 – 16:30</td>
<td>Interview with Swedish Embassy</td>
<td>32 Aberdeen Road, Avondale</td>
</tr>
<tr>
<td>16:45 – 17:00</td>
<td>Travel back to hotel</td>
<td></td>
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</table>

### Day 5: 15 April 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:30</td>
<td>Travel from hotel to Office</td>
<td>Hotel</td>
</tr>
<tr>
<td>8:30 – 10:00</td>
<td>Preparations for Debrief</td>
<td></td>
</tr>
<tr>
<td>10:00 – 11:30</td>
<td>Debriefing with UNICEF</td>
<td>UNICEF</td>
</tr>
<tr>
<td>12:00 – 13:00</td>
<td>Debrief with MoHCC and NAC</td>
<td>MoHCC</td>
</tr>
<tr>
<td>13:00 – 14:00</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>15:00 – 16:00</td>
<td>Skype interview: Florence Naluyinda-Kitabire</td>
<td>Hotel</td>
</tr>
</tbody>
</table>

**END OF MISSION**
## Annex III: Stakeholder list

<table>
<thead>
<tr>
<th>Name of person</th>
<th>Title</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geoffrey Larry Acaye</td>
<td>Health Manager</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Vandana Agarwai</td>
<td>Nutrition Manager – YCSD</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Shirish Balachandra</td>
<td>Branch Chief, HIV Services</td>
<td>CDC</td>
</tr>
<tr>
<td>Michael Bartos</td>
<td>Country Director</td>
<td>UNAIDS</td>
</tr>
<tr>
<td>Emmanuel Boadi</td>
<td>Project Manager/Coordinator</td>
<td>UNDP</td>
</tr>
<tr>
<td>Farai Charasika</td>
<td>Program Director</td>
<td>World Education Inc.</td>
</tr>
<tr>
<td>Ancikaira Chigumira</td>
<td>Deputy Director Nutrition Services</td>
<td>MoHCC</td>
</tr>
<tr>
<td>Shelly E Chitsungo</td>
<td>Health Specialist (MNH)</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Barbara Engelsmann</td>
<td>Country Director</td>
<td>OPHID</td>
</tr>
<tr>
<td>Lena Forsgren</td>
<td>First Secretary Development Cooperation</td>
<td>Embassy of Sweden</td>
</tr>
<tr>
<td>Dagmar Hanisch</td>
<td>Technical Specialist HIV Prevention and SRH</td>
<td>UNFPA</td>
</tr>
<tr>
<td>Rumbi Iza</td>
<td>Social Economic Analyst</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Margaret Jambere</td>
<td>District Officer Support and Quality Improvement Officer</td>
<td>KAPNECK</td>
</tr>
<tr>
<td>Angeline Katsalde</td>
<td>Finance Team</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Susanne Kinyua</td>
<td>Donor Relations Specialist</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Dr Madzima</td>
<td>Director, Family Health</td>
<td>MoHCC</td>
</tr>
<tr>
<td>Deborah Maleni</td>
<td>Social Economic Analyst</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Alexio Mangwiro</td>
<td>Country Director</td>
<td>CHAI</td>
</tr>
<tr>
<td>Yamikana Masharira</td>
<td>Finance Team</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Tendaye Mbengeranuka Mhaka</td>
<td>Key Populations Coordinator</td>
<td>NAC</td>
</tr>
<tr>
<td>Mutsa Mhangara</td>
<td>SI Coordinator, AIDS and TB</td>
<td>MoHCC</td>
</tr>
<tr>
<td>Joyce Mphaya</td>
<td>Chief – HIV/AIDS</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Emely Muchochomi</td>
<td>HR Officer and Acting HR Manager</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Fundai H. Mudzengerere</td>
<td>Research &amp; Program Audit Manager</td>
<td>World Education Inc.</td>
</tr>
<tr>
<td>Oscar Mundida</td>
<td>CCM Coordinator</td>
<td>CCM</td>
</tr>
<tr>
<td>Owen Mugurungi</td>
<td>Director of HIV/AIDS and TB Unit</td>
<td>MoHCC</td>
</tr>
<tr>
<td>Joseph Murungu</td>
<td>Director Care and Treatment, AIDS and TB Programme</td>
<td>MoHCC</td>
</tr>
<tr>
<td>Angela Mushavi</td>
<td>PMTCT and Paediatric HIV Coordinator</td>
<td>MoHCC</td>
</tr>
<tr>
<td>Leon Muwoni</td>
<td>Child Protection Specialist</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Florence Naluyinda-Kitabire</td>
<td>HIV AIDS Manager Zimbabwe 2010–13</td>
<td>UNICEF</td>
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<tr>
<td>Milicent Nyagata</td>
<td>Finance Team</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Tichaona Nyamundaya</td>
<td></td>
<td>EGPFAF</td>
</tr>
<tr>
<td>Diana Patel</td>
<td>Deputy Country Director</td>
<td>OPHID</td>
</tr>
<tr>
<td>Richard Sabumba</td>
<td>Logistics Manager, Directorate of Pharmacy</td>
<td>MoHCC</td>
</tr>
<tr>
<td>Prudence Samakande</td>
<td>HR Officer</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Beula Senzanje</td>
<td>HIV/AIDS Specialist</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Judith Sherman</td>
<td>Chief, HIV, UNICEF Malawi</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Vikas Singh</td>
<td>Chief – Planning and Monitoring</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Lia Tavadze</td>
<td>Human Rights and Gender Equality Advisor</td>
<td>UNAIDS</td>
</tr>
<tr>
<td>Gregory Thorne</td>
<td>Partner Management Branch Chief</td>
<td>CDC</td>
</tr>
<tr>
<td>Nicola Willis</td>
<td>Director</td>
<td>AFRICAID</td>
</tr>
<tr>
<td>Raymond Yekeye</td>
<td>Operations Director</td>
<td>NAC</td>
</tr>
<tr>
<td>Lloyd</td>
<td>Child Projection</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Munya</td>
<td>M&amp;E Specialist, PMU</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Therese</td>
<td>Consultant, PMU</td>
<td>UNICEF</td>
</tr>
</tbody>
</table>
Annex IV: Country Context: An overview of Zimbabwe’s PMTCT and paediatric HIV/AIDS programme

Geography and population
Zimbabwe lies north of the Tropic of Capricorn between the Limpopo and Zambezi rivers with an area of about 390,757 square kilometres. The country is landlocked, bordered by Mozambique in the east, South Africa in the south, Botswana in the west, and Zambia in the north and northwest. It is part of a great plateau, which constitutes the major feature of the geology of southern Africa. The country is administratively divided into 10 provinces: two urban and eight rural, which are in-turn sub-divided into 62 districts. The two urban provinces are Bulawayo and Harare; while the eight rural provinces are Manicaland, Mashonaland East, Mashonaland Central, Mashonaland West, Matabeleland North, Matabeleland South, Masvingo and Midlands.

According to the population census of 2012, the total population of the country was 13,061,239 (48% males and 52% females). The population was relatively young with 41% of the population being below age 15 years and about 4% age 65 years and above. The male/female sex ratio in the country was nearly 93. The majority of the population (67%) resides in the rural areas with population density of 33 persons per square kilometre. The 2012 census report stated that average life expectancy at birth was 38 years.

Table IV.1 below presents some of the important national socio-demographic indices.

<table>
<thead>
<tr>
<th>Item</th>
<th>ZDHS 2010/11</th>
<th>Census 2012</th>
<th>MICS 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude Birth Rate (births per 1,000 population)</td>
<td>Total</td>
<td>34</td>
<td>32</td>
</tr>
<tr>
<td>Number of women of reproductive age</td>
<td>Total</td>
<td>-</td>
<td>3,271,400</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>Total</td>
<td>58.5%</td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>61.5%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>57.0%</td>
<td>65.6%</td>
</tr>
<tr>
<td>Unmet need for family planning</td>
<td>Total</td>
<td>12.8%</td>
<td>10.4%</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>11.6%</td>
<td>9.5%</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>13.4%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Total fertility rate (children per woman)</td>
<td>Total</td>
<td>4.1</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>3.1</td>
<td>3.4</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>4.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>Total</td>
<td>960</td>
<td>525</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>53</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>55</td>
<td>68</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1,000 live births)</td>
<td>Total</td>
<td>57</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>53</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>55</td>
<td>68</td>
</tr>
<tr>
<td>Under-5 Mortality Rate (per 1,000 live births)</td>
<td>Total</td>
<td>84</td>
<td>84</td>
</tr>
<tr>
<td>Exclusive breastfeeding rate 0–5 months:</td>
<td>Total</td>
<td>31.4%</td>
<td>41%</td>
</tr>
</tbody>
</table>

Economy
Zimbabwe has abundant natural resources, including 8.6 million hectares of potentially arable land and more than 5 million hectares of forests, national parks, and wildlife estates. There are adequate supplies of surface and ground water that could be harnessed for generation of electric power, irrigation of crops,

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52 ZIMSTAT. Zimbabwe Population Census 2012.
53 Ibid.
and domestic and industrial use. Mineral resources are varied and extensive, including platinum, gold, asbestos, coal, nickel, iron, copper, lithium, and precious stones such as emeralds.\textsuperscript{54}

The economy is diversified but biased towards agriculture and mining, which are the country’s major foreign currency earners. In addition to mineral processing, major industries include food processing, construction, chemicals, textiles, wood and furniture, and production transport equipment.\textsuperscript{55} In recent years the mining industry has faced challenges such as frequent power outages, inefficient infrastructure, flight of skilled workers, and shortages of funds for working capital and recapitalisation. The manufacturing industry also has suffered constraints such as deindustrialisation, inadequate and erratic supply of key economic enablers (namely electricity, fuel, coal, and water), and the high cost of establishing business.

The agriculture sector has well-developed commercial and communal farming systems. The main agricultural export product is tobacco, along with maize, cotton, sugar, and groundnuts. However, the agricultural sector continues to face many challenges such as poor irrigation, unaffordable inputs, low capitalisation levels and limited exportation of crops.

Socio-economic and political situation

Zimbabwe experienced a multiplicity of development challenges since 1999, starting with the 1999/2000 Cyclone Eline floods that devastated some infrastructure and crops. The situation was worsened by recurrent droughts between 2001 and 2007 compounding the challenge of severe macroeconomic instability that was being experienced in the country during this period.\textsuperscript{56} The overall outcome of these continuous challenges was that the country’s real annual Gross Domestic Product (GDP) growth rate cumulatively declined by around 46% during the period 2000 to 2008.\textsuperscript{57} The macroeconomic instability was characterised by hyperinflation, which reached an annual inflation rate of 231 million percent in July 2008.\textsuperscript{58} The hyperinflationary environment adversely affected basic social services delivery in health, education, water and sanitation and social protection. The health and education sectors, for example, experienced severe budgetary constraints as well as an exodus of skills to other countries, thus, weakening the country’s social delivery service. The declining economy was openly characterised by various shortages (foreign currency, basic food, fuel, medical supplies and water); and high levels of structural unemployment and underemployment, poverty and food insecurity. The challenging socio-economic environment was exacerbated by the impact of the underlying HIV and AIDS pandemic and the cholera outbreak of 2008/2009. According to the MoHCW, the cholera epidemic affected around 100,000 people resulting in an estimated 4,300 deaths.\textsuperscript{59}

The Government of Zimbabwe (GoZ) introduced multiple stable currencies in the economy in February 2009. This move stabilised the macroeconomic environment, as reflected by a single digit hard currency inflation experienced since then. In 2010, the GoZ launched the Three Year Rolling Macroeconomic and Budget Framework, 2010–12 also referred to as the Short-Term Economic Recovery Programme II (STERP II), and began implementation of a five-year strategic development plan, the Zimbabwe 2011–15 Medium-Term Plan aimed at stimulating sustainable economic recovery and growth.\textsuperscript{60} There is evidence of growing confidence and improvement in the economy over the last few years. The GDP\textsuperscript{61} grew at 11% and 5% in 2012 and 2013, respectively. Despite promising developments in the country’s economic sphere, there are challenges that still remain to achieve sufficient recovery to enable effective rehabilitation of social and health services that had been undermined by years of economic decline and stagnation. One of the major concerns that the country is facing is the issue of low levels of formal

\textsuperscript{54} Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International. 2012. Zimbabwe Demographic and Health Survey 2010–11. Calverton, Maryland: ZIMSTAT and ICF International Inc.

\textsuperscript{55} ibid


\textsuperscript{58} ibid


\textsuperscript{61} ZIMSTAT. 2014. \textit{Quarterly Digest of Statistics 3rd Quarter 2014}.
employment (11 percent\textsuperscript{62}) which adversely affect the capacity of most households and individuals to afford basic commodities including health care services. To further guide national development from 2013 to 2018, the GoZ developed a new economic blue print, the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimASSET).\textsuperscript{63}

Health

Health care in Zimbabwe is provided by public facilities, not-for-profit organisations, the faith-based organisations (church organisations), company-operated clinics (e.g. the mining companies), the private-for-profit clinics, and the traditional medicine sector that offers treatment for a variety of illnesses. The health care delivery system is decentralised, but with policy, regulation and administrative guidance; human resource planning; donor coordination, resource mobilisation and allocation as well as surveillance, M&E being part of the central government’s responsibility under the MoHCC.\textsuperscript{64}

At the provincial and district levels, the health system is administered by the respective health offices, as representatives of the MoHCC. The Provincial Medical Office administers the provincial hospital and all district health offices within the province, including the allocation of resources, and the Provincial Medical Director reports to the Permanent Secretary, MoHCC. At the district level, the District Medical Officer administers the district hospital and all the rural health facilities within the district. The provincial and district members of staff are also charged with determining the financial, material and human resource needs of the catchment area, as well as providing regular reports to the central level.

The public health delivery system is organised in a hierarchical, four-tiered order as follows:

- **Primary Health Care Facilities**: comprises of rural health centres, rural hospitals and urban clinics at the entry level of care. The health facilities provide basic out-patient services including the essential package of maternal, newborn and child health (MNCH) services comprising of antenatal care, comprehensive PMTCT services, normal delivery, postnatal care as well as integrated management of neonatal and childhood illnesses (IMNCI). There are no attending physicians at this level and no diagnostic facilities. The link with, and support from the village health workers, enhances the capacity for provision of preventive and health promotion interventions at community level.

- **District /Mission Hospitals**: comprise of government district hospitals and mission hospitals of which some are designated as district hospitals, in those districts without a government hospital. In addition to services provided at the primary health care level, these facilities have capacity to carry out diagnostic services and conduct surgical procedures, provide emergency obstetric care that includes caesarean section, comprehensive PMTCT services, OI/ART services, safe blood transfusion and comprehensive management of newborn and childhood illnesses, including emergency paediatric care.

- **Provincial Hospitals**: constitute the highest referral level in the province and establishment includes specialists in different medical disciplines. The mandate is management of complicated paediatric, obstetrical, gynaecological and adult medical as well as surgical cases referred from the district level.

- **Central Hospitals**: constitute the apex in the hierarchy of health care in the country, with specialists in various medical disciplines. In addition to providing specialist services and managing the complicated referred cases, these institutions are actively involved in training of medical, nursing and paramedical personnel.

Delivery of health services is guided by the National Health Strategy (2009–15) under the theme “Equity and Quality in Health: A People’s Right”.

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Financing for health

Domestic financing of health care in the country is from several sources that include: government allocations, private voluntary organisations, medical aid health insurance schemes, and direct out of pocket payments. However, the health sector in Zimbabwe is characterised by a chronic shortage of financial resources – domestic health expenditure per capita was around US$9 in 2011, significantly less than the US$34 recommended by the Ouagadougou Declaration. As a consequence, the country is highly dependent on external sources of financing for the delivery of health services. Pooled funding mechanisms have been critical in ensuring that donor funds have been able to flow into the country during times of economic uncertainty, when donors were unwilling to provide funds directly to the Government.

The Health Transition Fund

The HTF was a 5-year plan formulated by the GoZ, UNICEF and other international partners to pool funds for critical health interventions for the period 2011 to 2015. The HTF aimed to raise US$435.34 million over 5 years to support the implementation of the National Health Strategy (NHS) (2009–13). The HTF was governed by a Steering Committee, chaired by the Permanent Secretary of MoHCC, comprising government and the donor community and representatives from civil society, who have contributed to the Fund. External partners who contributed to the Fund included: CIDA, European Union, Irish Aid, Norwegian Government, Swiss Embassy, Swedish Government and United Kingdom Aid/ DFID.

The pooled mechanism in principle aimed to reduce overhead costs in operations, reporting and fund administration so that funding is channelled towards achieving direct programme impact. Funds came into UNICEF financial systems and were pooled together, and UNICEF ensured financial regulations were met with contracts signed between funders and UNICEF. UNICEF tracked funds received and funds spent using existing financial systems (IPSAS – International Public Sector Accounting Standards) and financial updates were shared and discussed with HTF Steering Committee in monthly meetings.

The HTF’s broad objective was to improve MNCH by strengthening health systems and scaling up the implementation of high impact interventions through support to the health sector. The HTF’s key areas of support were (a) MNCH and nutrition, (b) Medical products, vaccines and technologies (essential medicines), (c) Human resources for health (Health Worker Retention Scheme), and (d) Health policy, planning and finance (Health Services Fund and Research).

Health Development Fund

Following the HTF, the GoZ, in partnership with the United Nations and Development Partners launched the Health Development Fund (HDF) in 2015, a multi-donor fund to the health sector, with a focus on reproductive, maternal, newborn, child and adolescent health (RMNCH-A). The HDF aims to raise US$680 million over 5 years. So far, the European Union and the governments of UK, Sweden and Ireland, as well as the Global Alliance for Vaccines and Immunisations (GAVI), have indicated their willingness to be part of the HDF.

Building on the achievements of two health sector programmes – the HTF, managed by UNICEF, and the Integrated Support Programme, managed by UNFPA – the HDF aims to consolidate and improve on gains made over the past 5 years by strengthening health systems and scaling up the implementation of high impact RMNCH-A, and nutrition interventions through support to the health sector.

Within the context of the 2016–20 National Health Sector Strategy, the HDF aims to ensure equitable access to quality health services for women and children, which will result in the reduction of maternal and child mortality by 50%, increase in access to family planning, halving the prevalence of stunting in under-five children, and e-MTCT of HIV, all by 2020, while combating HIV and AIDS, malaria and other preventable diseases.

67 http://www.unicef.org/zimbabwei/3182000.html
The HDF which will run between 2016 and 2020, will operate under seven thematic areas – maternal, newborn, child health and nutrition; sexual reproductive health rights; medical products, vaccines and technologies; human resources for health; health financing; health policy and planning; and technical support, operations, research and innovation.

Financing for HIV/AIDS

As shown in Figure IV.1, the resources available for AIDS in Zimbabwe have grown markedly since 2009, with around 85% of resources coming from external sources. However, domestic resources increased by 40% from 2011 to 2014. Domestic resources are principally sourced through the National AIDS Trust Fund, commonly known as the AIDS Levy.

The proportion of HIV expenditure on treatment and care rose from 44% in 2011 to 50% in 2015, and is anticipated to rise significantly over the coming decade as increasing numbers of people are put on lifelong ART.69

Figure IV.1: Public domestic and international resources available for AIDS in Zimbabwe, 2009–16 (US$m)70

![Graph showing public domestic and international resources available for AIDS in Zimbabwe, 2009–16 (US$m)](source: NAC & UNAIDS (2015): Information note: Funding AIDS in Zimbabwe.)

Domestic financing for HIV/AIDS

Despite the severe economic challenges that it faced in the period under review, the GoZ mobilised significant domestic resources through the AIDS Levy and maintained a budget line for the ART programme in the national budget. As noted above, the AIDS Levy was the main source of domestic funding to the national AIDS response. This is administered by the National AIDS Council of Zimbabwe (NAC), funded by a 3% taxation levy on personal and corporate income, and was boosted by economic growth between 2010 and 2012.71 The AIDS Levy is allocated and spent by NAC across programmes according to predetermined percentages set by the NAC Board.

The value of the AIDS Levy was severely eroded in 2008 due to the hyperinflationary environment, but significant improvement of inflows followed the introduction of the multi-currency system in 2009. About 50% of AIDS Levy funds were used over the review period for procuring ARVs, CD4 machines and test kits, while the rest went to other HIV programmes and coordination. The AIDS Levy’s budget and expenditure

70 Data was collected from the AIDSinfo Online Database, which presents country-reported Global AIDS Response Progress Reporting (GARPR) data. It should be noted that there are often substantial differences between GARPR country reported data and donor reported data through the OECD CRS database; and data reporting is likely to have improved over time, and as such, changes over time may not be fully representative.
71 The Government of Zimbabwe has also made indirect contributions to the HIV/AIDS programme, such as through its support for human resources for health, infrastructure and pre-service training. This is not quantified but has been a critical component of the programme’s decentralisation in recent years.
for the period 2008–14 is shown in Figure A4.2.\textsuperscript{72} In 2012 the AIDS Levy contribution in terms of numbers of persons on ART accounted for 27% of the total number on ART.\textsuperscript{73} All in all, domestic resources accounted for a minimum of 11% of all funding for the ART programme over the period of review (excluding indirect support for human resources for health, infrastructure and other essential programme components).

**Figure IV.2: AIDS Levy expenditure for OI/ART 2008–14**

![Figure IV.2: AIDS Levy expenditure for OI/ART 2008–14](source: Successive NAC Annual Reports)

**International financing for HIV/AIDS**

As shown in Figure IV.3, the largest providers of ODA for HIV/AIDS between 2005 and 2014 have been Global Fund (37%), the United States (33%), United Kingdom (11%), Germany (3%) and Sweden (3%). There have also been smaller bilateral contributions from Canada, Japan and Ireland.

**Figure IV.3: Gross ODA disbursements for HIV/AIDS in Zimbabwe by donor, 2005–14 (US$m)\textsuperscript{74}**

![Figure IV.3: Gross ODA disbursements for HIV/AIDS in Zimbabwe by donor, 2005–14 (US$m)](source: OECD CRS database)

\textsuperscript{72} NAC Annual Reports.

\textsuperscript{73} MoHCW. 2012. A Call to Action for Sustainable Solutions: Looking at funding options to achieve and sustain universal access to antiretroviral therapy.

\textsuperscript{74} Figures calculated using the OECD CRS sector codes 13040 (STD control, including HIV/AIDS) and 16064 (Social mitigation of HIV/AIDS).
The main drivers behind the increase in ODA for HIV/AIDS have been the doubling of United States Government/PEPFAR resources from 2012 to 2013, and the increase in the average annual size of Global Fund grants from US$67m under Round 8 grants (2010–13) to US$145m from 2014 onwards under the New Funding Model. Funding from Germany also increased, while funding from the United Kingdom and Sweden declined.

**Figure IV.4: Gross ODA disbursements for HIV/AIDS in Zimbabwe, 2005–14 (US$m)**

![Graph showing ODA disbursements](image)

Source: OECD CRS database.

**Funding for PMTCT and paediatric HIV**

As shown in Figure IV.5, the estimated annual costs of the e-MTCT Strategic Plan increase from US$52.7m in 2011–12 to US$60.1m in 2015–16. However, actual resources for PMTCT were only US$41.5m in 2012–13 (77% of target) and US$38.4m in 2013–14 (67% of target).

**Figure IV.5: Estimated costs of the e-MTCT strategic plan and resources for PMTCT, 2011–15 (US$ m)**

![Graph showing estimated costs and resources](image)


Figure IV.6 below sets out the resources for PMTCT by donor for 2013 and 2014. As shown, over 80% of funding came from three donors: the United States (33%), CIFF (27%) and DFID (20%). Funding from other sources included the Global Fund, CIDA, UNICEF and WHO, and others.

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75Ibid.

76Figures are presented by the government fiscal year. There are likely to be some differences between the cost categories used in the costing exercise and the reporting of resources available, although the respective methodologies are unclear.
In terms of funding for paediatric ARVs, we understand that domestic expenditure has accounted for around 30% of total expenditure, sourced through the AIDS Levy. The majority of expenditure has been financed by DFID in previous years, although the Global Fund will assume these costs from 2016.

Annex V: Timeline of key events during 2005–15

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>• Guidelines for antiretroviral therapy in Zimbabwe, 2005</td>
</tr>
</tbody>
</table>
| 2006 | • Zimbabwe National HIV and AIDS Strategic Plan 2006–10  
      • UNICEF PMTCT and Paediatric HIV Prevention, Treatment and Care National Plan 2006–10 |
      • Zimbabwe Maternal and Perinatal Mortality Study (ZMPMS 2007)  
      • Guidelines for Antiretroviral Therapy in Zimbabwe, 2007  
      • The Zimbabwe Maternal and Neonatal Health Road Map 2007 – 2015  
      • 2007 Zimbabwe Demographic and Health Survey 2005–06 |
| 2009 | • 2009 National HIV Estimates  
      • National HIV/AIDS and Tuberculosis Control Programme – National Guidelines for TB/HIV Co-Management  
      • NAC Interim Survey of the Impact of the Behaviour Change Strategy 2006–10  
      • The Zimbabwe Maternal and Neonatal Health Road Map (2009 – 2013): Equity and Quality in Health: A People’s Right |
      • MoHCW Advocacy and Communication Strategy to Support the Implementation of Revised ART, PMTCT and Infant Feeding Guidelines in Zimbabwe  
      • ZIMSTAT Zimbabwe Multiple Indicator Monitoring Survey (MIMS) 2009 Report  
      • Guidelines for Antiretroviral Therapy in Zimbabwe, 2010 |
| 2011 | • ZIMSTAT and MEASURE DHS, ICF Macro Zimbabwe Demographic and Health Survey 2010/11  
      • MoHCW Report of the Review of the National PMTCT and Paediatric HIV Programme 2006–10  
      • Zimbabwe National Plan for Eliminating new HIV infections in children and keeping mothers and families alive 2011–15  
      • MoHCW Zimbabwe Communication Strategy to support the elimination of new HIV infections in children and keeping their mothers alive: 2011–15  
      • Zimbabwe National HIV and AIDS Strategic Plan 2011–15  
      • The National Strategic Plan for Eliminating New HIV Infections in Children and Keeping Their Mothers and Families Alive 2011–15  
      • The Public Private Partnerships for TB/HIV – Strategic Plan Zimbabwe 2011 – 2016 |
| 2012 | • Bottleneck analysis introduced  
      • Cost Analysis of the Zimbabwe National Strategic Plan for Eliminating New HIV Infections in Children and Keeping Mothers and Families Alive 2011–15  
      • Zimbabwe National Census |
| 2013 | • MoHCW Infant and Young Child Feeding Policy  
      • National Stakeholder Consultation on Option B+ regimens  
      • Global Fund Concept Note development and approval  
      • Zimbabwe HIV Care and Treatment Strategic Plan 2013 – 2017 and Three Year Operational Plan: Towards Achievement of Universal Access to Quality HIV Care and Treatment Services  
      • MOHCC Report of Mid Term Review of the National e-MTCT Strategic Plan 2011–15  
      • The Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIM Asset) October 2013 – December 2018  
      • An Operational Plan for the Nationwide Transition to Option B+ in Zimbabwe  
      • Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe |
      • National Strategic Plan for Eliminating New HIV Infections in Children and Keeping Their Mothers and Families Alive 2014–18  
      • Zimbabwe’s participation in the Accelerating Children’s HIV/AIDS Treatment Initiative approved  
      • ZIMSTAT Zimbabwe Multiple Indicator Cluster Survey (MICS) 2014 |
| 2015 | • Paediatric Bottleneck Analysis Report for Twenty Selected Districts with Low Paediatric ART Coverage |
### Annex VI: Summary analysis against the components of the theory of change

<table>
<thead>
<tr>
<th>Component of theory of change</th>
<th>Evidence from Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>SD1: Coordinate programme design, planning and implementation among partners at all levels</td>
<td><strong>UNICEF has made critical contributions to the alignment of strategies, policies and implementation plans across partners and ensuring their coherence with national priorities.</strong> In particular, UNICEF has played a unique role in shaping and leading the HTF and the HDF and fulfilled a key procurement function in the earlier ESP, bolstering its coordination role and influence across a range of policy and programme areas of direct relevance to its work on children and AIDS.</td>
</tr>
<tr>
<td>SD2: Broker partnerships at all levels, including among private sector, civil society and multi-sector stakeholders, and encourage South–South as well as triangular cooperation among partners</td>
<td><strong>UNICEF is widely appreciated as a credible, trusted and reliable partner.</strong> While the GoZ has maintained its strong leadership of the HIV/AIDS response, UNICEF has served important roles as convener of, or participant in a number of relevant coordinating or working groups. UNICEF’s activities across many sectors, such as health, HIV/AIDS, nutrition, education and social protection, and its procurement functions, have increased its reach and leverage. There is however little evidence of work with the private sector, including private health institutions and practitioners. Furthermore, there is scope for UNICEF to promote greater engagement of civil society in the response, particularly for strengthening community responses and accountability mechanisms.</td>
</tr>
<tr>
<td>SD3: Ensure that HIV services for children receive adequate priority in global, regional and national decision-making</td>
<td><strong>UNICEF is recognised as a persuasive advocate for scaling up HIV services for children in Zimbabwe.</strong> Over the years, it has played an important role in various forums to build the commitment of national stakeholders to scaling up services for PMTCT and HIV care and treatment of young children. MoHCC and NAC respondents noted that the Global Plan served as a game changer in helping to set ambitious national e-MTCT goals and mobilise support for the national programme. <strong>UNICEF has also worked to strengthen the MNCH platform for the delivery of HIV services for women and children,</strong> by protecting access to MNCH services throughout the period, and by championing integrated approaches to service delivery. There is some evidence that UNICEF is now also promoting measures to build linkages between HIV and children programmes and other sectors and programmes, such as child protection, though more needs to be done.</td>
</tr>
<tr>
<td>SD4: Support key stakeholders at all levels to plan, resource and implement HIV services for children</td>
<td><strong>UNICEF has been actively engaged in a range of activities in support of scaling up HIV services for children.</strong> There is evidence of UNICEF’s contributions to a range of strategic and operational planning, policy development, and capacity development activities. Partners particularly value UNICEF’s flexibility, responsiveness and ‘hands-on’ approach to programming.</td>
</tr>
<tr>
<td>Assumptions related to thematic leadership, advocacy, coordination and partnership</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Strong global, regional, and national systems of coordination exist that can be leveraged to galvanise action on HIV and children</strong></td>
<td>A range of effective national coordination systems exists, under the stewardship of the GoZ and with the active participation of a wide range of partners. Coordination mechanisms set up under the Global Plan have also contributed to intensified support for e-MTCT and scale-up of HIV care and treatment among children.</td>
</tr>
<tr>
<td><strong>A wide range of partners at all levels exists that could be engaged on issues related to HIV and children</strong></td>
<td>A wide range of international and national stakeholders work on issues related to HIV and children in Zimbabwe.</td>
</tr>
<tr>
<td><strong>A minimum level of capacity among key stakeholders at country level exists that can be supported</strong></td>
<td>The technical and managerial capacity levels among stakeholders at country level are strong.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resource mobilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SDS: Initiate, support and coordinate movements, campaigns, and investment plans to mobilise financial resources</strong></td>
</tr>
</tbody>
</table>
helped to put in place a more coordinated and targeted approach to resource mobilisation. The sharing of simple concept notes with potential donors to gauge interest has also helped improve the efficiency of the fundraising process. However, UNICEF’s systems/processes are seen as slow – i.e. in the release of funds, and in reporting to donors. One development partner interviewee noted that their systems can be too burdensome and mean regular and timely reporting and delivery of outputs is not possible.

**SD6: Engage with donors, governments and country stakeholders to leverage additional global and domestic resources, and support countries to access external resources**

The national PMTCT and paediatric HIV care and treatment programme has been reasonably well resourced, although there have been some funding gaps. There was some difference of opinion between interviewees on this, but it was made clear by MoHCC in the debrief session that there had been funding gaps, which is supported by the available (but limited) data on costs and resources the e-MTCT Strategic Plan.

UNICEF has played a critical role in leveraging financial resources for the country PMTCT and paediatric HIV programme. This was widely recognised by stakeholders in a variety of ways, including supporting: the Global Plan development; bottleneck analysis; national review of PMTCT; identification of resource gaps; funding applications to donors (CIFF and Global Fund); and advocating for inclusion of paediatric ARVs in Global Fund and HDF budgets).

UNICEF has advocated for increased domestic spending, but this has not yet yielded significant results. Activities have included: co-hosting ‘Double Dividend’ meeting; and discussions with NAC to increase the provision of AIDS Levy funds for paediatric HIV. UNICEF’s role in supporting NAC in procuring commodities, during times of economic crisis was noted as critical.

There are encouraging signs for the programmatic sustainability of the PMTCT and paediatric HIV programme. The MoH is strong in the planning, budgeting and management of the programme, and while UNICEF and other donors contribute to this process, they are not seen as being central to it. UNICEF’s capacity-building activities are likely to have supported programmatic sustainability.

The strong dependency on donors to finance the programme raises critical concerns for longer-term financial sustainability. Domestic expenditure accounted for just over 1% of total resources for PMTCT between 2012 and 2014, and <30% of funding for paediatric HIV. This very strong dependency on donors to finance the programme means that the programme is a long way from reaching financial sustainability. While improved economic performance would boost domestic funding through the AIDS Levy, and UNICEF is exploring whether there is scope for the AIDS Levy to allocate more funding to paediatric HIV, there is a need to investigate other domestic financing options, particularly as additional resources will be required to ‘finish the job’ in years to come.

**Assumptions related to resource mobilisation**

| Flows of total ODA, and ODA for health and HIV/AIDS specifically, remain stable or grow over time | Total ODA for HIV/AIDS grew at a compound annual growth rate of 0.11 between 2005 and 2014, driven by large increases from the Global Fund and US. |
| Economic growth and growth in government expenditures takes place in countries where UNICEF | There has been severe economic instability from 2005 to 2009. The achievements in-country have astonishingly been made in spite of this instability, in no small part due to the role of donors ‘holding together’ the health system. Domestic public expenditure for HIV/AIDS did however grow in line with the recovering economy from 2009 onwards. |
A minimum level of capacity at country level exists to plan and budget for HIV in children

As noted above, there is strong capacity within the MoHCC to plan, budget and manage the HIV programme for children.

### Strategic information, knowledge generation and dissemination

**SD7: Generate, collate and disseminate high-quality global and national data for scaling up effective approaches to address HIV among children**

UNICEF has made substantial and appreciated investments in national processes to build critical knowledge on women and children, track progress in HIV programme scale-up and identify gaps in programme coverage. In particular, it has provided technical and financial support to the ZDHS and the MICS and to a range of focused reviews, evaluations and studies. It has also pioneered the application of innovative tools to identify problems and solutions e.g. bottleneck analysis. UNICEF has successfully pushed for finer age- and sex-disaggregation of national data.

**SD8: Provide support for governments and country partners to generate and collate SI and knowledge**

UNICEF has provided critical support over the evaluation period to strengthen the health information software in general and with respect to critical information on HIV service delivery and uptake. It has made important contributions to capacity-building and logistical support for building SI and knowledge at all levels of the health system.

**SD9: Support global- and country-level interpretation and translation of SI and evidence into sound policies, strategies and programmes**

Together with partners, UNICEF has made useful contributions at country level and through the global IATT in supporting the MoHCC to shift their strategies, policies and guidelines based on research finding and global guidelines. UNICEF’s role in its role in disseminating knowledge is much appreciated by partners, though perhaps it could do even more in this area.

### Assumptions related to strategic information, knowledge generation and dissemination

A minimum level of capacity at country level exists to generate and use SI and knowledge

Capacity at the country level to generate and use SI and knowledge has grown over time and is now very strong.

Support from technical partners is sustained for generating SI and knowledge

A number of partners contribute to this area and their support is well coordinated at the country level (through a range of effective coordinating mechanisms) as well as at the global level (through the IATT).

### Cross-cutting issues

**SD10: Work to ensure that effective interventions are adequately integrated within humanitarian responses**

There was little evidence on this from Zimbabwe. The country has experienced various chronic challenges (including a protracted economic crisis), as well as recent droughts and outbreaks of communicable diseases. However, there were mixed views on the extent to which these have constituted true humanitarian situations. UNICEF has not had a hugely visible role in relation to PMTCT and paediatric HIV specifically in emergencies – organisations such as World Food Programme were cited for their role in food security.
**SD11: Advocate for and support gender-equitable policies, budgeting and resource allocations, and gender-sensitive approaches to HIV programming and monitoring**

UNICEF takes a gender-specific approach to its programming, through its focus on women and children. This is well recognised, and UNICEF has also supported pilot projects on the involvement of men and boys. UNICEF has been instrumental in advocating for sex-disaggregated data to inform programming in Zimbabwe. However, while the policies are gender-specific, it is not clear that they are optimally gender-sensitive – there is scope for further work by UNICEF and partners to ensure that gender is fully mainstreamed into the response to HIV in children.

**SD12: Ensure that human rights and child rights are protected, promoted and fulfilled in HIV policies and programmes, and build related accountability mechanisms**

There is mixed evidence on the extent to which child rights are highlighted as a central part of the HIV response. While ‘rights’ are clearly articulated in UNICEF’s strategies (for example, in the CPDs), a rights-based approach was not visible to all stakeholders as a critical component of UNICEF’s response. There is some evidence that a lack of integration between sectors and programmes is a barrier to the implementation of approaches that consider the rights of the child holistically – for example, in relation to HIV testing in schools, or the interface between child protection programmes and HIV programmes. There was a perception that UNICEF could be doing more to promote a multisectoral and integrated approach at every level.

**SD13: Promote an equity focus in HIV services for children, and build related accountability mechanisms**

UNICEF has promoted a geographical equity focus through its emphasis on the most disadvantaged districts. UNICEF has been instrumental in ensuring that attention is paid to the most disadvantaged districts, and its work on bottleneck analyses is recognised as a critical contribution. The bottleneck analyses (undertaken at national level during the roll-out of MoRES in 2012, and then later in districts) have supported the creation of district implementation plans and the associated resourcing that is linked to need.

An emphasis on equity that goes beyond geography has been a less prominent feature of UNICEF’s work in Zimbabwe. While it has been a critical advocate for certain groups for whom progress is slower (i.e. through their advocacy around PMTCT, paediatric HIV, and adolescents), UNICEF’s equity focus in PMTCT and paediatric HIV is less visible to stakeholders in other ways. For example, in relation to the most disadvantaged at sub-district level, and in relation to key populations such as sex workers and the disabled.

**Assumptions related to cross-cutting issues**

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Evidence/Implications</th>
</tr>
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<tbody>
<tr>
<td>There is no convergence of unmanageable numbers of crises simultaneously</td>
<td>This assumption has held in Zimbabwe – there has been the protracted economic crisis, in addition to more acute events such as droughts and disease outbreaks; however, it was not emphasised as a severe challenge to the response in Zimbabwe.</td>
</tr>
</tbody>
</table>

| Functional coordination systems exist in emergencies | There is limited evidence of this from Zimbabwe – but it was not highlighted as a particular challenge to the response. |

| Political support for working towards gender equality in HIV/AIDS programming remains strong | This assumption has held in Zimbabwe – the evidence from interviews with government and partner suggests that there is a commitment to gender equality. The challenge comes from the operationalisation (see above and below). |
### Political support for rights-based approaches and funding remains strong

There is some evidence of this in Zimbabwe – there has been a commitment from the Government to scaling up these approaches, and PMTCT in particular has been highlighted as a human rights success story (although funding for the response is substantively provided through external sources, with the exception of the AIDS Levy).

### Political support for addressing inequity remains strong

There is some evidence of this in Zimbabwe – the Government has been open to the introduction of bottleneck analyses (as part of the introduction of MoRES in the ZCO) in order to inform the design of programmes and interventions that are specific to the needs of districts.

### UNICEF’s organisational structure

| SD14: UNICEF as an organisation responds to changes in the external environment and leverages its comparative advantage in PMTCT and paediatric HIV care and treatment | UNICEF has a strong CO in Zimbabwe with experienced, competent staff and a structure that has responded to changes over time. Staff are highly regarded by partners for their responsiveness and flexibility. ZCO has responded to the need for HIV to be integrated with MNCH and child health while maintaining influence and leverage. The HIV team has remained small, with vacant posts filled in 2012 in response to scale up.

**UNICEF has well-developed systems for translating strategy into objectives and work-plans.** These systems are less able to reflect team interdependencies for mainstreaming HIV. Roles and responsibilities between CO, RO and HQ are clear. The culture is hands-on and solution focused with strong connections to the field. |

### Intermediate outcomes

| Strategies, policies and implementation plans are aligned and coherent across partners at global, regional and country levels | There is good evidence that strategies, policies and implementation plans are aligned across partners and coherent with national and global priorities. |

| Levels of political commitment and capacity of governments and other global, regional and national stakeholders to plan for and support scale-up of HIV services for children are increased | The political commitment of Zimbabwe to plan for and support scale-up of HIV services for children is manifest over the last few years. |

<p>| Resource needs for PMTCT and paediatric HIV care and treatment are met in a predictable and sustainable manner | The national PMTCT and paediatric HIV care and treatment programme has been reasonably well resourced, although there have been some funding gaps – the available, but limited, data suggests that around 70% of resource need was met in 2013 and 2014. However, there is a strong dependency on donors to finance the programme, with domestic resources being closely tied to the country’s economic performance. This raises critical concerns for financial sustainability, particularly in Zimbabwe, which has witnessed a long period of economic instability. |</p>
<table>
<thead>
<tr>
<th>Mechanisms to ensure accountability for provision and scale-up of PMTCT and paediatric HIV care and treatment are strengthened at all levels</th>
<th>Accountability mechanisms for meeting targets at all levels of the health system are assured through formal channels in Zimbabwe, but the engagement of civil society in these accountability mechanisms is weak.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategies, policies and approaches to implementation are informed by evidence on what does and does not work and why in relation to PMTCT and paediatric HIV care and treatment</td>
<td>The MoHCC has been very attentive to evidence about what does and does not work and why in this area and very responsive to changes in international guidelines.</td>
</tr>
<tr>
<td>HIV policies and programmes are resourced and implemented in a gender-sensitive, equitable and human rights-based manner (including in humanitarian situations)</td>
<td>Gender, human rights and equity issues all feature as a part of the response to PMTCT and paediatric HIV in Zimbabwe; however, there is scope for their prominence to be increased. In relation to gender, the programmes (both within and outside of UNICEF) have a gender-specific approach in that they often focus on women for PMTCT and are effectively gender-blind for paediatrics. However, programmes around the involvement of men and boys are at a relatively nascent stage in terms of implementation – there have been pilots but more limited evidence of wider scale-up to date. At every level (within UNICEF, within the ZUNDAF and within the national programme as a whole), stakeholders recognise that there is scope for more systematic and comprehensive gender mainstreaming – moving beyond a gender-specific focus. Equity features as part of the programme through a focus on some of the most disadvantaged districts, and the creation of district specific implementation plans informed by bottleneck analyses. There has been an emphasis on scaling up coverage of services, including rural facilities, to work towards universal access to care. What is less prominent currently is an explicit focus on the most disadvantaged – for example, key populations that might be underserved, and communities who cannot, or do not, access health facilities. PMTCT has been highlighted as a human rights success story in Zimbabwe. But there is evidence that integrated responses that consider all of the rights of the child could be strengthened – this seems to be applicable within and outside of UNICEF, at least partly a function of the vertical nature of some programmes. There are interventions in places to tackle some of these issues though, and promote a more holistic approach (for example, integration of HIV-sensitive management into the National Case Management child protection programme).</td>
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</table>
Annex VII: Bibliography


MoHCW. 2012. A Call to Action for Sustainable Solutions: Looking at funding options to achieve and sustain universal access to antiretroviral therapy.


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