



Evaluation of the UNFPA support to the HIV response (2016-2019)



UNFPA Evaluation Office

2020



Foreword

A founding Cosponsor of UNAIDS, UNFPA is a key partner in the global HIV response. It is a co-convenor (together with other United Nations Funds and Programmes) on HIV prevention among adolescents, youth and key populations, as well as on decentralizing and integrating sexual and reproductive health and rights (SRHR) and HIV services. UNFPA also plays a technical role in prevention and condom programming within the Global Prevention Coalition and, as the current (2019) chair of the UNAIDS Committee of Cosponsoring Organizations, is at the centre of the mechanism for coordinating the global response to HIV and AIDS.

Compared with a decade ago, HIV infections have declined globally. AIDS-related deaths have seen a dramatic reduction and considerable progress has been made towards the 90-90-90 targets.¹ However, the global HIV care continuum is marred by considerable variations: several regions are experiencing sharp increases in new infections and across the world almost 10 million people await treatment. Further, 1.7 million people acquire HIV every year, half of whom are among key populations and their partners.

The evaluation of the UNFPA support to the HIV response covers the period from 2016 (when the current UNAIDS strategy was rolled out) to 2019. Its aim is to assess the contribution of UNFPA in the prevention of sexual transmission of HIV, the linking and integrating of HIV with other aspects of sexual and reproductive health and rights, sexual gender-based violence (SGBV), and the promotion of the rights of the most vulnerable, including those of adolescent girls and young women, other young people at risk and key populations.

The evaluation highlights how UNFPA has been able to leverage the UNAIDS Division of Labour to guide its support to the HIV response at global, regional and country levels and has made an important contribution to meeting the needs of the most vulnerable. However, it also indicates that the absence (at corporate level) of a clear strategy conveying a strong priority for realizing the rights of, in particular, key populations, has inhibited UNFPA from fully deploying its capacities to support the HIV response. UNFPA has demonstrated that linking and integrating SRHR, HIV and SGBV services is an effective approach to meeting the needs of the most vulnerable and key populations; in fact, it points to the need to develop and strengthen guidance to regional and country offices on piloting and scaling integration at national level.

The evaluation also recommends that UNFPA builds on the results it has achieved and develops a strategy for its support to the HIV response. This strategy should detail the role of UNFPA at global, regional and national levels and, aligning its responsibilities as a UNAIDS Cosponsor with UNFPA core mandate areas, should seek synergies between the HIV programming and other internal strategies and programmes in support of the transformative results.

I am confident that the lessons learned and the recommendations highlighted by this evaluation will help to enhance further the contribution of UNFPA to the HIV response. The evaluation results are also particularly relevant as UNFPA channels its efforts to align its programming to respond and recover from the COVID-19 pandemic.

Marco Segone
Director, Evaluation Office

¹ By 2020, 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and, 90% of all people receiving antiretroviral therapy will have viral suppression.

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Abbreviations and Acronyms

AfriYAN	African Youth and Adolescent Network	FHI	Family Health International
AGYW	Adolescent Girls and Young Women	FSW	Female Sex Worker
AIDS	Acquired Immunodeficiency Syndrome	FTE	Full Time Equivalent
ANC	Antenatal Care	GBV	Gender-Based Violence
ART	Anti-Retroviral Therapy	GPC	Global HIV Prevention Coalition
ARV	Anti-Retroviral Pharmaceuticals	HIV	Human Immunodeficiency Virus
BMGF	Bill and Melinda Gates Foundation	HRBA	Human Rights-Based Approach
CARG	Community ART Referral Group	HTC	HIV Testing and Counselling
CCM	Country Coordination Mechanism (Global Fund)	IAWG	Inter-Agency Working Group
CCO	Committee of Cosponsoring Organizations (UNAIDS)	IBBS	Integrated Biological and Behavioural Surveillance Study
CCP	Comprehensive Condom Programming	ICPD	International Conference on Population and Development
CDC	Centre for Disease Control, United States Government	ILO	International Labour Organization
CO	Country Office	INGO	International Non-Governmental Organization
CSE	Comprehensive Sexuality Education	IPPF	International Planned Parenthood Federation
CSO	Civil Society Organization	JUNTA	Joint United Nations Team on AIDS
DREAMS	Determined, Resilient, Empowered, Aids-free, Mentored and Safe (young women)	KP	Key Population
EAC	East African Community	LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
ECHO	Evidence for Contraceptive Options and HIV Outcomes	LNOB	Leave No One Behind
ECOM	Eurasian Coalition on Male Health	MDG	Millennium Development Goal
EECA	Eastern Europe and Central Asia	MDSR	Maternal Death Surveillance and Review
EECARO	Eastern Europe and Central Asia Regional Office of UNFPA	MEAC	Ministry of Education, Arts and Culture
EHG	Euro Health Group	MGECW	Ministry of Gender Equality and Child Welfare
EmONC	Emergency Obstetrics and New-born Care	MISP	Minimum Initial Service Package
ERG	Evaluation Reference Group	MOH	Ministry of Health
ESA	East and Southern Africa	MoHSS	Ministry of Health and Social Services
ESARO	East and Southern Africa Regional Office of UNFPA	MoHSW	Ministry of Health and Social Welfare
EWNA	Eurasian Network of Women with AIDS	MSM	Men Who Have Sex with Men
		MSMIT	Men Who Have Sex with Men Implementation Tool
		MSW	Male Sex Worker

MSYNS	Ministry of Sport, Youth and National Service	TRANSIT	Transgender People Implementation Tool
NAC	National AIDS Committee	TWG	Technical Working Group
NAEC	National AIDS Executive Committee	UBRAF	Unified Budget, Results and Accountability Framework (UNAIDS)
NCDC	National Centre for Disease Control	UHC	Universal Health Coverage
NIMART	Nurse-Initiated Management of ART	UMIC	Upper Middle-Income Country
NGO	Non-Governmental Organization	UN	United Nations
NSF	National Strategic Framework	UNAIDS	United Nations Joint Programme on HIV and AIDS
OECD	Organisation for Economic Cooperation and Development	UNCT	United Nations Country Team
OFL	Office of the First Lady (Namibia)	UNDP	United Nations Development Programme
OPSI	Organisasi Perubahan Sosial Indonesia	UNESCO	United Nations Education Social and Cultural Organization
ORN	Out-Right Namibia	UNFPA	United Nations Population Fund
PCB	Programme Coordinating Board	UNICEF	United Nations Children's Fund
PEPFAR	President's Emergency Fund for AIDS Relief (US)	UNPAF	United Nations Partnership Framework
PF	Parliamentary Forum	UNSDG	United Nations Sustainable Development Goals
PLHIV	People Living with HIV	USAID	United States Agency for International Development
PMTCT	Prevention of Mother-to-Child Transmission	USD	United States Dollar (\$)
PNC	Postnatal Care	VTC	Voluntary Testing and Counselling
PrEP	Pre-Exposure Prophylactic	WFP	World Food Programme
RACI	Responsible, Accountable, Consulted and Informed	WHO	World Health Organization
RAGSI	Regional Advisory Group on Strategic Information	YKP	Young Key Population
RATESA	Regional AIDS Team for ESA		
RHSC	Reproductive Health Supplies Coalition		
RIAP	Regional Intervention Action Plan		
RO	Regional Office		
SADC	Southern Africa Development Community		
SCM	Supply Chain Management		
SDG	Sustainable Development Goals		
SFH	Society for Family Health Namibia		
SGBV	Sexual Gender-Based Violence		
SRH	Sexual and Reproductive Health		
SRHR	Sexual and Reproductive Health and Rights		
STI	Sexually Transmitted Infection		
SWIT	Sex Worker Implementation Tool		
SYP	Safeguard Young People programme		
The Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria		
TMA	Total Market Approach		

Glossary of Terms

Term	Definition	Source
Combination HIV prevention	A combination HIV prevention approach provides defined packages of services, including behavioural, biomedical and structural components, tailored to high priority population groups within their specific local contexts. A focus on supporting prevention choices helps to overcome fragmentation of prevention programmes into distinct streams for each prevention tool or intervention, often championed by different agencies and implemented separately. This does imply, however, that local stakeholders – including local governments, local civil society organizations and local communities – are at the centre of their own responses.	UNAIDS (2018) <i>HIV Prevention 2020 Road Map</i>
Key populations	UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the main key population groups. These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere - they are key to the epidemic and key to the response. The term “key populations at higher risk” also may be used more broadly, referring to additional populations that are most at risk of acquiring or transmitting HIV, regardless of the legal and policy environment.	UNAIDS (2015) <i>Terminology Guidelines</i>
Risk	Risk is defined as the risk of exposure to HIV or the likelihood that a person may acquire HIV. Behaviours, not membership of a group, place individuals in situations in which they may be exposed to HIV and certain behaviours create, increase or perpetuate risk. Avoid using the expressions “groups at risk” or “risk groups” - people with behaviours that may place them at higher risk of HIV exposure do not necessarily identify with any particular group.	UNAIDS (2015) <i>Terminology Guidelines</i>
Sexual and reproductive health package	This term refers to programmes, supplies and multi-integrated services to ensure that people are able to have not only a responsible, satisfying and safer sex life, but also the capability to reproduce and the freedom to decide if, when and how often to do so. It is particularly important that this decision be free of any inequality based on socioeconomic status, education level, age, ethnicity, religion or resources available in their environment. A sexual and reproductive health package aims to guarantee that men and women are informed of, and have access to, the following resources: safe, effective, affordable and voluntary acceptable methods of birth control; appropriate health-care services for sexual and reproductive care, treatment and support; and comprehensive sexuality education.	UNAIDS (2015) <i>Terminology Guidelines</i>
Sexual gender-based violence	This is now the terminology that is increasingly being used in all contexts, as this is one of the most common forms of violence encountered, including in intimate partner relationships as well as against those who have different sexual orientations.	

Vulnerability	Vulnerability refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk, and they may be outside of their control. These factors may include: lack of the knowledge and skills required to protect oneself and others; limited accessibility, quality and coverage of services; and restrictive societal factors, such as human-rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatize and disempower certain populations). These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.	UNAIDS (2015) <i>Terminology Guidelines</i>
Vulnerable populations	Vulnerable populations are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers. These populations are not affected by HIV uniformly across all countries and epidemics. These guidelines do not specifically address vulnerable populations, but much of the guidance can apply to them.	WHO (2014) <i>HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines</i>
Young people, youth and adolescents	<p>Child: a person under 18 years of age, as defined by the United Nations.</p> <p>Adolescent: a person aged 10 to 19 years, as defined by the United Nations.</p> <p>Young person: a person between 10 and 24 years old, as defined by the United Nations.</p> <p>Youth: a person between 15 and 24 years old, as defined by the United Nations. The United Nations uses this age range for statistical purposes, but respects national and regional definitions of youth.</p> <p>Children: According to Article 1 of the Convention on the Rights of the Child, “a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier”.</p> <p>Adolescents: Individuals between the ages of 10 and 19 years old are generally considered adolescents. Adolescents are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age. Also, different social and cultural factors can affect their health, their ability to make important personal decisions and their ability to access services.</p> <p>Youth: This term refers to individuals between the ages of 15 and 24.</p> <p>Young people: This term refers to those between the ages of 10 and 24.</p>	<p>UNESCO (2018) <i>International technical guidance on sexuality education: An evidence-informed approach</i></p> <p>WHO (2014) <i>HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines</i></p>
Linkages and integration	<p>Linkages refer to bi-directional synergies in policy, systems and services between SRHR and HIV. It refers to a broader human rights-based approach, of which service integration is a subset.</p> <p>Integration refers to the service delivery level (whether at a facility or in the community) and can be understood as joining operational programmes to ensure effective outcomes through many modalities (multi-tasked providers, referral, one-stop shop services under one roof, etc.).</p>	Interagency Working Group on SRHR and HIV Linkages (2017) <i>SRHR and HIV Linkages: Navigating the work in progress 2017</i>

Executive summary

PURPOSE AND SCOPE OF THE EVALUATION

UNFPA is a key partner in the global response to the human immunodeficiency virus (HIV). It works at global, regional and national levels and advocates for sexual and reproductive health and rights (SRHR), scaling up integrated SRHR services, intensifying HIV prevention, supplying male and female condoms and lubricants, and tackling gender inequalities. UNFPA is a founding Cosponsor of UNAIDS and, in the UNAIDS Division of Labour, is a co-convenor (with UNDP) on HIV prevention among key populations (KPs). UNFPA is also a co-convenor on HIV prevention among adolescents and youth (with UNICEF and UNESCO), and the integration of SRHR and HIV services (with WHO).

The purpose of this evaluation is to assess the performance of UNFPA in integrating its support to the HIV response within the broader context of SRHR, population dynamics, gender equality and human rights. The evaluation covers the period 2016-2019 and all types of interventions and responses to HIV supported by UNFPA at global, regional and national levels.

METHODOLOGY

The evaluation aims to identify the contribution made by UNFPA and adopts a theory-based approach with analysis of the intended results of UNFPA support. It also analyses the contextual factors related to the nature of the HIV epidemic and the response. The evaluation team developed a theory of change for all aspects of UNFPA support and, ultimately, detailed evaluation questions, which set out the areas of research. Associated with each question, key causal assumptions were tested via indicators using primary and secondary data gathered, analysed and presented by the evaluation team.

Data collection was structured around two regional and five country case studies supported by a wide range of methods: key informant interviews, a review of all relevant documents and data sets at global, regional and country level, and an online survey of key informants in 59 countries.

MAIN FINDINGS

The UNAIDS Division of Labour has served as an organizing framework to guide UNFPA efforts to promote HIV prevention and to link and integrate sexual reproductive health and rights/HIV/sexual gender-based violence (SRHR/HIV/SGBV) programming and services. Some UNFPA regional offices and country offices studied have been able to match their respective capacities, comparative advantages and mandates to their assigned role in HIV support, often with minimal resources. Country offices in Eastern Europe and Central Asia (EECA) and East and Southern Africa (ESA) have benefited from technical assistance, coordinated advocacy and programmatic support from regional offices: a level of

support which may not be available in other UNFPA regions. For UNFPA overall, there is a tension between the role UNFPA has assumed under the UNAIDS Joint Programme, and the perceived diminished priority of HIV within the UNFPA strategic plan 2018-2021 (with reduced human and financial resources allocated to HIV dedicated programming). This has limited the ability of UNFPA to fulfil its expected leadership roles.

UNFPA has directed considerable effort towards promoting the rights of the most vulnerable, including adolescent girls and young women (AGYW), other young people at risk and KPs. This includes identifying crucial issues for policy and advocacy, and supporting efforts to improve the legal and policy environment for young people and key populations. However, these efforts are hindered by the fact that the transformative results in the UNFPA strategic plan 2018-2021 do not refer specifically to the rights of young people and key populations in relation to HIV prevention, testing and treatment (although the ESA Regional Office has adopted a fourth transformative result: The elimination of sexual transmission of HIV and sexually transmitted infections). Another constraint to effective rights promotion has been the limitations UNFPA has experienced in basing its groundwork for rights policy and advocacy on an understanding of the challenges faced by the most vulnerable at the point of service delivery.

UNFPA has demonstrated a commitment to promoting linkages and supporting the integration of SRHR/HIV/SGBV services to improve access for marginalized, at-risk persons and key populations. UNFPA has also contributed to achieving quality, client-centred services at country level, especially in ESA, with strong support from the regional office, effective regional partners, and access to multi-year/multi-country funding for support to linkages and integration. However, efforts to scale integration of SRHR/HIV/SGBV services to national level face significant institutional and operational challenges. UNFPA has gained important experience at the regional and national level in ESA, but this does not yet sufficiently inform advocacy at global level. There is also a gap in UNFPA support to supply chain management for condoms and, in general, support to comprehensive condom programming (CCP) in the countries studied.

UNFPA has been active in forging partnerships and working with networks on critical aspects of the HIV response. At regional and country level, UNFPA has demonstrated an ability to foster strong relationships with organizations and networks led by adolescents, youth and key populations to support their capacity to engage meaningfully in national dialogue and action. At global level, a lack of common understanding within the organization on the priority assigned to the HIV response impairs UNFPA capacity to execute its mandate for leadership on HIV prevention. For instance, UNFPA has not yet maximized its comparative advantage and taken a lead role in revitalizing condom

programming and SRHR/HIV/SGBV integration in response to the ECHO trial that highlighted the need to integrate HIV prevention, including condom programming, into family planning services.

UNFPA is an active and respected participant in mechanisms for coordinating support to the HIV response at global, regional and national levels. At global level, UNFPA staff participate actively in mechanisms and processes for budgeting and accountability of the UNAIDS Joint Programme and play a central role in the UNAIDS Committee of Cosponsoring Organizations (CCO) and the Global HIV Prevention Coalition. At both regional and country levels, UNFPA has supported efforts to improve sustainability and encourage national investment alongside its United Nations partners and other sources of financial support. However, many countries remain highly dependent on external sources of finance for HIV prevention.

CONCLUSIONS

1. UNFPA has been able to utilize the UNAIDS Division of Labour to guide its support to the HIV response in a manner consistent with its comparative advantages. However, UNFPA strategic plan 2018-2021 does not explicitly recognize the central role UNFPA should play in preventing sexual transmission of HIV and realizing the rights and meeting the needs of key populations. As a result, there is an imbalance between the outward-facing ambition of UNFPA to fill a leadership role in the global HIV response and the inward-facing attention and priority paid to this responsibility. This imbalance, combined with the lack of an agreed UNFPA HIV strategy supported by a theory of change, and the necessary financial and human resources, has limited the ability of UNFPA to use advocacy to shape the global agenda and ensure prioritization of comprehensive HIV prevention. In countries where external resources are limited and the allocation of UNFPA core resources is constrained by the UNFPA business plan, these factors have contributed to an insufficient level of attention to HIV prevention in family planning and a lack of prioritization for comprehensive condom programming.

2. UNFPA has made important contributions to realizing the rights and meeting the needs of the most vulnerable, including adolescent girls and young women and key populations. However, a number of factors inhibit the capacity of UNFPA to play its expected role in championing their rights and the ability of country offices to engage on sensitive issues in order to reform the broader legal and policy framework. The absence (at corporate level) of a transformative result conveying a strong priority for realizing the rights of, in particular, key populations, and the lack of an explicit strategy for UNFPA support to the HIV response, diminish the focus required for more effective action on rights. This is further limited by a UNFPA business model that does not foresee service delivery as a mode of engagement in many countries, hence constraining the capacity of country offices to address the ability of the most vulnerable and key populations to access quality services in HIV prevention, testing and treatment free from discrimination. These are

often countries (as in EECA) where the pace of HIV infection is rising and is concentrated among key populations. Yet, support to rights promotion and meeting the needs of the most vulnerable is of limited effectiveness when not rooted in efforts to improve access to rights-based services.

3. UNFPA support has demonstrated that linking and integrating SRHR/HIV/SGBV programmes and services is an effective approach to meeting the needs of adolescent girls and young women, other vulnerable groups and key populations. UNFPA has also responded effectively to the proven link between sexual and gender-based violence and HIV infections among adolescent girls and young women by extending the integration agenda to include SGBV. UNFPA has made an important contribution to achieving quality, integrated services in SRHR/HIV/SGBV, especially in countries taking part in the *2gether 4 SRHR* programme in ESA. This can be attributed to access to consistent financial support for this large multi-country project focused on linkages and integration, combined with a strong regional partnership with the Southern Africa Development Community (SADC), and sustained advocacy and technical support by UNFPA staff. However, the understanding, level and nature of support to integration varies widely across UNFPA regions and countries. Furthermore, the relative absence of UNFPA support to comprehensive condom programming in many countries can undermine some of the results obtained through linkages and integration of SRHR/HIV/SGBV.

4. UNFPA has effectively forged partnerships and worked with networks at regional and country level to promote meaningful participation of adolescent girls and young women, key populations and other vulnerable groups in the policy process. UNFPA has also contributed to the effectiveness of networks and civil society organizations (CSOs) led by adolescents, youth and key populations. However, empowering these partners requires adequate and sustained investment over time in order to build their capacity to engage in advocacy and policy-making to improve the HIV response, broader SRHR policies and the overall legal framework. Yet, UNFPA support to networks is currently constrained by a lack of guidance on how to extend participation beyond the stages of programme design and implementation into accountability by partner governments for effectively realizing the rights of young people, key populations and other vulnerable groups.

5. UNFPA participates actively in platforms and mechanisms for coordinating actions in support of the HIV response at global, regional and national levels. These platforms have successfully avoided duplication of efforts and conflicting messages from the United Nations country teams in host countries. UNFPA participation in coordinating mechanisms does, however, require a significant investment of time and resources. In addition, coordination among partners with a view to increasing and sustaining investments in HIV prevention, testing and treatment has been limited. This is despite the fact that the need is particularly acute in countries transitioning to upper-middle income country (UMIC) status, where resource-allocation models for

large-scale programmes can result in abrupt reductions in multilateral support. Reliance on external funding for key aspects of the HIV response by many countries presents a continuing risk to the sustainability of progress made.

RECOMMENDATIONS

1. Clarifying the role and strategic orientations of UNFPA on HIV

While the UNAIDS 2018 Division of Labour helps to guide UNFPA interventions, it cannot replace a clear statement from UNFPA senior management regarding the roles and responsibilities of the organization in the HIV response. UNFPA, as a matter of organizational priority, should develop and adopt a strategy for its support to the HIV response. This strategy should include the appropriate level of human and financial resources, setting priorities, and accommodating the flexible application of the business model. It should be supported by a theory of change detailing the role of UNFPA at global, regional and national levels, aligning UNFPA responsibilities as a UNAIDS cosponsor with UNFPA core mandate areas, and seeking synergies between UNFPA HIV programming and other internal strategies and programmes, in support of the transformative results of the UNFPA strategic plan 2018-2021.

2. Meeting the needs of those left behind and promoting their rights

UNFPA needs to take steps to close the gap between rhetoric and action regarding human rights-based approaches in SRHR. To this end, it should develop tools for operationalizing the UNFPA commitment to rights in different technical areas, including in contributing to the HIV response. This should include explicit programming tools placing the promotion of rights - including the rights of adolescent girls and young women, key populations and other vulnerable groups - as a core strategic pillar of UNFPA work in support of the HIV response. It should also include efforts to promote rights literacy among UNFPA staff, service providers and communities. Finally, it should encompass the strengthening of accountability mechanisms or other components related to the identification (and follow-up) of potential violations of rights, especially in relation to access to quality SRHR services.

3. Linking and integrating SRHR/HIV/SGBV

Linking and integrating SRHR/HIV/SGBV services is key to an effective and sustainable national response to HIV. There is a need for UNFPA to build on lessons learned from the ECHO trial results, as well as from the experiences in EECA, ESA and other regions, to develop and strengthen guidance to regional and country offices on piloting and scaling linkages and integration at national level. This guidance should take stock of the diversity of contexts in which UNFPA operates, and should be communicated across all regional and country offices. The intent is to ensure that UNFPA maintains strong leadership on linkages and integration, and that country offices can be effective in supporting related programmatic action at country level, with regional offices providing the advocacy and technical support as needed.

4. Asserting leadership in comprehensive condom programming

UNFPA should continue to assert the critical importance of comprehensive condom programming and promoting its role in championing triple protection (prevention of HIV, other sexually transmitted infections (STIs) and unintended pregnancies). This should include providing support to condom programming (male and female condoms and lubricants) that is comprehensive and covers both supply and demand. Important elements of a comprehensive approach should include, in particular, further integration of condom programming into UNFPA support to family planning programmes. It should extend to strengthening supply chains (including in countries that do not currently benefit from the UNFPA Supplies Programme) and bolstering demand creation, especially among young people. A comprehensive approach to condom programming should also foresee the reinforcement of public-private-people partnerships for increasing access to, and uptake of, condoms and lubricants.

5. Forging partnerships and supporting networks

UNFPA should increase support to the development of the community of regional and national networks by leveraging and allocating resources to strengthen the capacity of CSOs (particularly those catering for or led by KPs, adolescent girls and young people) to engage effectively in policy dialogue, and to access funding from national and international sources. UNFPA should also promote linkages between global, regional and national networks for advocacy and engagement of KPs, AGYW and other young people. Finally, UNFPA should explore collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria to support grant applications and the implementation of HIV prevention programmes, especially for programmes focused on AGYW and KPs.

6. Coordination and sustainability

UNFPA should take action to address risks to the sustainability of the HIV response as part of its role as a UNAIDS Cosponsor participating in the Joint Programme at global, regional and country levels. UNFPA should also advocate and collaborate with other development partners to promote sustainable HIV programming, including transition from external funding and integration of HIV into national and sector development programmes. It should advocate for increased emphasis on prevention within HIV responses under national stewardship and support national strategies and plans for incorporation of the essential package of SRHR interventions, including on HIV/STIs, into universal health coverage mechanisms. UNFPA should also consider technical assistance to national authorities developing proposals for external funding for the HIV response and ensure that the support to capacity development of health-care providers for family planning and other SRHR services does incorporate rights-based HIV prevention, testing and links to treatment.



© UNFPA Namibia/Emma Mbekele. UNFPA supported comprehensive sexuality education programme for adolescents and youth in Namibia



INTRODUCTION

1.1 PURPOSE AND OBJECTIVES

The purpose of the evaluation is to assess the performance of United Nations Population Fund (UNFPA) in integrating its approach to supporting the response to the human immunodeficiency virus (HIV) within the broader context of sexual and reproductive health and rights (SRHR), population dynamics, gender equality and human rights. As part of this assessment, the evaluation will pay particular attention to the contribution of UNFPA to:

- The prevention of the sexual transmission of HIV
- The linking of HIV with other aspects of SRHR and sexual and gender-based violence (SGBV)²
- The promotion of gender equality and human rights in the context of HIV.

The objective of the evaluation is two-fold:

1. To assess how the UNFPA framework has guided the programming and implementation of UNFPA interventions in relation to HIV. This framework has been determined by UNFPA strategic plans 2014-2017 and 2018-2021 and by the United Nations Joint Programme

on HIV and AIDS (UNAIDS) Unified Budget, Results and Accountability Framework (UBRAF) 2016-2021, and is further determined by thematic strategies and programmes.³

2. To facilitate learning and to derive good practices from UNFPA experience in supporting efforts to address HIV across a range of key programmatic interventions in the three above-mentioned overlapping and mutually reinforcing thematic areas and in differing regions and contexts.

1.2 SCOPE OF THE EVALUATION

The evaluation covers the period from 2016 (under the current UNAIDS Strategy 2016 to 2021) through to 2019 and it encompasses all types of interventions supported by UNFPA and relevant at the global, regional and/or national level in its response to HIV. The thematic scope (or areas of investigation) of the evaluation was established in the terms of reference⁴ and was subsequently refined and specified at inception phase through a set of detailed evaluation questions, as indicated in Table 1.

2 During the evaluation period, documents describing programmes and UNFPA support to the HIV response have evolved in their use of terminology. By 2018, most documents refer not just to SRH but to SRHR. There was a similar shift from references to GBV to the use of SGBV. The shift from GBV to SGBV stems, in part, from the increasing work of UNFPA in humanitarian settings and on the women, peace and security agenda (which was a priority in previous strategic periods/under previous UNFPA strategic plans). SGBV is now the terminology that is increasingly used in all contexts as this is one of the most common forms of violence encountered, including in intimate partner relationships. For consistency, the present report uses SRHR and SGBV throughout, unless quoting from a document, which uses the earlier terminology.

3 E.g. UNFPA strategies for adolescents and youth and for family planning as well as for the UNFPA Supplies Programme.

4 Evaluation Office, UNFPA. Terms of Reference: Evaluation of UNFPA Support to the HIV and AIDS Response (2016-2019), New York: September 2018. p. 13-15. See Annex 6.

TABLE 1: Evaluation criteria, areas of investigation and evaluation questions

Evaluation criteria, areas of investigation and evaluation questions
<p>Area of Investigation 1: UNFPA support to linking SRHR, HIV and SGBV, including integrated SRHR, HIV and SGBV service delivery</p>
<p>Evaluation Question: To what extent has UNFPA contributed to establishing and strengthening bi-directional linkages (policies, systems, communities and services) between SRHR, HIV and SGBV and to integrating SRHR, HIV and SGBV service delivery? (Relevance, Effectiveness, Sustainability)</p>
<p>Area of Investigation 2: UNFPA support to the HIV response corresponds to the needs of the at-risk and the most vulnerable, the marginalized and key populations (KPs)</p>
<p>Evaluation Question: To what extent has UNFPA support to HIV strategies and programmes contributed to meeting the needs of the at-risk, most vulnerable and marginalized people, especially (but not exclusively) adolescents and youth, key populations, women and persons with disabilities? (Relevance, Effectiveness, Gender Equality)</p>
<p>Area of Investigation 3: UNFPA support to the promotion of human rights and gender equality in the context of HIV</p>
<p>Evaluation Question: To what extent has UNFPA support contributed to engage and empower communities (including, but not only, adolescents and youth, key populations and women) to understand and claim their rights while also effectively advocating for policies and laws affecting human rights, gender equality and access to SRHR, HIV and SGBV services? (Relevance, Effectiveness, Gender Equality)</p>
<p>Area of Investigation 4: UNFPA efforts to act as a broker to forge partnerships and facilitate meaningful participation of a broad spectrum of partners in the HIV response</p>
<p>Evaluation Question: To what extent has UNFPA been effective at global, regional and country levels in forging and/or supporting networks, coalitions and partnerships to ensure meaningful participation of governments, civil society (especially adolescents and youth and key populations) and the private sector in dialogue and action on HIV prevention – including programme design, planning and implementation? (Effectiveness, Gender Equality, Sustainability)</p>
<p>Area of Investigation 5: UNFPA efforts to optimize its comparative advantage within UNAIDS Division of Labour</p>
<p>Evaluation Question: To what extent has UNFPA been able to ensure its comparative advantages at global, regional and national levels are recognized within its roles and responsibilities under the UNAIDS Division of Labour? (Effectiveness, Coordination, Efficiency, Sustainability)</p>
<p>Area of investigation 6: UNFPA efforts to support coordination of actions and resources to strengthen national leadership</p>
<p>Evaluation Question: To what extent has UNFPA effectively supported and participated in platforms for coordinating and sustaining resources and programmes aimed at preventing HIV, especially at national level? (Efficiency, Coordination, Sustainability)</p>

The geographic scope of the evaluation is global with a focus on those countries where the HIV epidemic is greatest and where the incidence is rising. At inception phase, a set of countries and regions was selected for case study in order to provide a robust, illustrative sample of UNFPA support to the HIV response in very different contexts.



2

UNFPA SUPPORT TO THE HIV RESPONSE – AN OVERVIEW

2.1 THE GLOBAL CONTEXT FOR UNFPA SUPPORT TO THE HIV RESPONSE

2.1.1 Miles to go

Major success has been recorded in the global response to HIV in the past two decades.⁵ The number of new HIV infections per year peaked in the mid-1990s. The number of AIDS-related deaths per year reached its highest level in 2004, an estimated 1.7 million persons. By 2018, AIDS-related deaths had declined to an estimated 770,000.⁶ Since the turn of the millennium, access to life-saving anti-retroviral therapy (ART) has grown exponentially, from less than one million people covered to 23.3 million people covered by 2018. Similarly, by 2017, 80 per cent of pregnant women living with HIV were able to access the necessary services and drugs to avoid mother-to-child transmission.⁷

Despite these achievements, complex challenges persist and the UNAIDS Global AIDS Update 2018, summarizing the epidemiological evidence and trends, was appropriately entitled *Miles to Go*. The HIV epidemic continues to evolve, as does the social, political, scientific and financial context of the response.

2.1.2 The current situation for HIV

In 2018, an estimated 37.9 million people were living with HIV (including 1.7 million children), with a global HIV prevalence of 0.8 per cent among adults. Globally, in 2018, an estimated 79 per cent of people living with HIV (PLHIV) knew their status, 62 per cent of PLHIV were on treatment and 53 per cent of PLHIV were virally suppressed.⁸ Unfortunately, while the number of new infections continues

to decline it does not do so at a rate commensurate with achieving the global target of fewer than 500,000 new infections in 2020 and fewer than 200,000 by 2030. Among children and adults of all ages, annual HIV infections have declined from an estimated 2.1 million in 2010 to 1.7 million in 2018, a 16 per cent reduction, which will fall far short of achieving the 2020 goal.⁹

There are also important regional differences in the progress made in responding to HIV and AIDS. East and Southern Africa (ESA) is home to 54 per cent of the world's PLHIV. Between 2010 and 2018, AIDS-related mortality in ESA declined by 44 per cent and annual new HIV infections dropped by 28 per cent. In contrast, in the same period, the annual number of new infections increased in three regions: Eastern Europe and Central Asia (EECA) (29 per cent), Middle East and Northern Africa (10 per cent) and Latin America (7 per cent).

2.1.3 Key populations and vulnerable groups

Globally, over half (54 per cent) of new HIV infections (15-49 years) were among key populations in 2018: transgender women (1 per cent), sex workers (6 per cent), people who inject drugs (12 per cent), gay men and other men having sex with men (MSM) (18 per cent), clients of sex workers and other partners of people from KPs (18 per cent).¹⁰ Globally, KPs are estimated to have a much higher risk of HIV infection than the general adult population: 22 times higher among gay men and other MSM, 22 times higher for people who inject drugs, 21 times higher for sex workers and 12 times higher for transgender people.¹¹

Adolescents and youth are also particularly vulnerable to HIV infection, especially adolescent girls and young women

5 For a more complete overview of the global and regional context for HIV and AIDS see: UNFPA, Evaluation of UNFPA Support to the HIV Response (2016-2019) Inception Report: New York City April 2019.

6 UNAIDS, Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with Services. Global AIDS Update 2019. Geneva, July 2019, p.6.

7 UNAIDS, 2018, Miles to Go: Closing Gaps, Breaking Barriers, Righting Injustices. Global AIDS Update 2018. AVERT website: <https://www.avert.org/global-hiv-and-aids-statistics>. WHO, 2015, Global Health Sector Response to HIV, 2000–2015.

8 UNAIDS, 2019, p.6.

9 UNAIDS, 2019, p.7.

10 UNAIDS 2019, Communities at the Centre, p. 28.

11 UNAIDS 2019, Communities at the Centre, p.27.

(AGYW). In sub-Saharan Africa in 2017, for instance, females aged 15-24 represented 10 per cent of the population but accounted for a quarter of new HIV infections.¹²

Although access to testing and treatment has increased dramatically in recent years, KPs, adolescents, and youth are often left behind.¹³ As noted by UNAIDS, “as the world continues on the path towards ending the AIDS epidemic, national epidemics will be increasingly concentrated among populations at higher risk of HIV infection”.¹⁴ Thus, KPs, AGYW, and adolescents and youth more generally (including young key populations (YKPs)) are increasingly the focus of the evolving HIV response around the world.

2.2. GLOBAL INITIATIVES AND TARGETS

Over time, the HIV response has been shaped by agreed development targets and funding commitments made by governments around the world and at the United Nations.

Between 2000 and 2015, the United Nations Millennium Development Goals (MDGs) highlighted and assigned specific targets to HIV, specifically, MDG 6: Combat HIV and AIDS, malaria and other diseases.¹⁵ By mid-2015, UNAIDS reported that MDG 6 relating to HIV had been achieved ahead of schedule.¹⁶

Informed by a qualitatively different strategy, the Sustainable Development Goals (SDGs) of 2016 integrate the HIV response across ten diverse areas of action.¹⁷ The targets most specific to HIV are SDG Target 3.8, on achieving universal health coverage (UHC), access to quality health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all, as well as SDG Target 3.3, which commits to ending AIDS as a public health threat by 2030. In addition, SDG Target 3.7 calls for “universal access to sexual and reproductive health-care services, including for family planning, information and education,¹⁸ and the integration of reproductive health into national strategies and programmes”.

The 2030 target for ending the global AIDS epidemic aligns the SDGs with the UNAIDS Fast Track strategy launched in

2014.¹⁹ The set of ambitious targets under the Fast Track strategy include 95 per cent of PLHIV knowing their status, 95 per cent of people who know their status being on ART, and 95 per cent of people knowing their status and on ART being virally suppressed (i.e. 95:95:95). The Fast Track strategy also sets interim targets for the achievement of ‘90:90:90’ by 2020.²⁰ The overall rationale for the strategy was that “without scale-up, the AIDS epidemic will continue to outrun the response, increasing the long-term need for HIV treatment and increasing future costs”.²¹ It is clear that, by 2018, significant progress had been made towards the Fast Track targets, yet significant additional efforts are still required if the targets are to be reached by 2020. Not least, a scale-up of HIV prevention efforts is necessary, as well as increases in resources committed to the response.

In 2017, the Global HIV Prevention Coalition (GPC) was formed by the United Nations, civil society, and private and national government stakeholders. The aim was to place renewed emphasis on primary HIV prevention and on the importance of creating differentiated HIV prevention packages for different groups and in different settings. It also promoted a ten-point action plan for accelerating combination prevention at the country level.²² Within its first year, significant results were claimed by UNAIDS: “HIV prevention is back on national agendas”.²³

Another key development is the increasing commitment to UHC. By definition, the UHC agenda seeks to secure health coverage for all. But it is increasingly accepted that “to truly deserve the description of “universal”, it (UHC) must be anchored in the right to health and serve marginalized and key populations”.²⁴ Thus, in 2018, the World Health Organization (WHO) and UNFPA issued a broad-ranging call to action to attain UHC through linked SRHR, HIV and SGBV interventions.²⁵ This was further emphasized in 2019 when UNFPA presented a document to the International Conference on Population and Development (ICPD)²⁵ meeting in Nairobi emphasizing the essential role of SRHR

12 UNAIDS, 2018, Miles to Go.

13 However, in Eastern Europe and Central Asia, only 38 per cent of PLHIV were receiving ART in 2018. UNAIDS, *Communities at the Centre: Global AIDS Update 2019*, p. 275.

14 UNAIDS, 2018, Miles To Go.

15 Also a major emphasis within MDG 4 to reduce child mortality and MDG 5 to improve maternal health.

16 <https://www.avert.org/professionals/history-hiv-aids/overview>.

17 Areas of action: end poverty; end hunger; ensure healthy lives; ensure quality education; achieve gender equality; promote economic growth; reduce inequality; make cities safe and resilient; promote peaceful and inclusive societies; strengthen means of implementation. See https://www.unaids.org/en/AIDS_SDGs.

18 International Planned Parenthood Federation, *Sustainable Development Goals: A SRHR CSO guide for national implementation*, 2015, p.3.

19 UNAIDS 2014 Fast Track: ending the AIDS epidemic by 2030. https://www.unaids.org/en/resources/documents/2014/fast_track.

20 UNAIDS 90-90-90 testing and treatment targets: by 2020, 90 per cent of all people living with HIV will know their HIV status; by 2020, 90 per cent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; by 2020, 90 per cent of all people receiving antiretroviral therapy will have durable viral suppression. UNAIDS (2014) ‘Ambitious Treatment Targets: Writing the final chapter of the AIDS epidemic’.

21 UNAIDS 2014 Fast Track: ending the AIDS epidemic by 2030. https://www.unaids.org/en/resources/documents/2014/fast_track.

22 HIV Prevention Coalition (undated) *HIV Prevention 2020 Road Map accelerating HIV prevention to reduce new infections by 75 per cent*.

23 UNAIDS, *Implementation of the HIV Prevention 2020 Road Map: First Progress Report*, 2018, p.22.

24 Quoted from Frontline AIDS Internet Blog 1085 “Universal Health coverage a Game-Changer for HIV, Spring 2019”.

25 UNFPA and WHO, *Call to Action to attain universal health coverage through linked sexual and reproductive health and rights and HIV interventions*, July, 2018, p.1.

in UHC with specific reference to prevention and treatment of HIV and other sexually transmitted infections (STIs).²⁶

Linking closely to the UHC agenda, SDGs, the thrust of the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health, and the evolving HIV response, FP2020 is a multi-sectoral initiative established in 2012 working in 69 countries to ensure women are informed, empowered and free to decide when or whether to have children or access contraceptives. Partly based on the financial strength of the UNFPA Supplies Programme, UNFPA is a central partner to FP2020.

2.3 FINANCING THE RESPONSE

The Fast Track strategy argued that if the response was to "outpace" the HIV epidemic, more resources, rapid scale-up, and targeted programmes were required. UNAIDS estimated that to be on course for achieving the interim targets for treatment (as well as no more than 500,000 new infections and zero discrimination), the global total spent on HIV needed to increase by USD 1.5 billion each year in 2016-2020, and by 2020 an annual global total of USD 26.2 billion would be required. In simple terms, global HIV resources need to grow significantly.²⁷ Securing this growth in funding has proved difficult. Seismic shifts in the financial landscape of the HIV response have created a more complex situation. Globally, the majority of funding for HIV now comes from domestic sources (i.e. governments funding their own national HIV responses), not from international donors.

Historically, the largest sources of funds for HIV programming have been the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the United States President's Emergency Plan for AIDS Relief (PEPFAR). From inception to date, the Global Fund has achieved increased disbursements year-on-year, up to USD 17 billion in 2016, USD 18.5 billion in 2017 and USD 19.6 billion in 2018. Since its founding, the Global Fund reports investments of USD 41.6 billion as of June 2019, of which approximately half (USD 20.8 billion) were investments in response to HIV.²⁸

Since it started in 2003, PEPFAR has provided over USD 80 billion to HIV programmes, UNAIDS and the Global Fund. The PEPFAR budget allocation is divided between bilateral funding for the HIV response and funding channelled through the Global Fund. From 2016 to 2019 both components have been quite steady, with bilateral funding varying from USD 5.2 billion in 2016 to USD 5.4 billion in 2019. In the same period funding from PEPFAR to the Global Fund remained steady

at USD 1.35 billion.²⁹ Budget requests for 2020 foresaw a reduction to a total of USD 4.9 billion but the United States Congress has thus far refused to accept the proposed reduction.³⁰

Overall, global funding for the HIV response did not grow between 2012 and 2016. In 2017, there was a slight increase, yet it seemed unlikely at the time that this increased level would sustain itself beyond 2018 and there was a danger that overall funding would even drop again.³¹

Within the United Nations system, there has been an attempt to coordinate financing and agree on a business plan and monitoring arrangements for the HIV response through UBRAF.³² The current UBRAF, which covers the period 2016-2021, has a budget of over USD 3.5 billion. Although Cosponsors are expected to fund activities through their existing funding mechanisms, nearly one-third of core UBRAF funds (USD 44 million annually) were allocated to the 11 Cosponsors (based on the 2016-2017 budget). This funding is meant to enable and catalyse ongoing HIV programmes with Cosponsors and to support internal coordination and the multisectoral response to HIV.

2.4 THE EVOLVING ROLE OF UNFPA IN THE HIV RESPONSE

UNFPA has been a key partner in the global HIV response, working at global and regional levels, and on the ground in over 140 countries advocating for SRHR and for a scale-up in SRHR services, intensifying HIV prevention, supplying male and female condoms, and tackling gender inequalities.

UNFPA is a founding Cosponsor of UNAIDS. In the current UNAIDS Division of Labour, UNFPA is co-convenor (with UNDP) on HIV prevention among KPs, on HIV prevention among adolescents and youth (with UNICEF and UNESCO), and on decentralization and integration³³ of SRHR and HIV services (with WHO).

29 <https://www.kff.org/global-health-policy/fact-sheet>. The fact sheet notes that the US administration has requested a significant reduction in PEPFAR funding for 2020 but this has been rejected by the US Congress.

30 <https://www.kff.org/global-health-policy/fact-sheet/the-u-s-presidents-emergency-plan-for/>.

31 UNAIDS, 2018. Miles to Go: Closing Gaps, Breaking Barriers, Righting Injustices. Global AIDS Update 2018.

32 UNAIDS, 2016. UNAIDS 2016-2021 Unified Budget, Results and Accountability Framework (UBRAF).

33 The terms 'Integration' and 'linkages' are used quite specifically by UNFPA. 'Linkages' refer to bi-directional synergies in policy, systems and services between SRHR, HIV and, more recently, SGBV. It refers to a broader human rights-based approach, of which service integration is a subset. 'Integration' refers to the service-delivery level and can be understood as joining operational programmes to ensure effective outcomes through many modalities (multi-tasked providers, referral, one-stop shop services under one roof, etc.). WHO, UNAIDS, UNFPA, IPPF (2008). Gateways to integration: a case study series. <http://srhlinkages.org/>.

26 UNFPA, Sexual and Reproductive Health and Rights: An essential element of Universal Health Coverage, 2019, p.9.

27 <https://www.avert.org/professionals/hiv-around-world/global-response/funding>.

28 The Global Fund, accessible at: <https://data.theglobalfund.org/investments/home/-/HIV>.

Within the coalition of countries and development partners engaged in the GPC, UNFPA has been assigned technical support responsibilities for:

- HIV prevention among young women in high-incidence settings
- HIV prevention among KPs
- Condom programming.³⁴

In 2019, UNFPA assumed the role of chair of the UNAIDS Committee of Cosponsoring Organizations (CCO), placing it at the centre of the mechanism for coordinating actions of the Cosponsors.

Since 2011, the strategic direction of UNFPA has been focused on SRHR, as captured in the so-called “bull’s eye”.³⁵ However, the interrelationship between HIV and SRHR and related strategies and services, UNFPA personnel and resources devoted to HIV and the overall priority given to HIV by UNFPA has varied considerably over time.

2.4.1 UNFPA strategies and the HIV response

The goal of UNFPA Family Planning Strategy 2012-2020 is to “accelerate delivery of universal access to rights-based family planning as part of efforts to achieve universal access to sexual and reproductive health and reproductive rights”. The strategy notes:

“A number of groups such as adolescents, unmarried people, the urban poor, rural communities, sex workers and people living with HIV often face a combination of access barriers and rights violations, leading to high rates of unintended pregnancy, increased risk of HIV and STIs, coerced sterilization, limited choice of contraceptive methods and higher levels of unmet need for family planning. These groups require particular attention to promote their reproductive rights and ensure their access to rights-based family planning and other services for their sexual and reproductive health (SRH).”³⁶

Published in 2013, the UNFPA Strategy on Adolescents and Youth promised “bold initiatives to reach marginalized and disadvantaged adolescents and youth, especially girls” and argued that “for effective HIV prevention amongst adolescents and youth, focus and priority should be placed on ‘young populations at higher risk of exposure’”, i.e. KPs.³⁷ This theme was further developed in August 2019 with the

publication of a new UNFPA strategy for youth: *My Body, My World, My Life*, which emphasizes the importance of a “rights imperative”, including access to quality integrated and innovative adolescent and youth friendly SRHR services and action to prevent, inter alia, “new HIV and sexually transmitted infections”.³⁸

In the UNFPA strategic plan 2014-2017, all four strategic outcomes were directly related to contributions to the HIV response and two outcomes specifically mentioned HIV.³⁹ Strategic plan 2018-2021 took a different structure, focusing on three “transformative and people-centred” results to secure “universal access to sexual and reproductive health and reproductive rights”. In this strategy, HIV receives less explicit prominence and KPs are only mentioned when citing one of the SDG monitoring indicators. However, the intention is that HIV and the needs of KPs are addressed through full integration of HIV within and across UNFPA work on SRHR, SRH services and gender equality, and a stated intention to “focus first on ... those who are furthest behind”.⁴⁰ UNFPA HIV priorities help to emphasise this:

- **Programmes:** Human rights, SRHR linkages and combination prevention
- **People:** Adolescents and youth, sex workers, MSM, transgender people, women, indigenous people, migrants and refugees
- **Place:** Fast Track countries, humanitarian settings, emerging epidemics and high burden cities
- **Partners:** Governments, civil society and communities, United Nations system, the Global Fund, PEPFAR and private sector.

This emphasis on integration and on the most disadvantaged is also reflected in the activities planned for implementing the strategy:

- **Promoting human rights, reducing inequalities:** Engaging and empowering communities including the most vulnerable; addressing gender-based violence (GBV) and other harmful practices; addressing punitive law and improving policies

38 UNFPA, *My Body, My World, My Life: Rights and choices for all adolescents and youth: a UNFPA global strategy*, 2019, p.15.

39 UNFPA strategic plan 2014-2017. Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access. Outcome 4: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

40 UNFPA strategic plan 2018-2021. Transformative results: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage.

34 UNAIDS, 2018. HIV Prevention 2020 Road Map, p.28.

35 See UNFPA strategic plan, 2018-2020, Figure 1, p.3.

36 UNFPA, 2013. Choices not Chance: UNFPA Family Planning Strategy 2012-2020.

37 UNFPA, 2013. UNFPA Strategy on Adolescents and Youth: Towards realizing the full potential of adolescents and youth.

- **Linking HIV and SRHR (and since 2017, SGBV):** Providing integrated SRHR, HIV and SGBV services and commodities; addressing the unmet need for family planning for women living with HIV
- **Preventing sexual transmission of HIV and other STIs:** Promoting comprehensive condom programming (CCP); promoting comprehensive sexuality education (CSE); co-convening the global prevention coalition; and lubricant programming.

2.4.2 UNFPA financial resources related to addressing HIV

The evaluation covers two biennial budgeting periods for UNAIDS UBRAF: 2016-2017 and 2018-2019. UBRAF includes three different types of financial resources: (i) core funds that provide funding to the Secretariat (including for the implementation of its functions) and catalytic funding for the HIV-related work of Cosponsors; (ii) supplemental core funds that are raised through joint resource mobilization for strategic country, regional and global needs; and (iii) non-core funds, which represent the regular and extra-budgetary (HIV-related) resources of the Cosponsors that contribute to the achievement of UBRAF outputs.⁴¹

In June 2017, the UNAIDS Programme Coordinating Board (PCB) approved a revised resource mobilization and allocation model that dramatically altered the disposition of UBRAF core funds between the Cosponsors and the Secretariat. Under the new model, allocations to country level (which would previously have been programmed through the headquarters of Cosponsors) now flow directly to country level for programming.⁴² In total, the new system allocated USD 44 million to all 11 Cosponsors annually over the 2018-2019 biennium, while the UNAIDS Secretariat received an allocation of USD 140 million annually. Each Cosponsor (including UNFPA) was allocated just USD 2 million for 'flexible use' in each year of the new biennium, with the balance (USD 22 million) of funds for Cosponsors allocated through the country envelop system.

Compared with the 2016-2017 biennium, when UNFPA was allocated USD 21 million of UBRAF core funds, UNFPA allocation for 2018-2019 dropped by nearly half to just USD 11.14 million, of which USD 4 million was allocated to "flexible use" and USD 7.14 million to operations at country level,⁴³ in accordance with the new allocation model.

Overall, both the core and non-core HIV-related expenditures from UBRAF reported by UNFPA for the 2016-2017 biennium were USD 96.97 million. The total estimated available funds reported by UNFPA for the 2018-2019 biennium (from both UBRAF and other sources) are USD 104.97 million.⁴⁴ This figure represents a relatively constant level of expenditure. While the UBRAF core funds component was cut by 47 per cent, the slight increase (USD 8 million) is due to the fact that the overall figure captures both the UNFPA HIV-dedicated and UNFPA HIV-related expenditures. The latter are calculated using a formula that computes HIV expenditures across relevant strategic plan outputs where the implementation of activities is contingent upon programmes focused on "other objectives" (for example,, SRHR, SGBV) of the organization.⁴⁵ It is not clear whether the resources estimated with the formula represent expenditures catalysed by the UBRAF funds.

The critical point is the very significant reduction in flexible UBRAF funds available to UNFPA for HIV-dedicated activities in the transition between the two biennia. The net result was that UBRAF funding for flexible use, in particular, dropped by almost half. This, in turn, had a direct impact on the human resources dedicated to HIV support by UNFPA at all levels of the organization (see Section 2.4.3).

Figure 1 illustrates the breakdown of the 2016-2017 expenditures in each UNFPA region and at headquarters.

41 UNAIDS, 2020–2021 Work Plan and Budget, August, 2019, p.13.

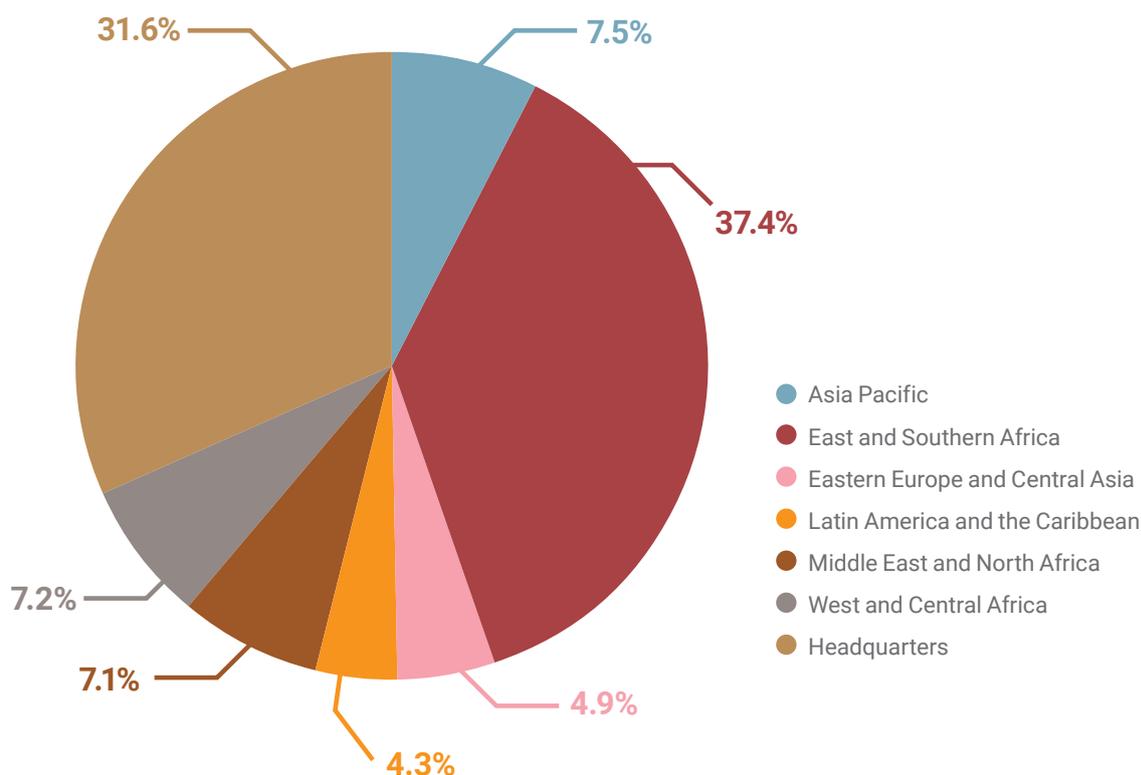
42 UNAIDS, 2018, Programme Coordinating Board. Progress on the Implementation of the UNAIDS Joint Programme Action Plan. P.5.

43 Unified Budget, Results and Accountability Framework (UBRAF) performance reporting. UNAIDS Programme Coordinating Board, 22 June 2018.

44 UNAIDS, Programme Coordinating Board (2017), UNAIDS 2018-2019 Budget. P.36. This represents 10.9 per cent of all planned expenditures in the biennium by the 11 Cosponsors and the UNAIDS Secretariat (a total of USD 961.3 million).

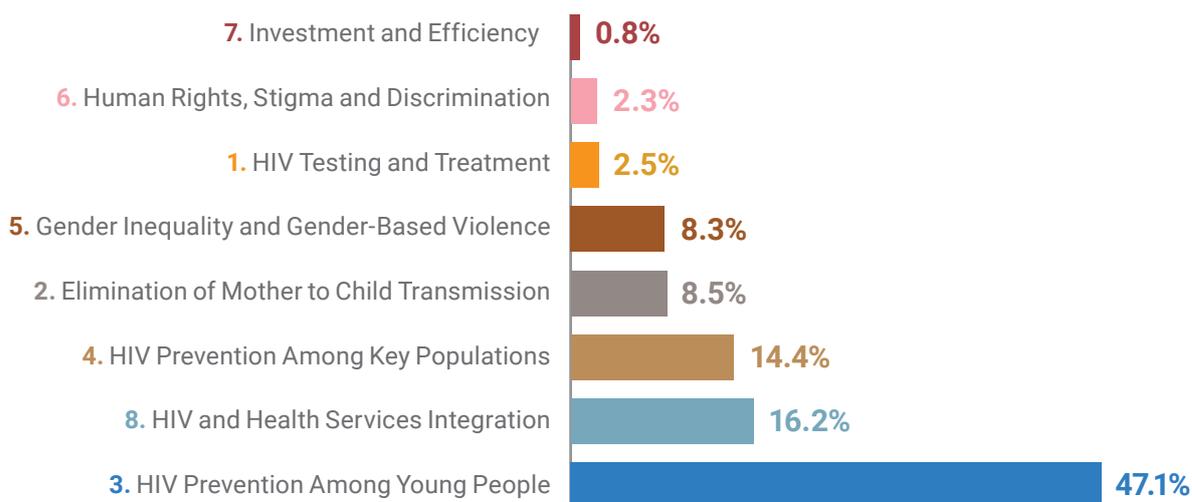
45 Examples: a percentage of the procurement of MISP is typically calculated as an HIV-related expenditure given the inclusion of condoms in MISP; a portion of family planning activities that reach women living with HIV is also calculated as an HIV-related expenditure since these contribute to the elimination of mother-to-child transmission. The formula is adjusted based on the HIV prevalence in a given country.

FIGURE 1: Distribution of UNFPA HIV expenditures and encumbrances by region (2016-2017)



It is also worth examining the distribution of UNFPA HIV-related reported expenditures by strategic results areas used in budgeting and accounting for expenditures under UBRAF.

FIGURE 2: UNFPA expenditures and encumbrances by UBRAF strategic results area (2016-2017)



Not surprisingly, the single largest area of expenditure by UNFPA in 2016-2017 was focused on UBRAF Strategic Result Area 3: prevention of HIV infection among adolescents and youth.

2.4.3 Human resources

The change in financial resources available to UNFPA over the four years 2016 to 2019 was also reflected in decreases in the overall number of “full time equivalent” (FTE) positions assigned to working on HIV at UNFPA headquarters and in regional offices and country offices. The total number of FTEs declined significantly after 2017.⁴⁶

TABLE 2: UNFPA full time equivalent positions allocated to HIV at all levels

	2016	2017	2018	2019	% in 2019
Headquarters	7	4	3	3	5.2
Regional offices	7.5	7.5	6	6	10.4
Country offices	68.86	70.9	49.1	48.85	84.4
Total FTE	83.36	82.4	58.1	57.85	100

In total, in 2019, UNFPA has allocated 57.85 FTE positions across headquarters, 6 regional offices (ROs) and 66 country offices (COs), with 84 per cent of FTE positions allocated to country offices.

TABLE 3: Full time equivalent positions by region (regional and country offices combined)

	2016	2017	2018	2019	% in 2019
Asia Pacific	7	7.7	7.1	7.1	13.0
Eastern Europe and Central Asia	5.7	4.1	4.7	4.7	8.6
East and Southern Africa	22.5	36.5	20.5	20.5	37.6
Latin America and the Caribbean	8.81	3.4	2	2	3.7
Middle East and North Africa	13.3	7.3	6.05	5.8	10.6
Western and Central Africa	19.05	18.4	14.45	14.45	26.5
Total	76.36	77.4	54.8	54.55	100.0

In 2019, the ESA region accounted for 20.5 FTE positions (working at the regional office and in 17 country offices) or 37.6 per cent of all UNFPA FTE positions at regional and country level. Western and Central Africa accounts for 14.45 FTE positions or 26.5 per cent of the total, with staff spread across 18 countries. The smallest allocation is to Latin America and the Caribbean.

46 UNFPA, UNFPA Staff Resources FTE, UBRAF and Non-UBRAF Funds 2016-2019. Excel file provided by UNFPA Non-Core Resources Branch, January 2019.



3

EVALUATION APPROACH AND METHODOLOGY

3.1 EVALUATION APPROACH

3.1.1 Contribution analysis

The evaluation applied contribution analysis as its central, theory-based analytical approach to exploring causes and effects in order to assess how UNFPA contributed to the HIV response. To this effect, the evaluation team:

- Set out the attribution problem to be addressed by building on the evaluation terms of reference and identifying the key evaluation questions during the inception phase
- Developed a reconstructed theory of change for UNFPA support to the HIV response, including key causal assumptions, which link UNFPA activities to results at higher levels
- Gathered evidence on the results identified in the theory of change, which both validate the evaluation assumptions and provide detailed information on the evaluation questions
- Refined and updated the theory of change based on the evidence gathered and further identified the contribution by UNFPA to the HIV response, while directly addressing the evaluation questions and thereby examining each area of investigation identified in the evaluation terms of reference.

As a design tool for the evaluation, the theory of change made it possible to visualize how UNFPA support to the HIV response operates at country, regional and global levels. In particular it was instrumental to:

- Identify causal linkages from UNFPA activities and investments through different results levels to the outcomes of UNFPA strategic plan 2018-2021 – without losing sight of UNFPA strategic plan 2014-2017
- Link UNFPA activities and investments to the strategic result areas of UNAIDS UBRF 2016-2021
- Make explicit the causal assumptions that must be realized if UNFPA support is to contribute to identifiable results at the output, outcome and goal levels

- Formulate the evaluation questions to be investigated, thereby setting the structure for reporting evaluation findings and formulating conclusions
- Develop the detailed evaluation design, as depicted in the draft evaluation matrix, including sources of information and data-collection tools.

UNFPA efforts in support of the HIV response were not organized into an explicit theory of change before the evaluation took place. Because of this, the evaluation team, in close consultation with the HIV team and the Evaluation Reference Group (ERG) developed a draft theory of change that was further refined during the evaluation. It is presented in Section 3.2.⁴⁷ The theory of change developed during the inception phase of the evaluation was used to develop the draft evaluation matrix, which, in turn, served as the primary tool for collecting and compiling evaluation evidence for each case study and for the overall draft report. The completed evaluation matrix is provided in Annex 1.

3.2.1 Evaluation criteria

The criteria used for this evaluation encompass, yet are not limited to, the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD-DAC) evaluation criteria. In addition, the evaluation examines how UNFPA interventions have targeted those most at risk, including adolescents, youth and KPs. It also investigates the extent to which UNFPA has been supporting gender equality in the context of the HIV response, not least in its efforts to combat SGBV in the context of HIV.

⁴⁷ For a complete description of the resources consulted and the process followed to reconstruct the theory of change see UNFPA, Evaluation of UNFPA Support to the HIV Response (2016-2019): Inception Report, 2019, p. 15-16.

TABLE 4: *Evaluation criteria*

Evaluation question/Area of investigation	Evaluation criteria
1. UNFPA support to linking and integrating SRHR/HIV/SGBV	Relevance, Effectiveness, Sustainability
2. UNFPA support corresponds to needs of the most vulnerable, marginalized and KPs	Relevance, Effectiveness
3. UNFPA support to human rights and gender equality in HIV	Relevance, Effectiveness, Gender Equality
4. UNFPA efforts to forge partnerships and facilitate meaningful participation	Effectiveness, Gender Equality, Sustainability
5. UNFPA optimizes comparative advantage within UNAIDS	Effectiveness, Coordination, Efficiency, Sustainability
6. UNFPA support to coordination and sustainable resources	Efficiency, Coordination, Sustainability

3.2 THEORY OF CHANGE

This section presents the overall theory of change for UNFPA support to the HIV response as developed during the inception phase, updated during data collection, and refined during the analysis and reporting stages of the evaluation. The theory of change presented here attempts to capture all of the different ways in which UNFPA currently supports the response to HIV, in vastly differing contexts and at different levels (global, regional and national). In this

sense, nowhere has the evaluation team seen this theory of change implemented in its entirety.

In fact, the theory of change encompasses a wide range of activities and a multilayered chain of results, which are difficult to effectively implement and sustain given the current staffing and financial resources available to UNFPA for the HIV response.

3.3 DATA COLLECTION AND ANALYSIS METHODS

3.3.1 A case study focus

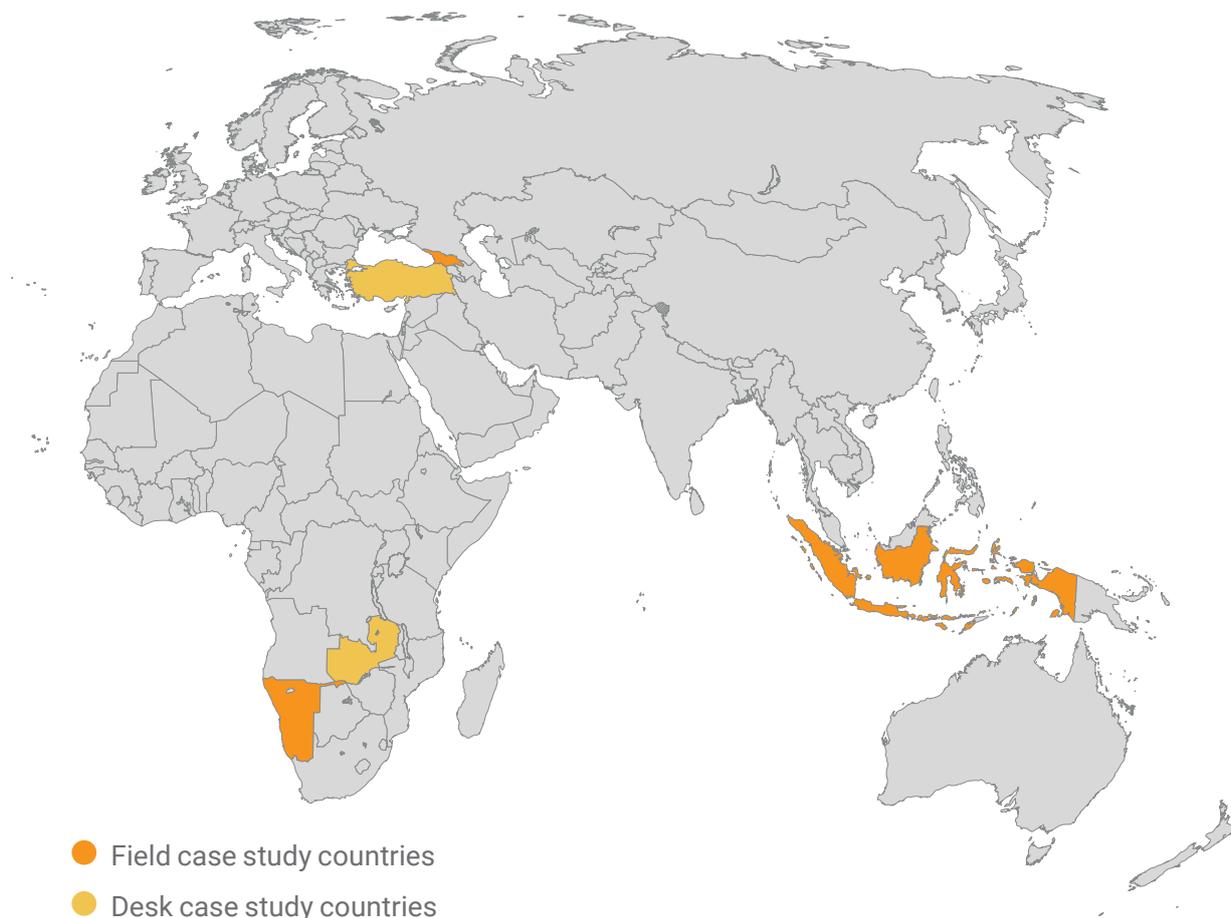
The evaluation data collection was structured around a series of regional and country case studies supplemented by key informant interviews and a comprehensive review of relevant documents and data sets at global, regional and country levels. In total there were two regional and five country case studies undertaken during the evaluation.

TABLE 5: Geographic coverage of regional and country case studies

Desk regional case studies	Field country case studies	Desk country case studies
Eastern and Southern Africa (ESA)	Namibia	Zambia
Eastern Europe and Central Asia (EECA)	Georgia	Turkey
	Indonesia	

The regions and countries for case studies were selected during the inception phase in order to provide an illustrative example of UNFPA work to support the HIV response in very diverse contexts.

FIGURE 4: Map of field and desk country case studies



The designations employed and the presentation of material on the map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

Table 6 presents an overview of the rationale for selecting each of the case study countries and regions.

TABLE 6: Rationale for case study selection

Selected country or region	Rationale
Turkey	<ul style="list-style-type: none"> • Located in a region where HIV infections are rising • Engagement by UNFPA with non-governmental organizations (NGOs) active in services to refugees • Focus on human rights for KPs, including among refugees
Zambia	<ul style="list-style-type: none"> • Established member of HIV Prevention Coalition • UNAIDS Fast Track country • Participates in UNFPA regional HIV and SRHR Linkage Project
Georgia	<ul style="list-style-type: none"> • Located in a region where HIV infections are rising • Shifting epidemic now mainly the result of sexual transmission including among KPs (MSM and sex workers) • Focus on prevention policy and upstream engagement
Namibia	<ul style="list-style-type: none"> • UNAIDS Fast Track country • Participates in UNFPA regional HIV and SRHR Linkage Project • Examples of innovative approaches to integration
Indonesia	<ul style="list-style-type: none"> • Fast Track and HIV Prevention Coalition country • Increasingly difficult context for KPs, especially MSM • UNFPA focus on services to female sex workers (FSWs)
East and Southern Africa (ESA)	<ul style="list-style-type: none"> • East and Southern Africa Regional Office (ESARO) linkages to regional partners including the Southern Africa Development Community (SADC) and the East African Community (EAC) • Location of linkages and integration programmes (<i>2gether 4 SRHR</i>)
Eastern Europe and Central Asia (EECA)	<ul style="list-style-type: none"> • Concentrated epidemic and critical need for services for KPs • Rising rates of HIV infection and increasing rate of STIs

The results of the three field-based country case studies have been summarized in separate country case study notes published by the Evaluation Office of UNFPA (www.unfpa.org/evaluation).

3.3.2 Data-collection methods: supporting and supplementing the case studies

In order to compile the evidence collected for each of the case studies and to frame the analysis in a regional and global context, the evaluation team relied on a series of data-collection methods:

- A comprehensive review of documents on the HIV response and the role played by UNFPA at global, regional and country levels (Annex 2)
- Interviews with key stakeholders at global and regional levels (Annex 3)
- Interviews and group discussions with key informants during the field-based country case studies, including:
 - UNFPA representative and key county office staff working on diverse aspects of the HIV response
 - Ministry of Health (MoH) officials, especially those responsible for HIV policies and national strategies and programmes for HIV prevention
 - Staff of the UNAIDS Secretariat and other participants in the Joint United Nations Team on AIDS (JUNTA)⁴⁸
 - Staff of ministries for women and adolescents and youth and sport
 - Staff of the education ministries responsible for in- and out-of-school learning – especially comprehensive sexuality education and HIV prevention awareness for adolescents and youth
 - Service providers in HIV prevention and treatment and family planning who have benefited from UNFPA-supported capacity-development activities support

⁴⁸ At country level, the United Nations agencies cooperating in support to the HIV response almost always work through a joint team. In some countries, it is called the Joint UN Team on AIDS (JUNTA) and in others the UN Joint Team on AIDS (UNJTA) for consistency, this report uses JUNTA as the applicable acronym.

- Bilateral and multilateral development partners supporting the national HIV response
 - National affiliates of international non-governmental organizations (INGO) active in supporting the HIV response and/or providing integrated HIV and SRHR services
 - National civil society organizations (CSOs) and community-based organizations active in HIV and SRHR, especially implementing partners of UNFPA
 - Clients and end-users of SRHR service points who may have integrated HIV prevention services into their work
 - Representatives of networks and organizations representing adolescents and youth, women and KPs and, in particular, those advocating for access to HIV and SRHR services freed from stigma, discrimination, coercion and violence
 - Community leaders, advocates and other key informants.
- Visits to selected sites where UNFPA is supporting delivery of services in HIV prevention and treatment and, in some cases, the integration of SRHR, HIV and SGBV services
 - An online survey of a selected set of key stakeholders.

Interviews at regional and national levels were carried out using a common, semi-structured interview protocol (Annex 4).

3.3.3 Online survey of key informants

To supplement information gathered during the case studies, the evaluation conducted an online survey (based on closed and open-ended questions - Annex 5) of key informants in the 59 countries. UNFPA HIV focal points helped identify potential respondents among the UNFPA country offices, national government ministries and agencies, CSOs and other development partners engaged in support of the HIV response.

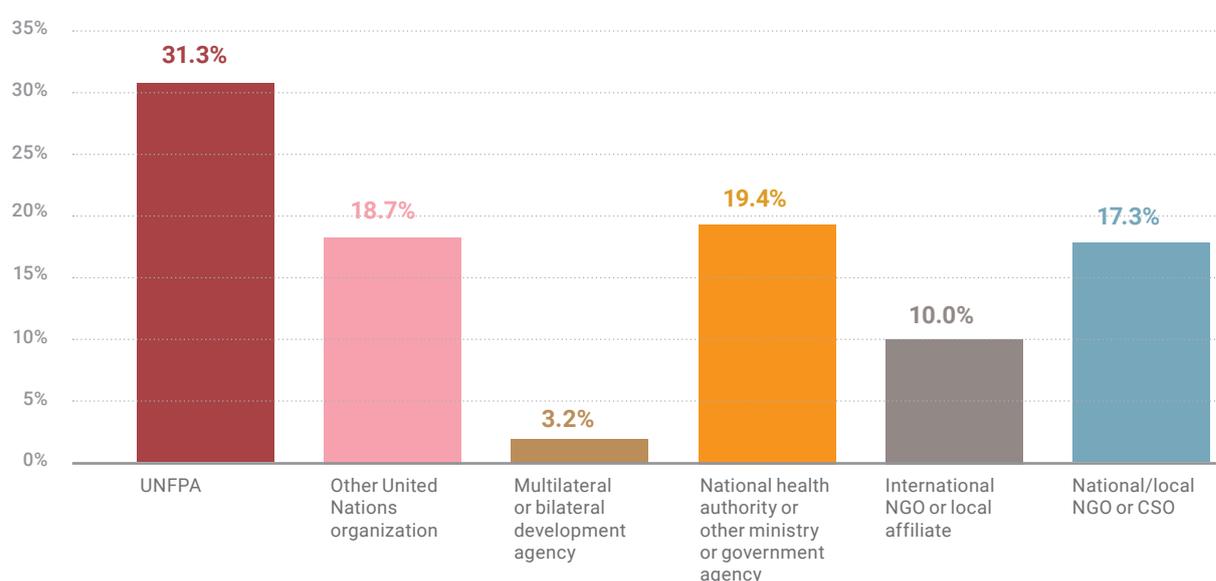
3.3.4 Data-collection results

The evaluators were able to access all the sources of information identified in the draft evaluation matrix. Relevant documentation and quantitative information were provided to the evaluation by UNFPA staff at headquarters and in regional and country offices. During the field-based country case studies in Georgia, Indonesia and Namibia, the evaluation team identified and collected supplementary documents and data sets.

With the aid of UNFPA staff, the evaluation team was able to identify and interview key informants (in one-on-one interviews, group discussions and during site visits) at global, regional and national levels. The desk-based regional and country case studies relied on documentation compiled by the concerned UNFPA country offices, supplemented by telephone interviews with a small sample of key informants (Annex 3).

The response to the online survey was quite strong. Of the original 557 potential respondents in the sample frame, 278 completed the survey for an overall response rate of 50 per cent. Of equal importance, the group of respondents included significant numbers from each of the different categories of key informants as illustrated in Figure 5.

FIGURE 5: Online survey respondents by organization type



While the largest group of respondents are employed by UNFPA (31.3 per cent), almost one fifth are with national health authorities (19.4 per cent) and over a quarter of the respondents work with an NGO or CSO (27.4 per cent).

3.3.5 Data analysis and triangulation

The evaluation followed a structured plan for analysis and triangulation of the data gathered using all methods described above. In the first step of the analysis process, the team responsible for each region and country case study compiled the relevant data for each case study and completed an evaluation matrix, which presents all relevant data from multiple sources and which was necessary to formulate evidence-based findings corresponding to each evaluation assumption under the six evaluation questions. For the field-based country case studies, preliminary evaluation findings were also presented to local stakeholders for discussion, comment and validation at the end of the field mission in each country. The evidence gathered was analysed and compiled into a formal country case study note, which was then submitted to the relevant country and regional offices for comments prior to finalization.

At the end of the data-collection phase, the evaluation team met for a three-day data consolidation workshop in Copenhagen to present, discuss, critique and summarize all the evaluation information into a set of preliminary evaluation findings and tentative conclusions. This was followed by the development of the draft evaluation report for submission to the Evaluation Office of UNFPA.

At each step of the analysis process, the evaluation team has applied triangulation as the key method for validating findings. Triangulation involves bringing diverse sets of evaluation evidence to bear on the same evaluation assumptions and questions, including:

- Quantitative data drawn from different global, regional and national sources
- Opinions and experiences gathered from stakeholders representing a diverse set of organizations and operating in different contexts on different aspects of UNFPA support, including the utility and accessibility of services in HIV prevention and treatment
- Observations made at sites in the field catering for a diversity of clients under significant differences in the nature of the HIV epidemic and the operational and organizational context
- Documentary evidence representing a wide range of experience and views (of authors and organizations) on the most effective ways to support the HIV response
- Case study results from regions and countries, which are extremely varied in context and experience.

The evaluation team applied the principle of triangulation, both internally (within a given data set of information such as the results of interviews) and externally (across different data sets, as when comparing the results of the online survey with those of the country case studies). In the findings section of the report, whenever triangulation reveals evidence that runs counter to an expressed evaluation finding, the contradiction is identified.

3.4 LIMITATIONS

The evaluation team encountered some challenges, which present some limitations to the generalization of findings and conclusions. Most importantly:

1. The support to the HIV response at UNFPA takes place through a diverse set of activities and investments at global, regional and national levels in the absence of the guiding structure of a formal programme and an explicit theory of change. This makes it difficult to delineate the boundaries of UNFPA support.
2. The HIV epidemic takes very different forms in different regions and countries (see Section 2.1) which, in turn, shapes the structure and level of the UNFPA response. As a result, it is difficult to generalize across the organization evaluation findings that are applicable to one region or to countries that have a specific profile.
3. At every level, the response to HIV is a collective enterprise, starting most obviously with the Joint United Nations Programme on HIV and AIDS (UNAIDS) and extending to the joint work of United Nations entities, INGOs, bilateral development partners, national governments and CSOs at country level. This presents a real challenge to the problem of attribution. How can any one result be attributed to the work of UNFPA when there are so many actors involved?

Table 7 identifies how the evaluation responded to each of these challenges.

TABLE 7: Evaluation response to major challenges and limitations

Challenge/limitation	Evaluation response
1. There is an absence of an agreed formal theory of change or a defined programme of UNFPA support to the HIV response	The evaluation conducted extensive document searches and interviews and reviewed budget and expenditure information at global, regional and national levels to draw clearer boundaries around UNFPA support. Most importantly, the reconstruction of the theory of change allowed the evaluation to identify all credible areas of UNFPA action in support of the response to HIV
2. Extremely diverse regional and national contexts for the HIV epidemic and the UNFPA response limits the extent results can be generalized	The primary method for addressing this challenge was the careful selection of countries and regions for the case studies, which illustrated many of the most important contexts in which UNFPA supports the HIV response (Table 12).
3. The joint nature of UNAIDS programme and UBRAF combines with extensive involvement of other development partners to limit UNFPA share of investments and activities, which worsens the problem of attribution	The problem of attribution is the main reason the evaluation applied contribution analysis as its main design principle and analytical model. In doing so, the evaluation shifted its focus from identifying results attributable to UNFPA to documenting how UNFPA contributes to results achieved in combination with the work of other actors

In summary, while the challenges faced by the evaluation and the resulting limitations are real, specific features of the evaluation, including sample selection, data-collection methods and the analytical model, were designed and implemented specifically to counter these challenges. As a

result, the findings and conclusions presented in Section 4 and 5 are supported by a strong body of evaluation evidence. The evidence for all findings is presented in the evaluation matrix (Annex 1).



© UNFPA Georgia. Youth celebrating World AIDS Day



4

EVALUATION FINDINGS

4.1 STRATEGIC CHOICES AND COMPARATIVE ADVANTAGE

Summary

The UNAIDS Joint Programme Division of Labour is an important vehicle for guiding UNFPA efforts at global, regional and national levels to promote HIV prevention and SRHR, HIV and SGBV linkages and integration. It serves as an organizing framework to steer the coordination and convening among participating United Nations agencies based on comparative strengths and capacities. For UNFPA, there is a tension between the role it has taken under UBRAF and the perceived diminished priority for HIV under UNFPA strategic plan 2018-2021. This has limited the ability of UNFPA to take on its expected leadership role, particularly at global level. At country level, UNFPA country offices in Georgia, Namibia, and Zambia (supported by strong technical and programmatic capacities in the UNFPA Eastern Europe and Central Asia Regional Office (EECARO) and ESARO) have been able to match their respective capacities, comparative advantages and the UNFPA mandate to their assigned roles in HIV (sometimes with minimal resources, as in Georgia). However, UNFPA cannot fully deploy its technical capacity and strategically leverage its mandate unless it embraces a strong focus on HIV prevention, especially among other KPs, as exemplified by Indonesia.

For details of the evidence supporting findings in Section 4.1, see the evaluation matrix (Annex 1): Assumptions 5.1, 5.2 and 5.3.

4.1.1 Making and advocating strategic choices

Tension between a UNFPA leadership role and the strategic profile of support to HIV

UNFPA staff face significant constraints as they try to strategically position and guide support to the HIV response and advocate for critically important, strategic choices by partners. These constraints arise from factors that are in tension with sometimes negative consequences at global, regional and national levels. The factors are:

1. The UNAIDS Joint Programme Division of Labour and UBRAF, which serve as a guide for UNFPA (and other participating Cosponsors) to “maximize the effectiveness and impact of UN HIV-related resources. They provide a basis for adapting work based on the comparative advantage and core mandates of each organization, their in-country presence, existing national priorities, capacity, and the availability of funding” and suggest a strong leadership role for UNFPA.⁴⁹
2. A willingness and a demand among other UNAIDS Cosponsors and international partners in the HIV response for UNFPA to play a very strong advocacy role and help to “drive the agenda” for HIV prevention and the rights of the most vulnerable and KPs
3. The relatively low perceived priority of HIV in UNFPA strategic plan 2018-2021 when compared to its predecessors
4. A context of diminished human and financial resources dedicated to supporting the HIV response within UNFPA combined with the lack of an organizational strategy and plan for operationalizing support to the HIV response, with the HIV team now situated within the SRH Branch of the Technical Division.

⁴⁹ UNAIDS, *UNAIDS Unified Budget, Results and Accountability Framework 2016-2021*, UNAIDS/PCB (37)15.19, Issue date: 20 October 2015, p. 14.

These four factors combine in a way that produces an important contradiction in the “outward-facing” ambition of UNFPA to fill a leadership role in the global HIV response and the “inward-facing” attention and priority paid to the same task as reflected by UNFPA strategic plan 2018-2021 and how HIV is positioned at UNFPA.

The evaluation approached the problem of assessing this apparent tension by first examining the way in which supporting the response to HIV is positioned strategically and operationally within UNFPA and comparing that with its assigned and expected role.

Supporting the HIV response as a strategic priority for UNFPA over two strategic plans

UNFPA has been guided by two different strategic plans during the evaluation period. UNFPA strategic plan 2014-2017 defined four transformative outcomes with an explicit reference to HIV in the first outcome.

“Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access.”⁵⁰

This first stated outcome was to be achieved through:

- One output on integrated, gender-responsive SRH services that meet human rights standards (with specific reference to integrating HIV into ante-natal care and family planning)
- Three outputs that represent the “three major pillars of the work on SRH” (family planning, maternal health and HIV)
- A final output that detailed the delivery of SRH in humanitarian settings.⁵¹

As a result, strategic plan 2014-2017 provided a high level of visibility for UNFPA support to the HIV response by signalling its importance within a highest level outcome as one of the three pillars of UNFPA work on SRH, at an equal level of priority to work on maternal health and family planning.

The transition to strategic plan 2018–2021 brought the perception of a decrease in the visibility of UNFPA support to HIV within the document itself. Strategic plan 2018-2021 focuses on achieving universal access to SRHR to improve the lives of adolescents, youth and women by organizing the work of UNFPA around three: “transformative and people-centred results in the period leading up to 2030. These include: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c)

an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage.”⁵²

The staff of UNFPA ESARO responded to strategic plan 2018-2021 with the argument that responding to HIV remained a critical challenge in the region, given continuing high levels of new infections and large numbers of PLHIV. As a result, the regional office instituted a fourth, regional transformative result: end sexual transmission of HIV, with a clear priority of reaching first those left furthest behind.⁵³

Support to the HIV response does feature in strategic plan 2018-2021 mainly through the indicators identified in the integrated results and resources framework. This framework includes indicators for the overall goal (10 indicators), four outcomes (20 indicators) and 14 development outputs (57 indicators). In total there are just three HIV-specific indicators identified in the results framework.⁵⁴ In 2016, the HIV team at UNFPA attempted the development of a strategy specifically to guide UNFPA support to the HIV response, but the draft document was not formally adopted by the Technical Division.

Organizational structures and human resources

As detailed in Section 2, UNFPA has seen a notable reduction in the level of human resources allocated to the HIV response during the evaluation period. At regional and country office levels, the number of FTE positions dedicated to supporting HIV initiatives reduced from 77 to 55, a drop of 29 per cent between 2016 and 2019. The cut was even more significant at headquarters, where dedicated FTE positions were more than halved, from seven to three. In the same timeframe, the former HIV/AIDS Branch at UNFPA was discontinued and the - now much smaller - informal HIV team was embedded in the SRH Branch. Interviews with key stakeholders, both inside and outside UNFPA, indicate that the decline in the visibility of HIV in strategic plan 2018-2021, the concurrent decrease in dedicated HIV staff and the demise of the HIV/AIDS Branch has led many to conclude that the UNFPA response to HIV is not as high a priority as it has been in the past. At the very least, this has resulted in a lack of common understanding, within UNFPA, of the importance of HIV.

⁵² UNFPA, strategic plan 2018-2021, p.5.

⁵³ UNFPA, Fulfilling the Promise: East and Southern Africa Annual Report 2018. June, 2019. p. 3.

⁵⁴ UNFPA strategic plan 2018-2021: Annex 1. Integrated results and resources framework, p 7-27. Impact indicator 5: no. of new HIV infections per 1,000 uninfected populations, by sex, age and key populations; outcome 1, output 2, indicator 2.1, no. of countries that have applied the SRH/HIV integration index; and outcome 2, indicator 1: percentage of women and men 15-24 years old who correctly identify both ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission.

⁵⁰ UNFPA, strategic plan, 2014-2017, p.6.

⁵¹ UNFPA, strategic plan, 2014-2017. P7.

Has HIV been mainstreamed in strategic and organizational terms?

It could be argued that strategic plan 2018-2021 and its new organizational structure represents a credible UNFPA effort to “mainstream” support to the HIV response in the face of declining non-core resources received under UBRAF (Section 2.4). When using the term mainstreaming it is important to differentiate between mainstreaming HIV at a national level (with the HIV response mainstreamed across all sectors of

activity, not simply the health sector) and mainstreaming the HIV response within an organization. The evaluation team approached the question of whether the HIV response had been mainstreamed effectively from 2016 to 2019 through a set of success factors identified by Swiss Development Cooperation.⁵⁵ Table 8 provides an assessment of the extent to which UNFPA has mainstreamed the function of supporting the HIV response.

TABLE 8: *Mainstreaming support to the HIV response*

Success criteria	Level of mainstreaming at UNFPA
1. HIV understood as a development issue	Good understanding apparent among HIV-associated staff at headquarters and RO and CO levels but less appreciation of the importance of a sustained HIV response more broadly at UNFPA
2. Commitment and active support of decision makers	Not evident in the changes to strategic plan 2018-2021
3. Clearly defined objectives for mainstreaming of HIV/AIDS	No evidence found of an explicit strategy with objectives for mainstreaming HIV/AIDS strategically and organizationally (with the exception of a fourth transformative result on HIV prevention adopted by UNFPA ESARO in 2018)
4. Knowledgeable, compassionate and skilled staff	Confirmed by evidence at headquarters, RO and CO levels but with limitations due to staffing levels
5. Expertise and support available and made use of	Small headquarters team has difficulty meeting needs/demands for technical support
6. Sufficient allocation of resources (financial, human and technical)	Staffing reductions have resulted in increased workload for staff at all levels, but especially headquarters
7. Willingness to learn, reflect and share experiences	Global, regional and country exchanges and workshops indicate strong willingness to learn

While UNFPA has met some of the success criteria for mainstreaming support to the HIV/AIDS response, it has either not met or only partially met others. Most importantly, UNFPA staff and UNFPA partners interviewed have questioned whether the function has demonstrated commitment and active support from within the organization, as reflected in strategic plan 2018-2021, allocation of human resources and organizational structure.

Continuing high workloads and high demand for UNFPA support to the HIV function

The perceived decline in the strategic and organizational priority of the HIV response at UNFPA would not be problematic if it were accompanied by a downward adjustment in the level of organizational ambition or by a

realignment of expectations or demands on the part of the partners of UNFPA. Yet, there are a number of indicators that neither UNFPA ambitions nor external demands for UNFPA leadership have subsided, even as UNFPA faces a reduction in the financial and human resources to respond to those requests, particularly, but not exclusively at headquarters level. These indicators include:

- The responsibilities assigned to UNFPA under the 2018 guidance on the Division of Labour among UNAIDS Cosponsors.⁵⁶ UNFPA acts as co-convenor for: HIV prevention among KPs; decentralization and integration of SRHR and HIV services; and HIV prevention among young people. UNFPA also provides inputs into a range of other results areas (see Section 4.1.3)

⁵⁵ Swiss Development Cooperation, *Mainstreaming HIV/AIDS in Practice*. 2010, p.23-24.

⁵⁶ UNAIDS, *UNAIDS Joint Programme Division of Labour: Guidance Note*, 2018, p.12-13. Accessible at: https://www.unaids.org/sites/default/files/media_asset/UNAIDS-Division-of-Labour_en.pdf

- Continuing high demand (confirmed in interviews) by other UNAIDS Cosponsors and global CSOs for a high level of UNFPA engagement and leadership around issues relating to its co-convenor and as a partner in other areas of the Division of Labour, including, for example, acting as a global champion on the needs and rights of KPs
- The continuing demanding workload faced by the headquarters HIV team, which in 2019 includes chairing the UNAIDS Committee of Cosponsoring Organizations
- The complex and wide range of activities, investments, initiatives and outputs in support of the HIV response, which engage UNFPA staff at global, regional and local levels in dramatically varying contexts (as illustrated by the reconstructed theory of change - Section 3.2).

At headquarters level, not having a clear HIV-specific strategy has resulted in UNFPA staff having a sense that they are expected to do the same level of work as before but with fewer resources. Financial and progress reporting for UBRAF are time-consuming and run parallel to other organizational processes, adding to the sense that UBRAF drives overall programming, rather than other, strategic UNFPA imperatives.

The dilemma of how to balance available resources with the demands of the global HIV response is not unique to UNFPA. Interviews with staff of other UNAIDS Cosponsors indicate that they also face a tension between the role as set by the Division of Labour and the strategic imperatives of each organization. While the Division of Labour and organizational mandates may be aligned on paper, one key informant noted: "In terms of critical work that needs to be done, our own organizational strategic plans must also drive things."

Nonetheless, UNFPA faces a particularly difficult challenge. Its external roles and commitments, as expressed in the UNAIDS Division of Labour and share of the UBRAF budget, have not diminished while the strategic profile, organizational visibility and human-resource complement of the HIV/AIDS function have been reduced during the evaluation period. As a result of these factors and the absence of a specific strategy for the function, there is no common understanding within UNFPA as to how this stream of activities "fits" within the overall programme.

UNFPA leadership at global level: Integration and CCP

Externally, at global level, key informants noted several areas where they expected to see greater UNFPA engagement to move the dialogue forward.

One area mentioned was the need for UNFPA to take the lead in responding to the substantial unfinished agenda to advance SRHR, HIV and SGBV integration, given the results of the Evidence for Contraceptive Options and HIV Outcomes (ECHO) trial, which emphasized the need for

integration as a key strategy.⁵⁷ UNFPA is uniquely positioned to call for stronger global and national commitments and accountability for informed choice for family planning and HIV prevention and treatment. While SRH Branch has engaged in post-ECHO trial dialogue, UNFPA is not seen as taking the lead. Rather, WHO has moved swiftly to engage across its SRHR and HIV teams to offer practical strategies for moving forward.

UNFPA has participated in these efforts, including by advocating for an integrated focus on STI management. However, the external stakeholder view is that UNFPA is following rather than leading: "This is where we would have expected UNFPA to jump on the news, but we haven't seen anyone from their SRHR side worrying about this in a visible fashion." (Key informant, staff from United Nations agency at global level).

In the HIV Prevention 2020 Road Map, UNFPA is identified as the technical assistance focal point for the area of work related to condoms. It is notable that, since at least 2015, UNFPA has been engaged in promoting condom programming at global, regional and, to some extent, country levels. Most importantly, the 20 by 20 initiative, aimed at increasing condom use and availability in low- and middle-income countries to 20 billion by 2020, is an initiative spearheaded by UNFPA in collaboration with (originally) the World Bank, the United States Agency for International Development (USAID), the International Labour Organization (ILO) and the Reproductive Health Supplies Coalition (RHSC). The report of the September 2018 20 by 20 workshop described it as a joint initiative of UNFPA and USAID in collaboration with AIDSFree, PEPFAR, and the RHSC. The same report characterized 20 by 20 as a "coalition of condom manufacturers, international donors, national governments, social marketing organizations and NGOs".⁵⁸

In November 2017, the Mann Global Health Group, with funding from the Bill and Melinda Gates Foundation (BMGF) published a study of condom markets in Botswana, Kenya, Tanzania, Zambia and Zimbabwe, to "support global condom efforts to achieve 20 by 20/UNAIDS objectives on condom use for HIV prevention".⁵⁹ The third 20 by 20 workshop held a year later considered the results of this study and other condom market research commissioned by UNFPA and UNAIDS in the prior two years and drafted potential country work plans for consideration in condom programming in Kenya, Nigeria, South Africa, Uganda, Zambia and Zimbabwe.⁶⁰

57 [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)31288-7/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31288-7/fulltext)

58 UNFPA and USAID, Accelerating Commercial Engagement in Sub-Saharan Africa: Report of the Third 20 by 20 Workshop. September, 2018. p. 4.

59 Mann Global Health, The Condom Program Pathway, November, 2017. p.8.

60 Report of the Third 20 by 20 Workshop, pgs. 41-43.

In addition, UNFPA is serving as co-convenor along with UNAIDS of the Global Condom Working Group which, in 2019, published technical guidance to support countries making funding requests of the Global Fund and other donors.⁶¹ UNFPA also led an important initiative to update and revise the 2011 WHO/UNFPA/Family Health International 360 (FHI 360) advisory note on additional lubricants, which aims to ensure that safe, acceptable, and affordable lubricants are available to all.⁶²

Despite its engagement in 20 by 20 and the Global Condom Working Group, UNFPA is not seen as having a distinct strategy towards condoms as part of the contraceptive mix, i.e. one that advocates for dual protection in high HIV incidence areas, and its investments in condom and condom promotion is perceived as weakening over time. At a meeting of the Global HIV Prevention Working Group in 2018, UNAIDS called for UNFPA “to consider clarifying its corporate commitments/position vis-à-vis condom distribution, promotion and investments”.

The evaluation found little evidence of UNFPA engagement in broader support to condom programming at country level in the country case studies of Namibia and Zambia. Up to this point, UNFPA efforts at global advocacy on broader issues of condom supply and demand are not evident at country level.

4.1.2 Strategic choices at regional and national levels

ESARO and EECARO support strategic activities within the contexts of two very different epidemics

Almost all of the countries within the ESA region have generalized HIV epidemics, yet the rate of new infections is decelerating. In EECA, in contrast prevalence is very low, but new infections are on the rise and are concentrated among KPs, especially MSM, sex workers and people who inject drugs. UNFPA EECARO reports that in 2019, 95 per cent of all new HIV infections in the region were registered among KPs and their sexual partners. Given the serious nature of the epidemic, UNFPA EECARO is committed to working on HIV prevention with or without UBRAF funds and has dedicated core resources to this end. UNFPA EECARO also focuses on the need to improve the enabling environment for action in HIV prevention, with special attention to building capacity of county offices and partners using the Men Who Have Sex with Men Implementation Tool (MSMIT), the Sex Worker Implementation Tool (SWIT) and the Transgender People Implementation Tool (TRANSIT). It is also addressing needs of migrant KPs with partners from governmental and civil society sectors. Because of its focus on KPs, human rights are a critical issue for EECARO.

It has regularly undertaken routine environmental scanning to identify and follow up on reports of rights issues and violations within the region.

ESARO plays a major strategic role in support to SADC, the EAC and other regional forums of parliamentarians and human-rights institutions to develop regional policies, strategies, model laws and guidelines on SRHR, HIV and SGBV integration. It also supports the expansion of scalable integrated SRHR-HIV services and youth-friendly services within the context of a generalized epidemic, as well as advocating for targeted services among KPs. Given their extensive work in SRHR-HIV linkages and the *2gether 4 SRHR* regional programme, ESARO is seen as contributing regionally and globally on strategic HIV leadership both within UNFPA and externally.

Perhaps the most striking example of a strategic choice made by UNFPA ESARO was its adoption, in 2018, of a fourth transformative result (to supplement the three transformative results of the UNFPA strategic plan 2018-2021) to end the sexual transmission of HIV, with a clear priority of reaching first those left furthest behind.⁶³

Making strategic choices at country level

The field-based country case studies provide evidence that UNFPA country offices have developed and implemented programmes of support to the HIV response that are strategic within their respective national contexts.

For example, interviews with government and civil society informants support the notion that UNFPA Georgia has been strategic with its relatively small set of resources in supporting critical issues in HIV prevention. Its main implementation strategy has been to work with partners on the elaboration of national strategy documents, standards and protocols and related training materials in anticipation of the impending Global Fund transition and the shifting burden of implementation to the national government. Within its broader portfolio of SRHR and gender activities, the UNFPA country office has embraced a focus on comprehensive prevention programming for KPs (MSM, sex workers and people who inject drugs), including young key populations. However, condom programming has been limited, other than the development of policy briefs to make the case for investment in family planning programming and supplies. The lack of a strategic remit for demand-creation activities (under the UNFPA business model for middle-income countries) and the discontinuation of UNFPA Supplies Programme funding for condom procurement (apparently made on the assumption that the Global Fund would provide the necessary funding for condoms for HIV prevention) are seen as contributing factors to this decision.

61 Global Condom Working Group, Developing Effective Condom Programmes, Technical Brief, October, 2019, p.2.

62 UNFPA, IPPF, USAID and WHO, Global Consultation on Personal Lubricants: Meeting Report, 8-10 November, 2016, Bangkok, p.2.

63 UNFPA ESARO, Fulfilling the Promise: East and Southern Africa Annual Report, 2018, p.3.

In Namibia, UNFPA has consistently played its strongest role through advocacy, technical assistance and financial support for the integration of SRHR, HIV and SGBV in health services and through programming focused on the needs and rights of adolescents and youth and KPs. Condoms have been addressed under the Safeguard Young People (SYP) programme umbrella, as UNFPA participated in drafting the sections on adolescent girls, young women, condoms and KPs in the National Strategic Framework (NSF) on HIV. The county office has been careful to ensure that it engages in advocacy and technical and financial support in areas important to the NSF. Its partners highlighted the consultative processes developed by UNFPA with the result that each partner ministry of the Government of Namibia is assured that UNFPA is supporting interventions of strategic importance.

In contrast, the national response to HIV in Indonesia is predominantly driven by a large Global Fund programme. This has come to define and dominate the work of the UNFPA HIV team there. To its credit, the country office has worked to build on this component and has successfully achieved improvements to programming for FSWs to broaden its HIV prevention impact, for example in promoting partner notification protocols. However, there is little

evidence that UNFPA has challenged the rationale for its constrained role, nor has it actively and overtly attempted to position comprehensive HIV prevention as a priority issue in Indonesia beyond its work with FSW. In addition, the country's dysfunctional supply chain for "HIV condoms" is left unaddressed by UNFPA. It is also telling that neither the country's key HIV strategy document nor the Government of Indonesia's Family Planning 2020 commitment mention comprehensive condom programming, triple protection, dual protection (or female condoms).⁶⁴ Without a broader focus on HIV prevention, including condom programming, it is unlikely that UNFPA Indonesia can meet the expectations inherent in the global UNAIDS Division of Labour or the UNFPA strategic plan 2018-2021.

4.1.3 UNFPA comparative advantages and the UNAIDS Division of Labour

Within the UNAIDS Joint Programme and UBRAF framework, each programmatic area is led by one or two convening partners, whose role is to facilitate the contributions of the other United Nations funds and programmes through the provision of technical leadership, convening authority and standard setting. Table 9 presents the areas assigned to UNFPA as co-convenor or in an agency partner role.

TABLE 9: UNFPA roles in the UNAIDS Division of Labour

UNFPA in joint team convenor/co-convenor role	UNFPA in agency partner role ⁶⁵
<p>HIV prevention among KPs (gay men and other MSM, migrants, sex workers and transgender people)</p> <p>HIV prevention among young people (combination prevention; youth health and educational needs)</p> <p>Decentralization and integration of SRHR and HIV services</p>	<p>HIV testing and treatment (innovative testing strategies; access to treatment cascade; high-burden cities Fast-Track HIV services; medicines and commodities)</p> <p>HIV services in humanitarian emergencies</p> <p>Elimination of mother-to-child transmission of HIV and keeping mothers, children and adolescents alive and well (access to quality comprehensive elimination of mother-to-child transmission of HIV services; systems and services to meet the 90–90–90 targets for mothers, children and adolescents)</p> <p>Gender inequality and gender-based violence (strategic actions for gender equality and women and girls; gender-based violence)</p> <p>HIV-sensitive social protection</p> <p>HIV and universal health coverage, tuberculosis/ HIV, other comorbidities and nutrition</p> <p>Investment and efficiency</p> <p>Human rights, stigma and discrimination (legal and policy reform; access to justice and rights; HIV health-care discrimination eliminated)</p>

The other Cosponsors welcome the role of UNFPA under the Division of Labour and key informants have expressed a desire to see UNFPA more vigorously fulfilling this role at all levels. They consider that UNFPA has a significant

comparative advantage in HIV prevention, in particular condom programming and integration of SRHR, HIV and SGBV. Further, UNFPA is seen as having a well-established implementation platform with an extensive field presence

⁶⁴ National AIDS Commission, Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia, National AIDS Commission, 2015. Government of Indonesia, *Family Planning 2020 Commitment*, Government of Indonesia, 2017.

⁶⁵ The only area not assigned to UNFPA in an agency partner role is harm reduction for people who use drugs and HIV in prisons.

(including in humanitarian settings), solid connections to government ministries of health and other social sectors, and robust partnerships with civil society organizations. However, partners at global level note with concern that UNFPA has not been able to leverage its comparative advantage effectively, in part because of resource constraints. UNFPA has taken on a very demanding role within the Division of Labour and even if resources were available, increased effectiveness at global level requires a greater alignment and clarity within UNFPA about the “fit” of HIV activities within the overall UNFPA programme.

Flexible application of the Division of Labour at regional level

It is widely recognized among Cosponsor agencies that there must be flexibility for the application of the Division of Labour at the field level, given the interrelated factors of in-country capacities, the absence of some United Nations Cosponsors and the availability of resources. At regional level, it was evident that in the regions visited, regional office staff had afforded HIV priority within their respective portfolios and were able to leverage their comparative advantages to offer leadership at regional level and to support country offices to do the same. In EECARO, the political context and environment is very conservative and UNFPA staff consider themselves to be well positioned through its mandate to work on youth, data and gender programming as entry points rather than addressing HIV “head on.” Based on its mandate and commitment to advancing SRHR-HIV linkages, EECARO has worked to fulfil the Division of Labour in HIV prevention by working to build regional capacity for implementing

comprehensive HIV and STI programmes for KPs. UNFPA EECARO reports that it is also guided by the regional United Nations Common Position on ending HIV, TB and viral hepatitis.

In the ESA region, there is a clear Division of Labour whereby UNFPA contributes significantly to the joint UNAIDS programme through its strong perceived comparative advantage in SRHR, HIV and SGBV integration and in programming for adolescents and youth, including CSE. UNFPA convenes and provides leadership in the *2gether 4 SRHR* programme and leads on SGBV in non-emergency situations (UNAIDS leads in emergency situations). In addition, there is a clear allocation of roles with UNESCO under the SYP, with UNFPA contributing to CSE for out-of-school youth. The Regional AIDS Team for ESA (RATESA) supports joint work planning that clearly delineates roles and responsibilities among the United Nations agencies as per the Division of Labour.

Leveraging comparative advantages across different country office resource levels

At country level, during the field country case studies, the evaluation team reviewed in-depth the experience of three countries with very different contexts and resources for HIV programming. As such, there were three distinct scenarios regarding the extent to which they could leverage their respective comparative advantages within the Division of Labour.

TABLE 10: Resources and mandate fulfilment in field-based case study countries

Country	Resource environment to fulfil mandate	Mandate fulfilment
Namibia	Positive	Positive
Georgia	Constrained	Positive
Indonesia	Constrained	Constrained

In Namibia, there is strong consensus among key stakeholders that UNFPA has identified a strategic role in the national response to HIV reflective of its organizational comparative advantage and consistent with the agreed upon Division of Labour among the Cosponsors of the joint UNAIDS programme. Interviews with key stakeholders emphasized a strong fit between the roles taken on by UNFPA

and its related comparative advantages (both historical and technical) in terms of: SRHR, HIV and SGBV integration; CSE; behaviour change and communication, including “Condomize!” campaigns;⁶⁶ a recognized leadership role in supporting the lesbian, bisexual, gay, transgender and intersex (LGBTI) community; and access to the technical support from the ESARO.

⁶⁶ “Condomize!” designates UNFPA-supported awareness campaigns to improve condom access for vulnerable and at-risk populations, and to reduce the stigma associated with condom use. It includes a diversity of activities to advocate HIV prevention (with emphasis on correct and consistent condom use) and to build the skills of stakeholders (e.g., the media, youth peer educators, service providers) on condom promotion and distribution.

In Georgia, despite a very small allocation of UBRAF and core resources, UNFPA fulfils its role in the Division of Labour within the context of these limitations. Because UNAIDS does not have an in-country presence, UNFPA plays a lead role for the JUNTA and has effectively leveraged its mandate on SRHR for women and youth as a strategic entry point for its leadership role in HIV prevention. UNFPA has a strong reputation among its partners as a result of its long-standing presence in-country and has made good use of its comparative strengths to advocate and facilitate action for HIV prevention with a special focus on HIV and SRHR for youth and KPs.

In Indonesia, as already noted, the role of UNFPA has been shaped by the Global Fund financed project, which has played a central role in the national HIV response and contributes to a major component of the nation's HIV prevention strategy. In early 2017, UNFPA was requested by the Ministry of Health to take on the implementation of the FSW programme as a sub-recipient in the Global Fund Mechanism. This was a major commitment involving a large budget and has resulted in UNFPA taking on a role in service delivery, rather than a more upstream role (as per the UNFPA business model, which designates Indonesia as a "yellow quadrant" country – see Table 12) with a focus on supporting an enabling environment and institutional capacities. Further, the Division of Labour among United Nations agencies follows a very different approach from the other countries evaluated, as agency roles are delineated by KP group in contradiction to the global agreement. This has resulted in the reinforcement of "siloes" and vertical approaches and has diminished the opportunity for UNFPA and other members of the JUNTA to support integrated programming. In this configuration, UNFPA is not realizing its comparative advantage in terms of providing technical input, evidence and advocacy for comprehensive HIV prevention and for rights-based integrated SRHR, HIV and SGBV services.

Whatever the level of resources available, a significant majority of the respondents to the online survey of key informants at country level (76.3 per cent) either agreed or strongly agreed that UNFPA country offices make effective use of comparative advantages in supporting the national HIV response. Only 3.7 per cent disagreed (20 per cent neither agreed nor disagreed).

4.1.4 Technical capacity for effective programming

At global, regional and country levels, stakeholders have a positive opinion of the technical capacity of UNFPA staff dedicated to the HIV function. At global level, however, the HIV team recognizes that it is unable to "do justice" to all the different areas that are included in its workplan as well as effectively respond to *ad hoc* requests and needs from the different country and regional programmes. As noted by an HIV staff member at UNFPA:

"Within the workplan, there are 70 activities to be looked at, such as guidance on health and protection needs of sex workers in humanitarian settings, input to UNOCD (United Nations Office on Drugs and Crime) in prisons, update on UN guidance on HIV and sex work, contribution to an anti-trafficking policy paper to differentiate trafficking from sex work, etc."

Observations from key stakeholders, within and outside UNFPA, indicate that a lack of prioritization leads to too many activities being juggled by too few people with too little time. As a consequence, while key informants spoke of their regard for the technical capacity of those on the HIV team, they also noted their impressions regarding an overall lack of organization and focus at global level. There is general recognition that limited technical resources impact negatively on UNFPA effectiveness as a leader in global forums and limit its ability to advance its mandate related to HIV prevention.

Stakeholders lauded the technical capacity of UNFPA staff working on HIV in Georgia, Indonesia and Namibia country offices, as well as in the EECARO and ESARO. UNFPA Namibia has been able to provide high quality technical support to projects and programmes for HIV prevention and treatment, using its capacities in health sector integration, behaviour change communication for condom programming, CSE and SGBV. At times, this technical support is based on work done at UNFPA ESARO, while at other times it is provided by the Namibia country office. UNFPA Namibia also draws on expertise from other country offices in the region on an "as needed" basis, as when it accessed a specialist in "Condomize!" programming from the Lesotho UNFPA office. In Zambia, staff noted that they have maintained their technical capacity in the face of reduced resources and that they "multitask" in order to co-convene the local arm of the GPC with UNAIDS.

Key informants from governments and CSOs in Georgia and Indonesia stated that they trust UNFPA as a partner and noted that they are "there, when needed." In both countries, there was an appreciation for how UNFPA worked with other United Nations agencies. By combining resources and collaboration, they are able to achieve more together. In Georgia, UNFPA is seen as having the strongest technical capacity within the United Nations family in the area of HIV prevention. Its technical capacity and related reputation are based on a strong collaborative ethos and a staff of advisors who have extensive experience and expertise in the Georgian context. Their technical capacity is well suited to the skills required for a portfolio rooted in advocacy and capacity building, especially on topics that are politically sensitive in nature. This capacity is backed up by, and shared within, the EECARO, which helps to manage HIV prevention activities in an environment of constrained resources at country and regional levels. In Indonesia, no respondents questioned the technical capacity of UNFPA to carry out tasks with regard to

HIV or HIV/SRHR/SGBV linkages and integration in the event they were called upon to undertake those activities. Several respondents noted the benefit of technical expertise of the

Indonesia county office, including its expertise related to working at community level.

4.2 THE NEEDS AND RIGHTS OF KEY POPULATIONS AND THE MOST VULNERABLE

Summary

While the commitment to the rights and needs of the most vulnerable and KPs is consistent with the strategic plan 2018-2021, UNFPA transformative results are not well aligned with a strong priority for the rights and needs of KPs. Nonetheless, UNFPA has made a considerable effort to support rights promotion at regional and national levels. This has included identifying key issues for policy and advocacy, and organizing and supporting efforts to improve the legal and policy framework for adolescents, youth and KPs. A limitation to effective rights promotion has been the difficulty to ground UNFPA work on rights policy and advocacy in the experience of the most vulnerable and KPs and the challenges they face at the point of service delivery. This is particularly the case in countries that are not in the “red quadrant” of the UNFPA business plan and have a limited access to different modes of engagement (especially service delivery) and a reduced allotment of core resources. Generally, UNFPA has been effective in supporting networks and organizations to promote meaningful participation by vulnerable communities and KPs, despite occasional resistance and challenges in developing capacity and sustaining these same networks. Efforts to promote gender equality have mainly focused on CSE, prevention of early marriage and addressing the causes of SGBV, which are seen as central to promoting gender equality through an HIV lens.

For details of the evidence, supporting findings in Section 4.2 see the evaluation matrix (Annex 1): Assumptions 2.1, 2.2, 2.3, 2.4, 2.5, 3.1, 3.2 and 3.3.

4.2.1 UNFPA commitments to meeting needs and addressing rights of the most vulnerable in the HIV response

UNFPA is challenged to accommodate multiple organizing principles in supporting the HIV response including: a commitment to leave no one behind (LNOB); reliance on a human rights-based approach (HRBA) to programming; a focus on women, adolescents and girls in UNFPA strategic plan 2018-2021; the designation of roles (and allocation of resources) at country level according to the UNFPA business model; and UNFPA status as co-convenor for the prevention of HIV among KPs. During the evaluation period, UNFPA faced the challenge of guiding its support to the HIV response along these different organizing principles, while dealing with decreases in available financial and human resources. In practice, UNFPA has relied most often on the concepts of “marginalization”, “vulnerability” and the term “key populations” to target support to the HIV response at regional and national levels. UNFPA has used these concepts throughout the evaluation period to guide its commitment to meeting the needs of the most vulnerable, including KPs.

The strategic plan on meeting the needs of the most vulnerable and realizing rights

UNFPA strategic plan 2018-2021 identifies women, adolescents and youth as priority groups for programme focus. The plan also recognizes other groups central to the understanding of HIV epidemics and effective HIV responses. Notably, the strategic plan commits to promoting participation for “diverse young men and women, including those with disabilities” and addressing the SRHR of “those considered most vulnerable, including ... populations living with or at risk of HIV”. In public statements, senior managers at UNFPA have made it clear that UNFPA defines KP as including “lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) people”.⁶⁷

The strategic plan is also oriented to aligning UNFPA actions and priorities to the SDGs. In particular it addresses KPs and their rights through the achievement of SDGs 3.3.1 and 10.3.1

⁶⁷ Statement by UNFPA Executive Director Dr Natalia Kanem for the International Day against Homophobia, Biphobia and Transphobia 17 May 2019. (<https://www.unfpa.org/press/statement-unfpa-executive-director-dr-natalia-kanem-international-day-against-homophobia>).

“SDG 3.3.1: Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations.

SDG 10.3.1: Proportion of population reporting having personally felt discriminated against or harassed in the previous 12 months on the basis of a ground of discrimination prohibited under international human-rights law.”⁶⁸

Without specifying KPs, meeting the needs of the most vulnerable and realizing their rights is embedded as outcome number one of the strategic plan: “Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.”⁶⁹

There is, however, some misalignment between elements of UNFPA strategic plan 2018-2021 and different dimensions of UNFPA support to the HIV response. As noted in Section 4.1.1, the strategic plan focuses and organizes UNFPA work “around three transformative and people-centred results in the period leading up to 2030. These include: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage.”⁷⁰

In contrast, at least at global level, there is a strong consensus that the HIV response should focus on realizing the rights and meeting the needs of, in particular, KPs. As noted by UNAIDS in its 2019 update:

“The AIDS epidemic has put a spotlight on the many fault lines in society. Where there are inequalities, power imbalances, violence, marginalization, taboos and stigma and discrimination, HIV takes hold. The AIDS epidemic is changing: in 2018, more than half of all new HIV infections were among KPs—sex workers, people who use drugs, gay men and other men who have sex with men, transgender people and prisoners—and their partners. ... The sexual and reproductive health and rights of women and young people are still too often denied.”⁷¹

This global view of the epidemic is consistent with the roles of UNFPA as co-convenor (within the UNAIDS Joint Programme): HIV prevention among KPs (gay men and other men who have sex with men, migrants, sex workers and transgender people); HIV prevention among young people (combination prevention, youth health and educational needs); and decentralization and integration of sexual and reproductive health and rights and HIV services. On the other hand, the general priority given to maternal mortality, family planning and gender equality in strategic plan 2018-2021 does not readily align with either the global consensus on the need to address KPs in the response to the epidemic or the roles assigned to UNFPA in the UNAIDS Division of Labour.

A human rights-based approach and leave no one behind
UNFPA strategic plan 2018-2021 makes a specific commitment to LNOB under outcome number one with its focus on the SRHR of “every woman, adolescent and youth everywhere, especially those furthest behind”.⁷² This raises the question of how the concept of LNOB could assist UNFPA in putting into practice its commitments to meeting the needs and realizing the rights of the most vulnerable, including KPs.

In 2019, the United Nations Sustainable Development Group (UNSDG) produced an interim draft document, *Leaving No One Behind: A UNSDG Operational Guide for UN Country Teams*.⁷³ The guide identifies some of the main characteristics of LNOB and compares LNOB to a human rights-based approach (HRBA).⁷⁴ Table 11 summarizes the different characteristics of HRBA and LNOB (based on the UNSDG Guide). It also examines how these either support or challenge the HIV-specific commitments and potential roles of UNFPA.

68 UNFPA, strategic plan 2018-2021, pp.4,5.

69 UNFPA, strategic plan 2018-2021, p.7.

70 UNFPA, strategic plan 2018-2021, p.5.

71 UNAIDS Data 2019, p.2 foreword.

72 UNFPA strategic plan, 2018-2021. P.7.

73 UNSDG, 2019, *Leaving No One Behind: A UNSDG Operational Guide for UN Country Teams. Interim Draft*.

74 UNSDG, 2019, p.10.

TABLE 11: Human right-based approach and leave no-one behind and their implications for key populations and the most vulnerable

Human rights-based approach (HRBA)	Leave no-one behind (LNOB)	Implications for UNFPA support to the HIV response
A programming tool to strengthen and focus UN response	A guiding principle of the 2030 agenda, grounded in international law and human rights	Both consistent with a support to HIV having a strong focus on vulnerable and KPs
Based on country commitments and legal obligations grounded in human rights law	A political commitment by states when they sign on to the SDG Agenda	Both provide a basis for advocacy on addressing the needs and rights of the most vulnerable and KPs
A process for the analysis and assessment stage of programming that helps identify who is left behind and why	Deepens focus on inequalities, including multiple forms of deprivation, disadvantage and discrimination and “reaching the furthest behind first”	HRBA can assist in identifying those left behind while LNOB provides a strong rationale for addressing stigma and discrimination
Based on principles of non-discrimination and equality	Based on principles of non-discrimination and equality	Both consistent with addressing issues of access to quality services for vulnerable and KPs (including service delivery)
Addressing gender inequalities	Addressing gender inequalities	Consistent with UNFPA strategic plan emphasis on gender equality
Focus on empowerment of rights holders and capacity of duty bearers	Focus on rights, empowerment and capacity development	Consistent with a focus on the rights of most vulnerable and KPs as well as engaging both civil society and service providers
Active and meaningful participation in the planning and programming process	Active and meaningful participation in the planning and programming process	Both highlight critical importance of meaningful participation by vulnerable and KPs

It is clear from the Table 11 that both HRBA and LNOB are consistent with UNFPA support to HIV, with a clear focus on realizing the rights and addressing the needs of the most vulnerable and KPs. As a draft document produced in 2019, the SDG guidelines on LNOB are not yet explicitly incorporated into UNFPA support to HIV.

Rights and access for the most vulnerable are central to the reconstructed theory of change

This dual focus, realizing rights and meeting the needs of the most vulnerable, is a clear feature of the theory of change for UNFPA support to the HIV response developed during the inception phase of the evaluation and presented in Section 3.2. The intersection of realizing rights and meeting needs is explicit in the wording of one of the HIV-specific strategic outcomes in the theory of change: “Adolescents and youth, key populations and vulnerable and marginalized women are able to seek, access and receive HIV information and integrated SRHR/HIV/SGBV services free of stigma, discrimination and violence and legal safeguards to protect their reproductive rights are in place.”

There are grounds to argue (as in Section 4.1 above) that the transition from strategic plan 2014-2017 to strategic plan 2018-2021 resulted in less visibility for UNFPA efforts to support the HIV response, however the transition did not result in a diminished focus on reaching those left behind. What is less clear is the extent to which KPs are a priority in the overarching terminology of “leave no one behind and reach the furthest behind first”.⁷⁵ While KPs are among the groups that could be covered under LNOB, UNFPA has not made it clear, throughout the organization, that realizing their rights and meeting their needs is essential to the success of the HIV response and very important as a measure of successful application of an HRBA approach.

Challenges to action

The commitment by UNFPA to meeting the needs and helping to realize the rights of the most vulnerable so that no one is left behind brings up a number of challenges specific to the HIV response:

⁷⁵ Described as the “central transformative promise” of the 2030 Agenda for Sustainable Development and the associated SDGs UNSDG, 2019, Leaving No One Behind: A UNSDG Operational Guide for UN Country Teams. Interim Draft. p.6.

- In some countries, efforts to address the HIV prevention and treatment needs of KPs (especially gay men, other MSM, trans people and sex workers) are challenged by legal frameworks and rights environments, which limit their effectiveness. When working at capacity building and advocacy and policy development in countries with these challenges, UNFPA sometimes finds it difficult to be seen as unequivocal defenders and promoters of rights, especially of LNOB groups such as KPs
- Not leaving KPs behind requires a clear understanding of the barriers and challenges they face in accessing services free of stigma and discrimination. This requires engagement with service providers and service-delivery mechanisms, which is difficult in countries where the UNFPA business model emphasizes support to policy development
- While a clear understanding of barriers faced by the marginalized is essential, addressing those barriers requires meaningful participation by those otherwise left behind in the national and local dialogue on the HIV response
- In some countries, CSOs are the most readily available channel for reaching those left behind, especially KPs. However, these same CSOs may have limited national reach and face their own sustainability challenges.

UNFPA has attempted, with varying levels of success, to respond effectively to these challenges depending on the regional and national context of the HIV epidemic. These efforts illustrate the difficulty of separating the task of realizing rights and meeting the needs of the most vulnerable. At least four separate, yet intrinsically linked actions are essential to meeting the needs of marginalized and KPs. They are:

1. Effectively supporting efforts to realize the rights of marginalized and KPs
2. Supporting networks and organizations to enable meaningful participation by marginalized and KPs
3. Identifying and supporting efforts to improve HIV prevention and treatment services to increase access and reduce/eliminate barriers for vulnerable and KPs
4. Effectively supporting linking and integrating SRHR/HIV/SGBV services for greater access and reduced stigma and discrimination.

There is no prescribed or preferred sequence in the actions listed above. Rather they are mutually reinforcing. All are required to effectively support meeting the needs of the marginalized and KPs and act on the principle of LNOB.

4.2.2 Contributing to realizing rights

Members of KPs and other at-risk or vulnerable groups often experience stigma, discrimination and even sometimes criminalization when seeking SRH services. Experienced directly, this puts individuals' lives and health at risk through poor quality information, treatment and care in health facilities. In addition, personal experiences, negative reports from peers, or fears about the likely behaviour of health personnel or of being seen by community members to access certain services can effectively dissuade KPs and other at-risk and vulnerable groups from seeking care and securing their rights. These facts strongly suggest that effective UNFPA support to the HIV response requires addressing the legal framework and enabling environment for the target groups. However, since inequalities, stigma and discrimination are most often manifested at service delivery level, work in support of rights has to be grounded in and linked to experience in support of improved services (and service delivery) for the most vulnerable and KPs.

Working on rights promotion at a regional and national level

The most compelling evidence of UNFPA support to realizing the rights of the vulnerable and KPs gathered by the evaluation is found at regional and national levels. The regional and country case studies illustrate examples of UNFPA support to improvements in the legal framework and enabling environment for rights, especially adolescents, youth and KPs. They also point to some important limitations.

Across the ESA region for example, from 2014-2016, the SYP programme supported a systematic review of laws and policies in 23 countries. The review helped UNFPA to identify the key issues for advocacy and policy change, such as:

- Differences in the minimum age of consent for men and women (lower for girls)
- Lack of legal and policy provision on age of consent for medical treatment, which creates major barriers to accessing health care
- The fact that "only half of countries across East and Southern Africa have provisions to manage learner pregnancy but the majority of those countries approach it from a punitive perspective".⁷⁶

At a national level in ESA, the SYP programme 2018 annual report noted, "in Namibia, under the SYP umbrella, UNFPA participated in drafting the sections on adolescent girls, young women, condoms and key populations in the National Strategic Framework in HIV. SYP also supported the National Study on Child Marriage conducted by the Ministry of Gender Equality and Child Welfare".⁷⁷ In

⁷⁶ UNFPA, The Safeguard Young People Programme: Three Years On: Addressing the urgent needs of youth across Southern Africa. (2017), p.7.

⁷⁷ UNFPA, Safeguard Young People Programme: Annual Report, 2017, (September 2018), p.7.

addition, in Namibia UNFPA supported the development of the National Strategic Framework for the HIV and AIDS Response which identified a lack of attention to rights as a factor contributing to a negative impact on KPs and highlighted solutions required.

UNFPA Namibia also worked with key partners to address a range of the rights-related challenges facing adolescents and youth as well as the LGBTI community. Examples include: supporting the Ministry of Education, Arts and Culture (MEAC) with curriculum development and life-skills teacher education on CSE; supporting the Ministry of Youth, Sport and National Service (MYSNS) on many different aspects of CSE and in working with peer educators on youth empowerment; supporting Africa Youth and Adolescent Network (AfriYAN) Namibia and the MYSNS in "Condomize!" campaigns aimed at adolescents and youth, particularly university students; and supporting participation by organizations representing the LGBTI community in the Technical Working Group (TWG) on KPs.

Also in ESA, UNFPA Zambia has used UBRAF and *2gether 4 SRHR* programme funds to support capacity building of the Human Rights Commissioners in order "to enhance the commission's capacity to promote, protect and fulfil human rights and address the needs of people living with HIV, LGBTI-persons, key populations and other vulnerable groups".⁷⁸ This led to a National Action Plan being adopted and implemented with support from the United Nations Interagency Team in Zambia.

UNFPA Zambia also supported the local NGO Southern Africa and AIDS Information and Dissemination Service (SAfAIDS) to produce a Sex Workers' Advocacy Guide, which contains educational messages on integrated HIV and SRHR information and services for young sex workers, including topics such as HIV/STI prevention, where and how to access integrated services, contraception and safe motherhood, SGBV, getting back to school, etc. It is based on a booklet produced by SAfAIDS regional office and was adapted to a Zambian context with UNFPA funds, in collaboration with the MoH and the National AIDS Committee (NAC).

In EECA, the regional office has used the principle of bi-directional linkages between HIV and SRH to advocate for attention to, in particular, KPs. This allows the regional and country offices in EECA to advocate for a rights-based approach to the HIV response as one element in effectively addressing SRH for the most vulnerable; an approach that is more readily accepted by some national governments in the region.

UNFPA Georgia has focused advocacy on the promotion of supportive policies and strategies to secure the rights of

KPs, youth, women and girls. Efforts in support of a positive enabling environment are centred on three technical areas: HIV prevention for KPs (MSM, sex workers and YKPs); youth policy; and gender equality and rights. UNFPA Georgia has also supported an assessment by the Public Defender's Office in 2017 to evaluate the current status, gaps and challenges within and beyond the health sector on human-rights issues related to SRH and well-being, with special connection to marginalized groups, legal and policy frameworks, budgeting and financing, delivery and accessibility of health services, and the provision of remedies and redress. This was the first assessment of its kind in Georgia.

In the Asia Pacific region UNFPA Indonesia supported the development of a package to train health care providers on reducing stigma and discrimination for FSWs and, subsequently, MSM.⁷⁹ The report of the mid-term review of the UNFPA Indonesia country plan found that UNFPA had been able to advocate for increased attention and commitment to sensitive issues including provision of SRHR information to young people, although this is not considered a priority of the Government of Indonesia.⁸⁰

Perhaps as a result of this level of activity in support of the enabling environment for rights, UNFPA has gained a reputation for a commitment to an HRBA in its programming in support of HIV. The online survey of key informants found a high degree of consensus among respondents that UNFPA is effectively promoting an HRBA to HIV prevention. Fully 75 per cent of respondents either strongly agree or agree that UNFPA has "effectively promoted a human rights-based approach".

Limitations and challenges in supporting rights

The most important limitation on UNFPA work in support of the rights of the most vulnerable and KPs arises from two related problems illustrated by the case studies:

1. When UNFPA advocacy and policy work in support of rights is confined to an SRH context it can fail to address broader rights issues such as criminalization, lack of access to social support, the need for psycho-social care and even access to employment and housing. All of these issues have a direct impact on the ability of, in particular, the LGBTI community to access HIV testing, treatment and prevention services. This point was raised with some frequency by staff of organizations representing KP members.

78 UNFPA/UNICEF/UNAIDS/WHO (2018): *2gether 4 SRHR* Draft 2018 Annual Report, p. 19.

79 This became known as the IPSD programme (Indonesian acronym, translated as "implementation of reduction of stigma and discrimination"). This training is still used by the linkages project, UNAIDS, UNFPA, WHO and the national Ministry of Health.

80 UNFPA, Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to the Government of Indonesia (GOI) 2016 – 2020. Dated February 20, 2019. UNFPA. p.44.

2. Experience at country level shows that effective realization of rights through UNFPA support to the HIV response needs to be effectively linked to efforts to overcome stigma and discrimination at the point of service delivery. In some countries, this link is made more difficult because of the UNFPA business model, which excludes many countries from using core resources to support service delivery. In 2018, 76 of 121 countries reviewed by UNFPA were classified outside the “red quadrant” of the business model and thus excluded from using core resources to support service delivery.⁸¹

Influence of the UNFPA business model

Grounding rights advocacy and policy work in experience in service delivery at country level is directly affected by the UNFPA business model as modified in UNFPA strategic plan 2018-2021. The business model assigns countries to four different quadrants for allocating core resources and approving work plan activities or lines of business. There are four country quadrants and five available modes of engagement in the business model.⁸²

TABLE 12: Modes of engagement and country quadrants under the UNFPA business model (2018)

Modes of Engagement	45 Countries	16 Countries	17 Countries	43 Countries
1. Service delivery	Available	Not deployed		
2. Capacity development	Enabling environment, institutions and individuals	Enabling environment institutions and individuals	Enabling environment and institutions	Enabling environment
3. Partnerships and coordination, including South-South and triangular cooperation	Available			
4. Knowledge management	Available			
5. Advocacy, policy dialogue	Available			

(*) the red quadrant also applies to those counties with a humanitarian crisis

The service delivery mode of engagement encompasses procurement of reproductive health commodities, support to demand-creation activities (including campaigns), and rebuilding facilities and portions of facilities. Countries are assigned to quadrants based on indicators of financial capacity (gross national income per capita) and of need (maternal mortality ratio, proportion of births attended by skilled health personnel for poorest quintile of population, adolescent fertility rate, proportion of demands satisfied by modern contraception, gender inequality index and HIV prevalence rate).⁸³

The case study countries for the evaluation cover all four quadrants of the business plan. In 2018, Zambia was classed in the red quadrant and Namibia in the orange, while Indonesia and Georgia were classed in the yellow quadrant. Only Turkey was allocated to the pink quadrant, despite the presence there of a large body of Syrian refugees.⁸⁴

Perhaps more important than the assignment of modes of engagement across the four quadrants is the effect of the business model on the allocation of UNFPA core resources. The resource allocation model assigns highest priority to countries in the red quadrant.

81 UNFPA, UNFPA strategic plan 2018-2021: Annex 4 Business model, p.8.

82 UNFPA strategic plan 2018-2021: Annex 4: Business model, p.12.

83 UNFPA, 2018, Business model, p.15.

84 UNFPA, 2018, Business model, p.23.

TABLE 13: Resource allocation by quadrant

	45 Countries	16 Countries	17 Countries	43 Countries
Share of core resources	56-60%	14-18%	7-11%	15-17%
Share of population	21%	29%	9%	41%

UNFPA country offices are allowed some flexibility in the application of the business model. In countries that were not classified in the red quadrant but are undergoing a humanitarian emergency, country offices are permitted to programme activities such as support to service delivery. Similarly, country offices can access funds from other development partners to finance a full range of support. This is the path that allowed UNFPA ESARO and the relevant country offices to directly fund capacity development for individual health workers under the *2gether 4 SRHR* programme.

As UNFPA country offices try to link work on the legal framework and enabling environment for rights to practical experience in support to service delivery, the business model represents a constraint in all but the red quadrant countries. Among the evaluation case study countries this limiting effect is most pronounced in Georgia (Yellow) and Turkey (Pink) because of the very low level of non-core resources available in the EECA region. For EECA countries, UBRAF funding is very low and there are no large regional programmes funded from non-core resources. This was noted by key stakeholders interviewed in both countries, with particular emphasis on experience in Turkey. It was also noted as a constraint in Indonesia, with particular reference to financing.

Countries in the ESA region experience some constraints, but these are lessened in countries like Namibia (Orange) because of access to large-scale, multi-country projects funded by non-core resources. These funding sources have allowed, for example, Namibia to support aspects of service delivery that would not normally be funded in a country in the orange quadrant of the business model. This includes, for example, supporting capacity development for individual health sector workers (rather than, for example, curriculum development) and behaviour change communications and demand creation through “Condomize!” campaigns, which would normally only be possible in countries in the red quadrant.

Other constraints and limitations on work to promote rights

There are also constraints and limitations to UNFPA work to realize the rights of the most vulnerable and KPs, which are not related to the UNFPA business model. These include:

- In EECA generally, and specifically in both Georgia and Turkey, there is a difficult policy environment for raising issues and advocating for the rights of KPs,

especially sex workers and the LGBTI community. In both countries (and in the regional generally), UNFPA has responded by linking rights promotion for most vulnerable and KPs to broader initiatives in SRH.

- In Indonesia, UNFPA efforts to promote rights have reportedly been deflected by the national policy environment or diluted somewhat in the quantity and quality of rights-based content. For example, throughout the period covered by the evaluation, UNFPA Indonesia supported the National Population and Family Planning Board to strengthen “rights-based family planning”. However, respondents report that in the current socio-political context “rights-based” in the family planning system refers to “rights of married couples to reproductive health commodities and services” and not SRHR or rights-based service provision for members of KPs.
- UNFPA Indonesia supported the pilot of UNALA (in Sanskrit, “your ability to make decisions”), a civil society, private-sector initiative on adolescent SRH, which seeks to provide clients with information and facilitate access to SRH services. However, the pilot was developed without a strong rights-education approach. It is not empowering young people to understand and demand their rights related to SRH, rather it is simply providing reproductive health information.
- In Namibia, UNFPA has had considerable success in supporting the development of rights-focused material for adolescents and youth in the national CSE curriculum. Further, the curriculum directly addresses SRHR issues, including the rights of LGBTI learners. At the same time, however, the effect of this curriculum can be limited because it is taught in life-skills classes, which are not subject to examination and may not receive the same resources as other subjects.
- In Namibia, while professionals responsible for health and education services are comfortable with the principle of non-discrimination, their acceptance of the rights agenda does not necessarily extend, with some exceptions, to the recognition of the rights of KPs to SRHR as a right in and of itself.

The challenges faced by UNFPA Indonesia, illustrates a context in which UNFPA finds it difficult to advocate vigorously for human rights, including SRHR. Country office staff report that they can use generic phrases such as

“human rights” and “rights-based approaches” in discussions with the Government. However, they find that more specific aspects of human rights, especially sexual rights and many of the most basic practical implications of adopting a rights-based approach, are extremely difficult to raise with national authorities without damaging partnerships.

This illustrates a real dilemma for UNFPA rights promotion in Indonesia. On the one hand, there is clear demand from civil society partners and some United Nations agency peers for UNFPA Indonesia to be more active and more vocal on rights, particularly the rights of KPs. For example, respondents from CSOs in Indonesia argued that “UNFPA must be brave to talk to the government” and that “advocacy has become completely reactive. It is now all about harm reduction, not about the positive changes we would like to see”. However, on the other hand UNFPA knows that efforts to be more vocal in advocating for SRHR for the most vulnerable and KPs will not be well received by government partners and may even result in damaging the partnership.

Rights promotion at global level

At global level, the evaluation has limited evidence of UNFPA effectiveness in rights promotion for the most vulnerable and KPs. However, the UNAIDS Division of Labour is a strong indication that Cosponsors recognize a comparative advantage for UNFPA in addressing the needs of KPs. In addition, the UNFPA HIV team at headquarters note considerable activity in support of advocacy for rights in an HIV context, including hosting or presenting at events in multiple international forums and the development of special implementation tools for MSM, sex workers and transsexual people. Interviews with global stakeholders within and outside the UNAIDS consortium also indicate that these organizations value UNFPA leadership in realizing the rights of KPs but would gladly accept a more active occupation of this space by UNFPA.

Some examples of this perspective from CSOs operating at global level include:

- “They (UNFPA) must demonstrate the commitment to not leaving anyone behind. They must focus on KPs and raise issues for KPs with governments. They need to tackle criminalization and all the big issues for KPs – access to services and rights, link between KP care and SRHR and all that. They have privileged access to government so they must use that to do what CSOs find it harder to do.”
- “We don’t see UNFPA very often at the global meetings and I don’t hear loud statements from them on rights issues.”
- “They (UNFPA) are criticized for lacking teeth when they talk about issues such as HIV and KPs. We need them to have a moral and political stance on rights and they must not be fearful.”

4.2.3 Meeting the needs of the most vulnerable and disadvantaged

As noted above, UNFPA faces challenges and limitations in promoting the rights of the most vulnerable and KPs in the context of the HIV response. Nonetheless, the evaluation found that UNFPA regional and country offices were supporting important efforts to promote those rights in every region and country studied. Efforts to address the policy and legal framework and the enabling environment for rights provide the context for the way in which UNFPA contributes, at the programme and service levels, to meeting the needs of the most vulnerable and of the KPs.

In the ESA region, support to KPs draws on the resources of large, multi-country projects

In the ESA region, UNFPA has consistently supported efforts to address barriers to services, improve access and address stigma and discrimination at both regional and national levels. At regional level the SYP programme proved particularly effective in reaching marginalized young people through support to out-of-school CSE and the use of a mobile, web-based platform “Tune Me”. The regional office also seeks to improve access for young people with disabilities in the *2gether 4 SRHR* programme and has worked with partners on:

“A number of regional and global frameworks ... drafted to secure the rights of KPs, including the SADC Regional Strategy on HIV Prevention, Treatment and Care and SRHR Among Key Populations... and the Resolution on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity by the African Commission on Human and Peoples’ Rights.”⁸⁵

As UNFPA works to strengthen targeted efforts to meet the needs of the most vulnerable and KPs across the ESA it draws on two considerable strengths: a) the existence of strong and active regional mechanisms and partner CSOs and b) access to external resources for regional and multi-country programmes aimed at improving services for specific target populations.

The effect of these two large programmes is evident in Namibia, where UNFPA has worked with partners to identify and meet the SRHR/HIV/SGBV needs of adolescents and youth (including the need for effective prevention services, access to condoms and empowering information and knowledge). UNFPA has used the *2gether 4SRHR* programme (and its predecessor) as a mechanism to improve HIV and SRHR services to meet the needs of KPs mainly by engaging with government and supporting

85 UNFPA ESARO (2019). Annual Planning Meeting for the *2gether 4 SRHR* Programme. 21–25 January 2019. Johannesburg, South Africa, 9.

CSOs working on issues of most relevance to the LGBTI community.

UNFPA Namibia has also been actively involved in the SYP programme, focusing on the needs of adolescents and young people. Further, it has supported their partner, Society for Family Health (SFH), in training nurses on how to address the needs of KPs and has most recently been accessing separate funding through the headquarters of UNICEF, UNDP and UNFPA for a planned joint programme on young people with disabilities.

In Zambia, UNFPA supported development of policies and strategies that prioritize integration for adolescents and KPs, including draft National Guidelines for Comprehensive HIV Package for Key Populations, the National Adolescent Health Strategic Plan 2017-2021, National Guidelines and Standards for Adolescent Friendly Health Services. UNFPA Zambia also supported the development of a range of implementation guidelines with a focus on reaching the most vulnerable, including KPs. These include a clinical handbook on SGBV and guidelines on the use of HIV pre-exposure prophylactics (PrEP) and HIV self-testing. Addressing the needs of KP communities in Zambia is made more effective by the positive attitude of the Government of Zambia, which recognizes the need to improve services for KPs and creates a favourable environment for development partners to implement programmes.⁸⁶

Outside ESA, UNFPA uses different approaches to meet the needs of the most vulnerable and KPs

In EECA, UNFPA is not able to draw on large-scale multi-country projects with external funding to provide targeted support in order to meet the needs of the most vulnerable and KPs. UNFPA EECARO has responded to this challenge by ensuring that the results identified in the Regional Intervention Action Plan (RIAP) are organized according to outcomes explicitly targeting women, youth, adolescents and “strategic interventions that focus on ensuring benefits for the most vulnerable and marginalized”. UNFPA EECARO has also partnered with the International Planned Parenthood Federation (IPPF) across eight countries to “gather evidence, develop action plans and encourage the direct engagement of young key populations in increasing their access to HIV and SRHR services”.

This approach is reflected in the work of UNFPA Georgia, as it has engaged in policy and advocacy efforts in support of a positive enabling environment focused on HIV prevention for KPs (MSM, sex workers and YKPs), youth policy, and gender equality and rights. Programming interventions, in turn, have focused on strengthening the quality of SRH and HIV preventive interventions for KPs through

the introduction of the UNFPA implementation tools for sex workers, MSM and transgender people. UNFPA EECARO reports that this collaboration also resulted in the development of new regional guidelines in 2018: “Health, Rights and Well-Being: a Practical Tool for HIV and SRH Programmes with Young Key Populations in EECA”.

In the Asia Pacific region, UNFPA Indonesia support to HIV prevention provides an example of a programme mainly focused on the implementation of a large-scale test and treat programme for FSWs. UNFPA Indonesia has also provided valuable long-term support to Organisasi Perubahan Sosial Indonesia (OPSI), the sex worker network organization. This is aligned with the Division of Labour agreed in-country, by which United Nations agencies are each allocated a KP group as a focus for their efforts in HIV prevention and treatment, which in the case of UNFPA, is FSW.

The difficulty with the agreed JUNTA Division of Labour in Indonesia concerns the prevention needs of MSM and the transgender community, which are the responsibility of the United Nations Development Programme (UNDP). Recent reports highlight the needs of MSM as a group with a higher prevalence rate and larger population size than FSW. They also note that the prevention needs of MSM are not being met. As a result, UNFPA has missed an opportunity in Indonesia to deliver on its global mandate for HIV prevention for KPs and to secure LNOB.

4.2.4 Supporting meaningful participation

Supporting networks and organizations to enable meaningful participation by the marginalized and KPs is a key element of the UNFPA effort to realize the rights and meet the needs of the most vulnerable and KP communities. This requires clarity on how to distinguish “meaningful” participation from proforma consultation. The fundamental principles of meaningful participation are captured in the UNFPA strategic plan 2018-2021, in this case in reference to young people:

“UNFPA will promote and support the fundamental right of young people to participate in civil and political life. This will empower them to play a vital role in their own development and in that of their communities. This will be achieved by supporting local, youth-led initiatives and organizations that promote the equal participation of diverse young men and women, including those with disabilities and by creating partnership platforms for young people’s participation in the development agenda, including in humanitarian action and in sustaining peace and security.”⁸⁷

⁸⁶ A comprehensive list of key populations was included in: National HIV/AIDS/STI/TB Council, 2017, *National HIV and AIDS Strategic Framework (NASF) 2017 – 2021*.

⁸⁷ UNFPA strategic plan 2018-2021. p.14. See also: UNAIDS, 2007, *The Greater Involvement of People Living with HIV and AIDS, Policy Brief*.

Supporting meaningful participation at country level

The most direct evaluation evidence on UNFPA support to meaningful participation, as defined in UNFPA strategic plan 2018-2021, comes from the national level as captured in the country case studies. The overall pattern is one of differing levels of participation and differing success in UNFPA support.

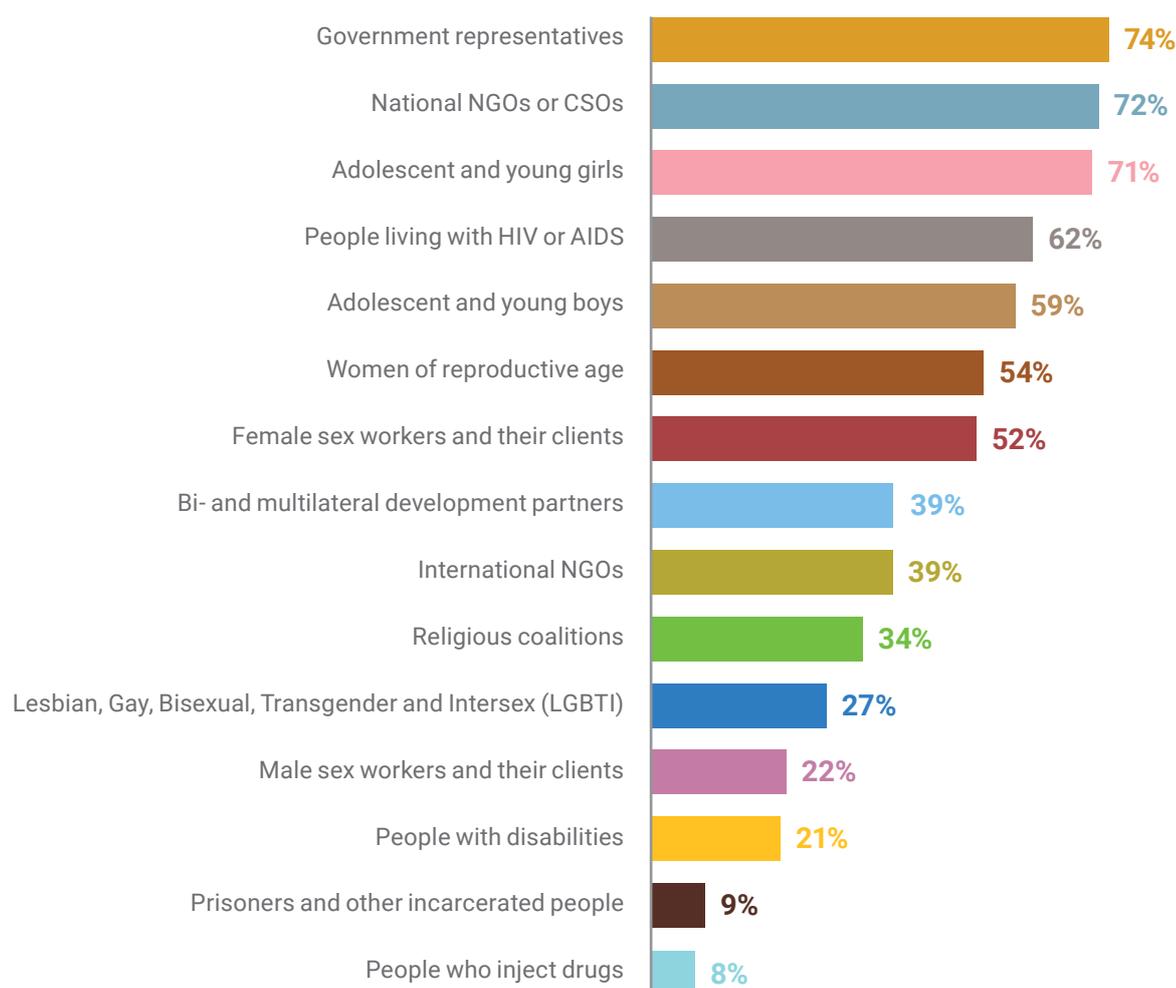
In Namibia, UNFPA was able to use the SYP programme and the *2gether 4 SRHR* programme to engage with and support networks and CSOs to help create space for what they themselves assess as meaningful participation in the national dialogue on an effective HIV response. In particular, staff of CSOs representing the LGBTI community in Namibia report that UNFPA has been a “pioneer” in advocating for their engagement in the national dialogue on HIV. They also note, however, that engagement with the Ministry of Health and Social Welfare (MoHSW) while important, does not address critical issues for the community outside the scope of health services. Addressing these issues would require engagement with, for example, the Ministry of Justice.

The networks and organizations supported by UNFPA in Namibia also raise important issues of capacity development and sustainability over time. While UNFPA Namibia is able and willing to fund activities and to support their participation, it does not appear to have the funding required to support longer term capacity development for its partners. This raises the question of whether the CSOs supported by UNFPA can sustain their activities and effectively take part in networks and partnerships in light of their dependence on diminishing sources of external finance.

UNFPA Georgia has also supported efforts to ensure meaningful participation by target group members including sex workers, MSM and YKPs. This was done by ensuring wide participation by stakeholders from community organizations, NGOs and state programme providers in the development of important packages of standards of HIV care and treatment for these groups. As one example, the UNFPA partner Tanadgoma works to ensure meaningful participation by KPs in service design and implementation using approaches from the UNPA implementation tools for MSM, sex workers and YKPs.

In its role as a Global Fund subrecipient, UNFPA Indonesia has developed close relationships with several key actors in the nation’s HIV programme. In particular, it has built the capacity of the sex worker network organization OPSI to engage at the national level in policy dialogue and advocacy. A representative of OPSI stated “UNFPA really put us in a strategic position. They really empower us and involve us. They know the Ministry of Health really wants us to be involved and they make that happen”. However, the concentrated focus of UNFPA Indonesia on the Global Fund-financed FSW programme has limited its ability to develop partnerships with other coalitions or networks of KPs.

The online survey at country level identifies the specific types of networks and organizations supported by UNFPA to achieve more meaningful participation for key stakeholders in policy debates, programme design, fundraising and advocacy. Not surprisingly, given active UNFPA support to national authorities, the most frequently noted category was government representatives at 74 per cent, followed by national NGOs and CSOs. Much less frequently cited was support to organizations representing specific groups of KPs, including the LGBTI community (27 per cent) male sex workers (MSW) at 22 per cent and people with disabilities at 21 per cent. Nonetheless, it seems significant that between a fifth and a third of respondents felt that UNFPA was effectively supporting meaningful participation by these groups. When asked to identify UNFPA strategies and actions in support of participation, the respondents listed: direct financial support; assistance with fundraising; creating space for civil society in the national debate on HIV and building organizational capacity.

FIGURE 6: Online survey: UNFPA effectively supports meaningful participation by these groups

The online survey also asked respondents at country level if they agreed that UNFPA support to networks, coalitions and partnerships has resulted in more and better joint policy development or programming on HIV prevention at national level. The response to this question was very positive with 76 per cent of respondents answering they either agreed or strongly agreed.

Supporting networks for participation at regional level

The work of UNFPA to support key stakeholders to achieve meaningful participation is ongoing and faces some important challenges, some illustrated above. The role is most challenging in countries where space is restricted for civil society to operate freely and/or there is limited space for open debate on matters deemed politically or morally sensitive. In such cases, UNFPA support is especially valuable and can prove highly effective at country level or, if necessary, by raising the debate to regional level where stakeholders can tackle difficult issues in a more open environment.

At regional level, UNFPA EECARO has worked in a catalytic

manner to build the capacity of networks to raise their own money and hence more actively participate in policy dialogue and advocacy. In 2019, EECARO was working closely with five main networks developing their capacities to address HIV in the region.⁸⁸ In ESA, UNFPA regional office has been effective at forging partnerships and working with networks to develop regional strategies, frameworks, guidelines and training modules on critical aspects of the HIV response. ESARO has provided significant support to AfriYAN, a network comprising networks of youth-led organizations, to undertake capacity building in all 21 countries of the region with 42 different organizations. The goal of AfriYAN is to bring the SRHR component into the work of their member networks. The regional office has also provided support to the SADC Parliamentary Forum (PF) as it works with parliamentarians in the region to promote actions to address the needs of adolescents, youth and KPs.

⁸⁸ Eurasian Coalition on Male Health, Sex Workers Advocacy Network, Eurasian Women's Network on AIDS, Eurasian Harm Reduction Association and IPPF.

4.2.5 Promoting gender equality

The UNFPA strategic plan 2018-2021 outcomes clearly assign a strong priority towards securing gender equality and the empowerment of women and girls. Attention to gender is also specifically linked to HIV with regard to young people, especially girls. UNFPA strategic plan 2018-2021 confirms that “a focus on girls during early adolescence is critical ... [as] such investments will lead to [...] lower HIV prevalence”.⁸⁹ It also promises to “engage men and boys to advance gender equality and women’s empowerment” and “ensure that men and adolescent boys have opportunities [...] to challenge harmful notions of masculinity and promote gender equality”.⁹⁰

UNFPA support to gender equality at country level

In all of the case study countries there are examples of UNFPA supporting policies and programmes aimed at improving gender equality among girls and young women and (specific to HIV) meeting the needs of women and girls in HIV prevention and treatment.

UNFPA Zambia, for example, implements a programme to fight child marriages, which integrates HIV prevention and SRHR, and UNFPA Georgia is collaborating with UNDP and UNWOMEN on a Sida-funded project to support policy, institutional and grassroots level interventions to promote gender equality. For UNFPA in Namibia, the SYP programme, with its focus on CSE and engaging adolescents and youth through social media, has been an important vehicle for addressing SGBV. Similarly, UNFPA Indonesia has collaborated with UNWOMEN to ensure that awareness of SGBV and required services to address it are integrated into the intimate partner notification model they are developing with partners in government and civil society. As part of the humanitarian programme operated by UNFPA Turkey, UNFPA has supported the Positive Living Association and the Red Umbrella Sexual Health and Human Rights Association to provide service units for refugees offering access to SRH services for vulnerable refugees, especially women and adolescent girls (including sex workers and other KPs), as well as addressing SGBV.⁹¹

As illustrated above, country offices are able to identify points of convergence between supporting the response to HIV and working to improve gender equality. These include:

- Supporting the development and use of a curriculum for CSE that deals frankly with issues of consent and the protection of girls and young women from SGBV (and the risk of HIV infection)

- Supporting and advocating for effective action to combat early marriage
- Supporting research and data gathering and analysis on the extent and effects of SGBV
- Supporting efforts to eliminate barriers to SRHR and to HIV prevention and treatment services for girls and young women
- Linking and integrating services in SRHR/HIV/SGBV.

The evidence from the regional and country case studies indicates that, at the very least, government and civil society partners view UNFPA as an effective partner in addressing these issues and approaching HIV through the lens of gender equality.

Challenges, limitations and the essential need to address SGBV

Like all its partners, UNFPA faces some important challenges in approaching gender equality generally and, more importantly, through an HIV prevention and treatment lens.

For example, effectively supporting CSE as a means of empowering girls and young women (including the most vulnerable among them) requires agility in navigating resistance and ensuring effective use of the curriculum. In Namibia, the issue has been ensuring that teachers in life-skills classes give adequate attention to the curriculum. In Indonesia, teachers and religious leaders have successfully resisted including segments of the curriculum addressing issues of sexual orientation and gender identity. In Georgia, there is no comprehensive and compulsory programme of age-appropriate life-skills/sexuality education; existing courses focus on biological aspects of reproduction and do not address critical issues such as harmful gender stereotyping and SGBV.

Similarly, efforts to improve access for girls and young women to SRH services may encounter strong resistance from health workers at the point of service delivery. In Namibia, UNFPA faces continuing difficulties with the values and attitude of some health services staff that combine to discourage access to HIV prevention and treatment services for adolescents and youth and KPs, especially the LGBTI community. There can also be conflicting approaches to empowering girls and young women promoted and supported by different development partners in the same country. In Namibia, the strong CSE initiative supported by UNFPA has been contrasted to a more abstinence-based approach to HIV prevention advanced and supported by the United States Agency for International Development (USAID) under its Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe Young Women (DREAMS) Programme.

Finally, there is both a challenge and an opportunity for UNFPA and its efforts to promote gender equality through

89 UNFPA strategic plan 2018-2021. p.13.

90 UNFPA strategic plan 2018-2021. p.15, 13.

91 This initiative operates with the financial support of European Union Civil Support and the Humanitarian Aid Office.

support to the HIV response in the area of SGBV. Interviews with key stakeholders and site visits during the field-based country case studies, especially Namibia, highlighted the very strong link between SGBV and HIV infection among adolescent girls and young women. UNFPA has already helped to research this link at country level (in Namibia it did so through giving support to the Ministry of Gender Equality

and Child Welfare). UNFPA also directs considerable effort towards supporting linking and integrating SGBV with HIV and SRHR services at national level. For UNFPA, combating SGBV, especially against adolescent girls and young women, could be the single most important point of convergence between addressing gender equality and supporting the HIV response.

4.3 LINKING AND INTEGRATING SRHR/HIV/SGBV

Summary

UNFPA is clearly committed to a strategy of promoting bi-directional linkages between HIV and SRHR at global, regional and national levels. It also focuses strongly, especially at regional and national levels, on promoting and supporting the integration of SRHR, HIV and SGBV services to improve access for marginalized, at-risk persons and members of KPs. At national level, UNFPA has contributed to achieving quality, client-centred services at health facilities level. Yet, efforts to build on pilot tests and to scale integration of SRHR, HIV and SGBV services to national level face significant institutional and operational challenges. Furthermore, the operational experience UNFPA has gained, in particular, at the regional and national levels in ESA does not sufficiently inform its advocacy work at global level. There is also a gap in UNFPA support to improving supply chain management for condoms for HIV prevention and in support to CCP, which is most acute in middle and upper middle-income (UMIC) countries not served by the UNFPA Supplies Programme.

For details of the evidence supporting findings in Section 4.3, see the evaluation matrix (Annex 1): Assumptions 1.1 to 1.7.

4.3.1 The UNFPA commitment to linking and integrating SRHR/HIV/SGBV

UNFPA has made a clear commitment and developed a significant history of support to bi-directional linkages (in policies, systems and communities) between services aimed at addressing HIV and SRHR. In recent years, this has been broadened to include linking HIV and SRHR to efforts to address SGBV. In some regions and countries, for example in ESA and the countries participating in the *Together 4 SRHR* programme, this commitment has gone beyond supporting linkages to promoting and supporting the full integration of SRHR, HIV and SGBV services.

The UNFPA commitment to linkage and integration at an organizational level is illustrated by the following examples:

- UNFPA strategic plan 2018-2021 promises that “UNFPA will focus first on increased utilization of

integrated sexual and reproductive health services and reproductive rights for those who are furthest behind”, based on a belief that “improving the integration of sexual and reproductive health and HIV programmes could better meet diverse HIV prevention needs”.⁹²

- Output number 2, of Outcome 1 of UNFPA strategic plan 2018-2021 commits UNFPA to achieve “strengthened capacities to provide high-quality integrated information and services for family planning, comprehensive maternal health, sexually transmitted infections and HIV”.⁹³
- Strategic Result Area 8 of UNAIDS UBRAF commits UNFPA specifically to “continue to promote the integration of sexual and reproductive health and rights services and HIV services by strengthening policy, systems and service delivery linkages”.⁹⁴

92 UNFPA strategic plan 2018-2021. pp. 10 and 9.

93 UNFPA, United Nations Population Fund: UNFPA strategic plan, 2018-2021: Annex 1, Integrated results and resources framework. 2017, p.13.

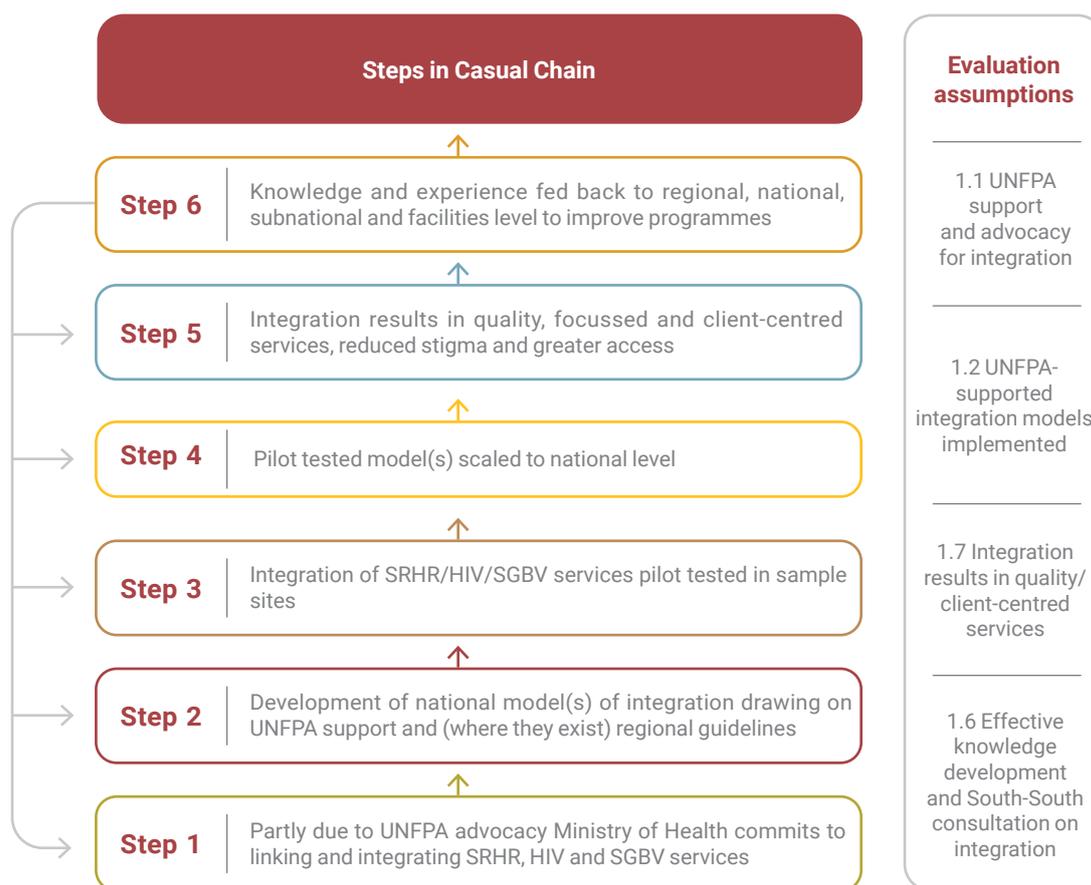
94 UNAIDS, UNAIDS 2018-2019 Budget, June. 2017, p.28.

- Under the UNAIDS Division of Labour, UNFPA is the Cosponsor, along with WHO, most directly linked to fast-track commitment number ten: taking HIV out of isolation through people-centred approaches. It does this by taking on the role of co-convening the UNAIDS Division of Labour area for: “Decentralization and integration of sexual and reproductive health and rights and HIV services”.⁹⁵
- UNFPA serves as co-chair with WHO of the Inter-Agency Working Group (IAWG) on linking SRHR and HIV.
- In the reconstructed and comprehensive theory of change for UNFPA support to the HIV response, developed by the evaluation team and presented in Section 3.2, linkage and integration of SRHR, HIV and SGBV services feature at every level of the chain of effects from activities and investments, through to outputs and outcomes.

The central role of linkage and integration was also highlighted to the evaluation team during discussions with UNFPA staff at global, regional and country levels. As a member of the headquarter HIV team pointed out: “Linking and integration of HIV into/with SRHR across policies and other UNFPA organizational mechanisms and into service delivery is a key part of our ‘strategy’ for supporting the HIV response. Integration is not just an end in itself. It is a matter of looking at clients as individuals with needs, not as an infection or a disease.”

Causal links in the process of integrating SRHR/HIV/SGBV
 In order to examine how UNFPA has supported linkage and integration of SRHR, HIV and SGBV services at all levels, the evaluation team developed a simplified model of the causal chain for integration from the level of advocacy to quality, client-centred integrated services.

FIGURE 7: Simplified causal chain for integration of SRHR/HIV/SGBV



95 UNAIDS, UNAIDS Joint Programme Division of Labour: Guidance Note 2018. 2018, p.13.

4.3.2 Varied approaches to advocacy for linkage and integration

UNFPA has been a consistent advocate for linkage and integration at global level during the evaluation period. Key informants interviewed at global level agreed that: a) linking and integrating SRHR, HIV and SGBV programmes and services is an essential strategy for taking HIV out of isolation, improving access and overcoming stigma; and b) UNFPA has consistently advocated for integration in the global forums on HIV strategies and programming. However, some staff of international CSOs and donor agencies at global level feel that the overall UNFPA-delivered message on linkage and integration of SRHR/HIV/SGBV is too general. According to them, it lacks specifics on those key challenges (as well as the good practices for overcoming them) needed to secure the benefits of linkages and integration at both the strategic and operational levels.

It is important to note that UNFPA has long been active in developing and promoting tools for assessing the quality of linkages and the level of integration in a specific health system. As a co-convenor along with WHO and IPPF, UNFPA has long supported the work of the IAWG on SRH and HIV linkages. As early as 2005, this group produced guidelines on linking SRH and HIV⁹⁶ and ultimately published a compendium of indicators and assessment tools (2014).⁹⁷ Within the evaluation period, the most notable work of the IAWG was the development and publishing (2016) of a series of “infographic” reports on linkage and integration in 25 different developing countries. These reports assessed the level of linkage and integration in each country using a detailed set of indicators from four main headings: the enabling policy and legal environment; integrated service delivery; focus on adolescents and youth; and focus on KPs.⁹⁸

The opportunistic case for integration

UNFPA regional offices in EECA and ESA have responded to the very different regional contexts of both the HIV epidemic and regional and national political realities by adopting very different approaches to advocacy for linkage and integration. In EECARO, the regional strategy has been opportunity-based and focused on finding opportunities for promoting linkages between SRHR/HIV/SGBV policies and programmes wherever it supports specific actions in response to HIV. The most important thematic umbrella for these efforts has been commitments by EECARO to outcome level results for adolescents and youth. This can involve linking with,

for example, the CSE advisor in UNFPA headquarters in the development of support to adolescents and youth. In general, the EECARO strategy can be characterized as a commitment to advocate for the integration of actions to respond to HIV into policies, plans and programmes aimed at other aspects of SRHR. These include, revision of health sector policies and protocols, working with youth and adolescent KPs, CSE, emergency obstetric and new-born care (EmONC), maternal death surveillance and review (MDSR), and adolescent and youth-friendly health services.

This “opportunistic” strategy of advocating and supporting linkage and integration on the part of EECARO is appropriate given the very limited personnel and financial resources available to UNFPA in the region (with no UBRAF funds allocated for programming - although UBRAF does co-fund some salaries, including the UNFPA HIV advisor in EECA). It is also realistic in light of the post-soviet, largely vertical and ‘siloed’ health systems prevalent in many countries in the region (including Georgia) and national governments that are reluctant to be seen to be addressing the rights component of SRHR and meeting the needs of KPs.

An exception to the opportunistic strategy for supporting linkage and integration on the part of EECARO arises from the large humanitarian emergency facing Turkey as it deals with both in-country refugees and cross-border operations for displaced persons in Syria. UNFPA support to the HIV response in humanitarian situations often includes support to the Minimum Initial Services Package (MISP), which directly promotes linkage of HIV services with the broader SRHR and SGBV agendas. In fact, humanitarian situations that normally feature large, forced population movements are, invariably, accompanied by increased levels of SGBV, which argues strongly for ensuring that efforts to address HIV and SRHR do not result in a neglected response to SGBV. The Indonesia case study also notes that UNFPA Indonesia supported the development of operational guidance for the MISP for reproductive health during humanitarian crises and that these services encompassed HIV prevention and treatment as well as efforts to address SGBV.

A multi-year regional approach to integration

The regional strategy used by UNFPA ESARO for advocating and supporting linkage and integration in ESA is much more forceful and direct than in other regions, based largely on two factors:

- A strong partnership relationship between ESARO and SADC, especially, the SADC sub-committee of health ministers and the SADC Parliamentary Forum
- Engagement in co-management of two large-scale, multi-country and sequential projects supporting linkage and integration in ten countries in the region.

The Joint UNAIDS, UNFPA Linkage Project 2011-2017, covered seven countries and focused on: i) linking SRHR/HIV and SGBV in policies, strategies and operational plans,

96 WHO, UNFPA, IPPF, UNAIDS, “Sexual and Reproductive Health & HIV/AIDS A Framework for Priority Linkages”, 2005. Accessible at: http://srhhivlinkages.org/wp-content/uploads/2013/04/frameworkforprioritylinkages_2005_en.pdf.

97 IAWG for SRH and HIV Linkages, IPPF, UNFPA, WHO, “SRH and HIV Linkages Compendium: Indicators and Related Assessment Tools”, 2014.

98 IAWG for SRH & HIV Linkages, IPPF, UNFPA, WHO, “HIV AND SRHR LINKAGES INFOGRAPHIC SNAPSHOT NAMIBIA 2016, p.2-7. Accessible at: http://srhhivlinkages.org/wp-content/uploads/HIVSRHRInfographicSnapshot_Namibia_final.pdf.

ii) piloting the provision of integrated SRHR/HIV and SGBV services and iii) documenting best practices.⁹⁹ In 2018, the linkages project was succeeded by the *2gether 4 SRHR* programme intended “to expand, scale up and consolidate gains from the first phase of the regional integration project”.

The *2gether 4 SRHR* programme is a joint, four-year, USD 45 million programme administered by UNFPA, UNAIDS, UNICEF and WHO and is funded by the Government of Sweden. The programme has five “focus” countries (Lesotho, Malawi, Uganda, Zambia and Zimbabwe) supported by all four partners in addition to five countries with a more established track record in integration, which are supported by UNFPA only (Botswana, Eswatini, Kenya, Namibia and South Africa).

Advocacy work by ESARO can also be linked back to products and initiatives of the UNFPA-supported IAWG on linkages and integration at global level. These include the development, in 2009, of a tool for the rapid assessment of SRHR and HIV linkages: subsequently applied in 30 countries, including Botswana, Lesotho, Malawi, Namibia, Zambia and Zimbabwe. The Namibia assessment report recommended the development of a strategy for linking and integrating SRHR and HIV, including strong advocacy and communications on HIV and SRHR linkages and integration.¹⁰⁰ Throughout the history of the two projects on linkages and integration, UNFPA ESARO has been recognized in participating countries as a strong advocate at regional and national levels for integrating SRHR, HIV and SGBV services.

Advocacy for integrating SRHR, HIV and SGBV in ESA has been made more effective by the UNFPA strategy of partnering with SADC and the EAC to develop regional commitments, strategies and guidelines that can serve as effective advocacy tools. One of the most important tools has been the development, in 2015, of regional standards for the integration of HIV and SRHR, which encompass national policies, laws, guidelines, operational plans, implementation planning, and human and financial resources. Most importantly perhaps, the SADC minimum standards also cover requirements at the facilities level, including minimum service packages for SRH, HIV, STIs, SGBV, antenatal care (ANC) and family planning.¹⁰¹

As noted by staff of ESARO, regional strategies and guidelines adopted by SADC (and model bills passed by the EAC) become aspirational documents for ministries of health in the region. Technical and senior management staff of ministries of health can use these documents (with support from UNFPA staff from regional and country offices) to advocate for changes in policies, laws and programmes at national level. There is evidence from both the Namibia¹⁰² and Zambia¹⁰³ case studies that the ESARO and UNFPA Namibia and Zambia have been active in using these advocacy tools at both regional and national levels. As a staff member in the MoH of Namibia noted, “UNFPA was the first and most consistent advocate for integration of HIV and SRHR among the United Nations family members (and bilateral development partners) in Namibia”.

Receptiveness of national health authorities to SRHR/HIV/SGBV integration

Turning from the regional to the national level, there is a very different pattern of UNFPA engagement in advocacy for, and direct support to, linkage and integration across the case study countries. As noted in the case studies of both Georgia and Turkey, national policies and priorities in the health sector constrain the ability of each UNFPA country office to advocate strongly for integrated service delivery. In the case of Georgia, this is partly because the HIV response is delivered through a state-run programme within a highly vertical system of public health delivery. This limits the feasibility of linking HIV and SRH services, but some opportunities do arise. For example, under the national Maternal and Neonatal Health strategy, counsellors refer patients to vertical HIV services based on perceived need, but voluntary testing and counselling (VTC) for HIV can be linked into ANC services.

Table 14 summarizes both the degree of engagement by the UNFPA country office and the receptiveness of national health authorities to these messages in the three field-based case study countries (where the evaluation team was able to crosscheck and triangulate evaluation information on advocacy efforts).

99 UNFPA/UNICEF/UNAIDS/WHO (2017): Strengthening SRHR/HIV and SGBV services in East and Southern Africa (ESA) to accelerate action on Sustainable Development Goals (SDG) 3 and 5 - A Joint United Nations (UN) Regional Proposal. P.2.

100 IPPF, UNFPA, WHO, UNAIDS, “Namibia: Rapid Assessment of Sexual and Reproductive Health and HIV Linkages, 2011, p.2.

101 Southern Africa Development Council, “Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region, 2015, p.22-26.

102 Inter-Agency Working Group on HIV and SRHR Linkages, HIV and SRHR Linkages Infographic Snapshot Namibia, 2016.

103 Inter-Agency Working Group on HIV and SRHR Linkages, “HIV and SRHR Linkages Infographic Snapshot: Zambia, 2016.

TABLE 14: UNFPA support to integration of SRHR/HIV/SGBV in three countries

Field case study country	Level of UNFPA engagement	Supported by regional strategy	Receptive national government	Resulting policy and programmatic investments
Georgia	Moderate – using technical assistance in SRHR as an opportunity to explore and promote linkage	Opportunistic	Open on a case-by-case basis but not systematically	Small-scale investments based on extreme resource constraints
Indonesia	Formally committed to linkage in the Country Programme Action Plan but little follow through	Not evident	Unknown and limited – lacks a national strategy for integration and linkages	Not evident
Namibia	High level of engagement – seen as a pioneer	Systematic and sustained	Clear commitment in strategic frameworks, policies, guidelines and programmes	Large scale programmatic investments and operational commitments
Note on humanitarian contexts	In all three countries, documents and key informants indicated that work on the MISP for use in humanitarian emergencies developed with UNFPA support aimed to achieve integration of SRHR, HIV, SGBV services in humanitarian settings			

The most advanced effort by UNFPA to support integration of SRHR, HIV and SGBV services from the policy level through to actual service delivery has clearly occurred in the ESA region under the linkages project from 2011 to 2017 and through the *2gether 4 SRHR* programme since then. These efforts are examined in detail in the sections that follow. However, that does not mean that no efforts to support linkage and integration have been pursued in Georgia or Indonesia.

In Georgia, UNFPA has adopted service integration as a deliberate strategy to address HIV prevention given its overall mandate in SRHR. This is clearly demonstrated by country office efforts to elaborate standard packages for HIV prevention and service standards for KPs, based on the UNFPA implementation tools for MSM, SWs and YKPs. However, there are potential missed opportunities for strengthening SRHR-HIV linkages, as there was little evidence noted for bi-directional integration in other selected areas such as cervical cancer screening, family planning counselling and service delivery (within the maternal neonatal strategy), VTC and routine maternal health surveillance activities. To strengthen capacity for delivery of quality integrated SRHR-HIV services, UNFPA Georgia supported

the development of an e-learning platform based on the aforementioned standard packages for HIV prevention. This helped to mitigate the lack of a systematized process for continuing medical education in the absence of an ongoing supervision and performance management system.

In Indonesia,¹⁰⁴ in 2017, UNFPA reported a range of key achievements in the field of SRHR,¹⁰⁵ including supporting the Government to improve midwifery education standards, updating SRHR-related SDG indicators, developing a costed national family-planning implementation plan and the adoption of the Minimum Initial Service Package Operational Guidelines into national disaster preparedness policies. In the field of adolescent SRHR, a range of achievements was also noted, including (1) the UNALA private sector initiative reaching over 2,500 young people with services and information and (2) making available Indonesia's

104 Inter-Agency Working Group on HIV and SRHR Linkages, HIV and SRHR Linkages Infographic Snapshot, Indonesia, 2016

105 The Government of the Republic of Indonesia and UNFPA, *The Government of the Republic of Indonesia and UNFPA: 2017 Key Achievements*, Jakarta: BAPPENAS and UNFPA, undated.

first comprehensive and multisectoral National Action Plan on Youth Development (2017-2019). With just one exception, these initiatives did not involve any significant degree of advocacy or policy development for linkages and integration between SRHR, HIV and SGBV. As such, they constitute missed opportunities or exemplify the difficulties attached to making progress on integration in Indonesia. The exception is the work around the MISP Guidelines,¹⁰⁶ which were adopted and adapted to secure a high degree of integration of HIV, adolescent reproductive health and SGBV services in humanitarian settings.¹⁰⁷ The MISP guidelines were developed through a global initiative of the Inter-Agency Working Group on Reproductive Health in Crises, of which UNFPA is a member.¹⁰⁸

It is important to note that the respondents to the online survey of key informants in 62 countries gave positive responses when asked about contributions by UNFPA to programmes that link HIV prevention and SRHR policies, systems and programmes. Of those who responded to the question, 55 per cent strongly agreed that UNFPA had been effective and a further 38 per cent agreed, giving a total positive response of 93 per cent.

4.3.3 Developing and piloting models of integration in East and Southern Africa

Of the case study countries, Namibia and Zambia provide the most complete examples of efforts to integrate SRHR, HIV and SGBV services. This is a result of a long history of advocacy at regional and country levels by UNFPA, the SADC regional commitments and guidelines on integration and ongoing investments under the Joint Linkages Programme and the *2gether 4 SRHR* programme. From advocacy and overall support to linkages and integration (as described above) the next steps in the causal chain of effects on integration (as in Figure 7) concern the development and pilot testing of national models of integration.

The process of support to implementing integration in both countries began with UNFPA supporting national authorities to incorporate linkage and integration as priority strategies within plans and programmes for SRHR and HIV. It then continued with support to national guidelines, development of models for integration and pilot testing of the resulting models. This work built on the rapid assessments carried out in 2011 in both Namibia and Zambia and on the *Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region* published in 2015.

TABLE 15: UNFPA support to developing national models of integration (Namibia and Zambia)

Namibia	Zambia
NSF for HIV and AIDS Response in Namibia (2016)	National Guidelines for SRH, HIV and GBV (2015)
National Guidelines on Health Services Integration: SRHR, HIV and Other Services (2016)	National Health strategic plan 2017-2021 incorporates 2015 guidelines
Baseline assessment and pilot testing of integrated service delivery in nine pilot sites (to 2016)	Implementation of pilot-integrated activities in nine model sites
Namibian Primary Health Care Integration Model (2018)	Implementation of the "One-Stop Service Model"

The Namibia integration model

In both Namibia and Zambia, the national model for integrating SRHR/HIV and (eventually) SGBV services incorporates a one-stop model for delivering integrated services. As an example, the Namibia model has seven key

features:

1. All services in SRHR and HIV offered every day
2. A nurse always works in the same, numbered screening room

¹⁰⁶ Ministry of Health Republic of Indonesia, *Operational Guideline on the Minimum Initial Service Package (MISP) for Reproductive Health Implementation in Health Crisis*, Ministry of Health, The Republic of Indonesia, 2017.

¹⁰⁷ Note: not identified by Indonesia CO as an HIV-related project.

¹⁰⁸ <https://www.unfpa.org/resources/what-minimum-initial-service-package>.

3. On arrival a receptionist assigns a client to a room and nurse
4. The client receives all services in one screening room
5. On the client's next visit, the receptionist assigns them to the same nurse and the same room
6. If needed, the client will be referred for HIV counselling in another room in the facility
7. If required, the client will be referred to a doctor or a hospital for specialist care.¹⁰⁹

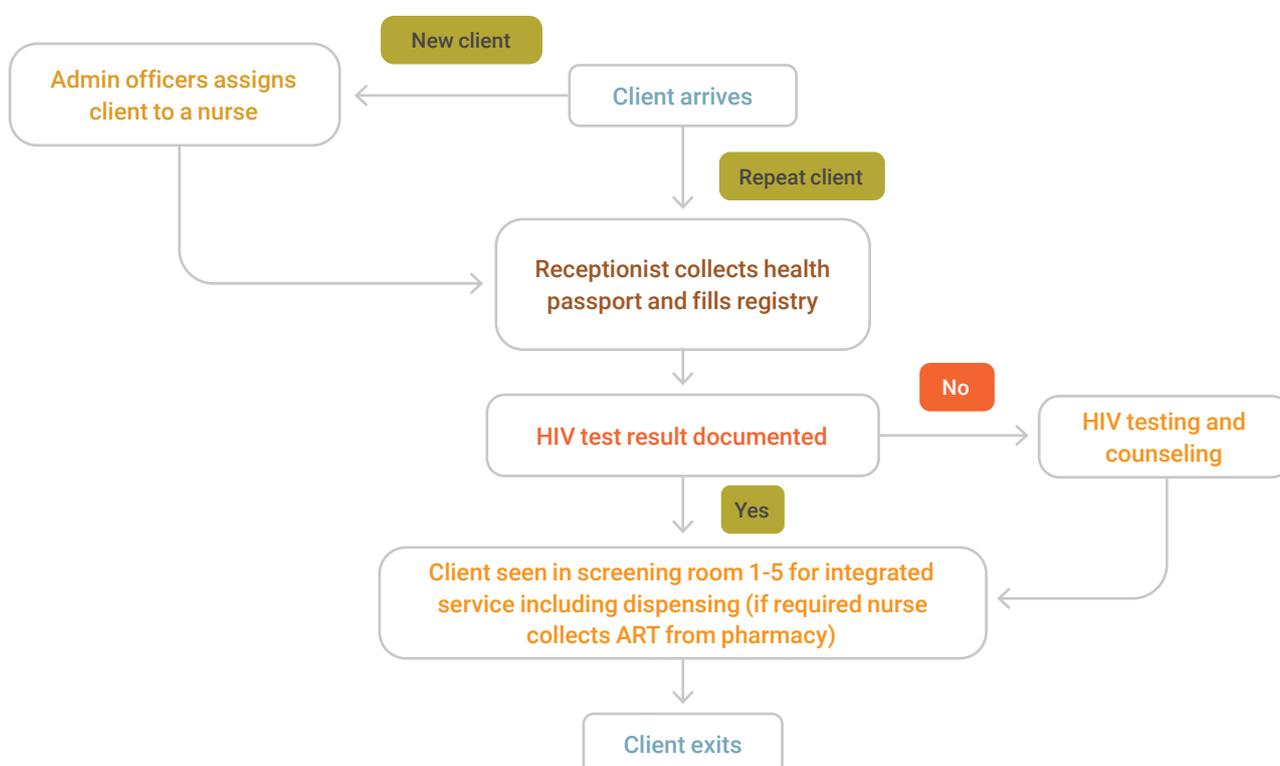
The Namibian guidelines on health services integration specify the integrated services to be provided in each health facility. They include ANC, postnatal care (PNC), family planning, immunization, screening for children and adults, dressings, tuberculosis, pap-smear, prevention of mother-to-child transmission (PMTCT) and ART. The Namibia model allows for HIV testing and counselling (HTC) in another room in the same facility as long as it is provided on the same day.¹¹⁰

In practice, facilities undertaking integration in Namibia have often made alterations to the operational model due to the practical realities of patient flow and constraints on the availability of personnel, space and equipment. The most common of these modifications involve wounds dressing and

cervical examinations and pap smears in their own dedicated rooms in the facility. All the facilities visited in Namibia during the evaluation had made arrangements for HTC to be done in a separate room (as allowed in the model) due to the time required for initial testing and for counselling in the event of a positive test.

Figure 8 presents a schematic diagram of patient flows observed by the evaluation team and described by staff at the Onandjokwe Primary Health Care Clinic in the Oshikoto Region of Namibia. It is evident from the patient flow diagram that, at least at this facility, health service providers have made a significant effort to develop, test and implement an integrated model of HIV and SRHR service delivery. SGBV as an element of integrated services has not yet been fully implemented in the sites visited by the evaluation in Namibia because of a shortage of nursing staff trained in the procedures for counselling and testing survivors of SGBV and providing evidence to the SGBV units of the local police forces. In the sites visited, SGBV survivors are most often referred to a district hospital, where staff are trained both in treating SGBV survivors and in gathering and transferring evidence.

FIGURE 8: Client flow under the Namibia model: Onandjokwe Primary Health Clinic



109 Ministry of Health and Social Services, Government of the Republic of Namibia, "The Namibian Primary Healthcare Integration Model: Rationale for Scale-Up for Policy Makers". 2018, p.4.

110 Ministry of Health and Social Services: National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services. (2016) p.48.

4.3.4 Challenges to scaling linkages and integration

All the country case studies indicate numerous problems and challenges in effectively supporting linkage and integration as key strategies for guiding the HIV response. In Georgia, the main challenge is the problem of promoting linkages within a health sector dominated by private hospitals and clinics and based on an inherited health sector organizational structure that is highly vertical. In Indonesia, the major problem is a lack of understanding and commitment to the concepts of linkage and integration for SRHR, HIV and SGBV services. There seems to be a general belief that linkage and integration are more suited, at least in principle, to countries undergoing a generalized HIV epidemic rather than one concentrated on KPs, as in Indonesia.

Operational challenges to integration

Among the case study countries, Namibia and Zambia provide useful examples of the organizational and operational challenges faced by countries that attempt to move the integration of SRHR, HIV and SGBV services from the pilot stage to implementation at a national scale. In both countries, the *2gether 4 SRHR* programme is serving to support the scaling of the national model from the original pilot sites to national level (step 4 in Figure 2). By March 2018, the number of integrated sites in Namibia had grown from the original pilot sites to 78 health facilities in almost every region of the country.¹¹¹ According to interviews with staff from the Ministry of Health and Social Services (MoHSS) in Namibia, by 2019 integration had been rolled out to 98 of 344 facilities. In addition, they noted that UNFPA and the Global Fund were continuing to support integration with a focus on regions and facilities with a high burden of HIV, especially in northern regions of the country.

In both Namibia and Zambia, the process of scaling integrated SRHR, HIV and SGBV services to provide national coverage has encountered a significant number of operational challenges. In Namibia, these challenges were identified in interviews with stakeholders in different offices in the capital, listed in programme review documents and confirmed during discussions with service providers at the sites visited. There is ample evidence of their frequent and serious nature. A fairly comprehensive list of these challenges was developed during the National Consultation Meeting on SRHR, HIV and SGBV Integration hosted by the MoHSS in 2018:

- Human-resource constraints
 - Staff vacancies at regional, district and health facility levels
 - Large and continuous training needs – including coordinated external training and provision of in-service training, mentoring and support, especially for Nurse-Initiated Management of Antiretroviral Treatment (NIMART)
 - Initial negative attitudes and resistance to change from staff members
 - Donor-funded staff in ART clinics required to spend 80 per cent of time on HIV services
- Infrastructure and space
 - Need to expand existing structures due to lack of screening rooms
 - Need for more benches/chairs and more space in waiting areas
 - Dilapidated infrastructure in some clinics
- Equipment
 - Shortage of basic equipment (blood pressure monitors, glucometers, etc.) to equip all screening rooms, leading to sharing between rooms and requiring nurses to move to find equipment
 - Lack of funds to procure needed equipment
- Other challenges
 - Ongoing challenges posed by data logging and entry using separate, disease-specific registers
 - Lack of an integrated data collection and analysis system for integrated service
 - The need for continuous sensitization of clients and community members to ensure understanding/acceptance of the new systems
 - The high volume of clients in some clinics.¹¹²

A general challenge noted in some health facility visits and interviews was the need for health centre staff (and, by extension, clients) to have access to specialized expertise in some areas. For example, while not all staff can be highly trained in NIMART, or in critical ANC, there is a need for more readily available mentoring and supportive supervision of staff who may not have been fully trained in all aspects of integrated care. In both Namibia and Zambia, some sites reported that stock-outs of key commodities, including those for family planning and, especially, condoms, raised challenges for effective integration of services.

¹¹¹ Ministry of Health and Social Services, Government of the Republic of Namibia, National Consultation Meeting on the Joint SRHR/HIV/GBV Integration and Validation Meeting for SRHR/HIV/GBV Tools: Meeting Report. March 2018, p. 4.

¹¹² Republic of Namibia, Ministry of Health and Social Services, National Consultation Meeting on the Joint SRHR/HIV/GBV Integration and Validation Meeting for SRHR/HIV/GBV Tools: Meeting Report. March 2018, p. 13.

Institutional challenges to integration

In addition to these operational challenges, there are sometimes institutional barriers to effective integration of services at a national scale. In Namibia, staff of PEPFAR and the United States Centre for Disease Control (CDC) have, along with the Directorate for Special Programmes of the MoHSS, pushed back against the integration process due to their view of its effect on retention of patients on ART. From their perspective, the drive to integrate HIV services into other SRH services at a clinical level puts at risk effective management of ART for HIV positive patients. This happens because HIV patients are now receiving services from nurses who may not be well trained in HIV treatment (when compared to the specialist nurses working in HIV-specific facilities). They also reported that facilities being integrated saw a decline in the rate that HIV patients were retained on ART in the period just after integration. However, in interviews at some of the same integrated sites, staff indicated that retention rates have since returned to pre-integration levels.

While integration in Namibia is mainly seen as the responsibility of the Directorate for Primary Health Care of MoHSS (with support from UNFPA), HIV programming is overseen by the Directorate for Special Programmes (with direct support from PEPFAR/CDC and the Global Fund). The National Integration Steering Committee, established during the first linkages project, has not been active during the *2gether 4 SRHR* programme. As a result, the process of scaling integration to national level has been carried out in the absence of a forum for discussing dissenting views and resolving disagreements among the key stakeholders inside and outside of the MoHSS.

4.3.5 Quality, client-centred services: the view so far

A key question regarding efforts to promote linkage and integration in SRHR/HIV/SGBV is whether this process results in improved, quality, client-centred services, which help to combat stigma and discrimination in the HIV response. While there is little direct, quantitative evidence available to provide a definitive answer to this question, the evaluation was able to gather some credible evidence of a positive effect, based on:

- A limited number of client exit interviews carried out in 2016 at the end of the linkages project in 2017 in Namibia for the end-of-project evaluation
- Reports of national consultation meetings on SRHR/HIV/SGBV integration in Namibia
- Interviews and group discussions with key stakeholders from Government and civil society in Namibia
- Interviews and group discussions with health services staff and a limited number of clients in the sites visited in Namibia.

The consensus across these different sources of evaluative information, while not in any sense definitive, does suggest that there are significant benefits from integration of SRHR, HIV and SGBV services in many instances (where integration at the facilities level has been carefully and systematically implemented). These positive results have two main dimensions: benefits for the health service and health practitioners, and benefits for their clients.

TABLE 16: Benefits reported for both clients and staff in integrated facilities in Namibia and Zambia

Benefits to the health system and to service providers	Benefits to clients, including youth and adolescents, KPs and PLHIV
Increased productivity of nursing staff	Reductions in client waiting time
A broader skill set for all of the staff allows for more flexible scheduling and assignment of nursing staff	Self-reported reductions in stigma for LGBTI community members and PLHIV
Increased job satisfaction for nursing staff who are no longer confined to one specialty area	Focus on individual clients and their needs rather than on diseases
Improved workflow within the facilities	Access by KPs to service providers trained in meeting their needs
Stronger and closer relationships with clients	A stronger and closer relationship between facilities staff and clients
Opportunities to learn and develop higher skills levels	Staff maintain higher skills level

In Namibia, the integrated sites visited also reported a separate programming innovation that was helping to reduce stigma toward PLHIV. This was the development and support of community ART referral groups (CARG) which allow a

single member of the group to travel to the health services facilities and collect anti-retroviral pharmaceuticals (ARVs) for the group in each community. This has apparently reduced the level of stigma within the communities themselves.

The Indonesia country case study did not provide the evaluation with significant examples of bi-directional linkages or integrated service delivery that could inform the question of quality, client centred integrated services. However, in Georgia, group discussions with service providers highlighted the importance of SRHR as an entry point to address HIV, given national government (and provider) reluctance to directly and explicitly address HIV prevention and treatment, especially for KPs.

In summary, the evidence available to the evaluation indicates that integration of SRHR/HIV/SGBV services at health facilities level constitutes a sound strategy for improving efficiency, reducing stigma and promoting access and thereby strengthening a national HIV response.

4.3.6 Learning and sharing experience in linkages and integration

The final step in the chain of effects for integrating SRHR/HIV and SGBV services (Figure 7) is generating knowledge in integration and feeding it back into practice at global, regional and national levels, especially through South-South exchanges.

As already noted, at global level, UNFPA has supported the ongoing work of the IAWG on integration and supported the production of assessment tools, indexes of integration and infographics on integration in selected countries. Key informants interviewed at global level also indicated that UNFPA staff participating in global forums and networks consistently advocate for support to linking and integrating actions in support of SRHR, HIV and SGBV. However, these same informants suggest that, at global level at least, UNFPA messaging on integration often lacks specificity on how integration should be implemented.

Before turning to the ESA region, it should be recognized that UNFPA promotes South-South cooperation and learning in other regions and countries. UNFPA Indonesia is actively involved in South-South cooperation and joint lessons learning. In 2016, UNFPA and UNAIDS organized a visit to Mysore in India to learn about HIV prevention among FSW with an SRH component. Indonesian CSOs were shown ways of reaching FSW in the street and effective training programmes for FSW. In 2017, the Indian organization visited UNFPA Indonesia partners in Jakarta.

The mid-term review of the Indonesia country programme also identifies: (1) South-South cooperation with 12 Asian and African countries on the role of Muslim leaders in family planning, comprehensive, rights-based clinical family planning and the role of Islamic youth leaders in adolescent reproductive health in 2016, (2) continued South-South cooperation through the international training programme and (3) the bilateral programme with the Philippines in

2017 and 2018.¹¹³ Although the South-South work with Muslim leaders was not related to bi-directional linkages and integrating SRHR, HIV and SGBV, it did contain SRHR components, i.e. equitable access to contraceptives and HIV prevention with condoms as dual protection. However, it was not specific to marginalized groups and was more focused on addressing HIV prevention in general.

In Georgia during the period under evaluation, the UNFPA country office provided opportunities for South-South exchanges. For example, in 2016 the UNFPA EECARO and IPPF European Network convened a Second Regional Consultation on HIV and SRHR among YKPs, which was attended by a Georgian delegation that included representatives from the National Centre for Disease Control (NCDC), the principal recipient of the Global Fund grant. UNFPA Georgia also supported colleagues to attend the IV International Workshop for Health Futures held in Istanbul to share expertise and experiences as speakers and facilitators. Attendance at regional and international conferences builds the capacity of national leaders and offers an opportunity for updates, meaningful dialogue and the establishment of direct contacts among medical professionals related to issues of interest.

South-to-South learning in ESA

Despite general support to South-South interchanges in Georgia and Indonesia, it remains clear that the most extensive efforts to promote exchange and learning directly related to linking and integrating SRHR, HIV and SGBV services have occurred in the ESA region and in countries participating in the linkages project and the *2gether 4 SRHR* programme. At regional level, these include:

- Meetings of regional project and programme steering and advisory committees aimed at “documenting lessons learned from implementation of the linkages project to amplify those lessons so that all countries can benefit from and adopt these to their unique circumstances”¹¹⁴
- Support under the *2gether 4 SRHR* programme to Botswana and Namibia “to document their models of integration and provide technical assistance to Botswana, Eswatini, Uganda and Zimbabwe”¹¹⁵
- Support to learning visits between countries, including visits by staff of the MoH in Botswana and Eswatini to South Africa in 2018
- Support to allow three countries in the region to

113 UNFPA, Mid-Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to the Government of Indonesia (GOI) 2016–2020. Dated February 20, 2019. UNFPA. p.52.

114 UNFPA/UNAIDS, Final Regional Project Steering Committee Meeting for the Joint UNFPA/UNAIDS Regional Project on SRHR and HIV Linkages, November 2017. P.2.

115 UNFPA/UNICEF/UNAIDS/WHO (2019): Draft: Regional Programme Steering Committee Progress Report and 2019 Work plans, 14 March 2019.

undertake strategic assessments of unwanted pregnancies and linkages between HIV and SGBV in 2019.

At country level in Namibia and Zambia, examples of knowledge generation and sharing of experience include:

- Twinning of Namibia with Uganda for South-South exchange of information on integration
- Development by the MoHSS Namibia with support from UNFPA of a journal article on integrated HIV/SRHR services at the Epako clinic
- National level consultation and validation meetings on integrating SRHR, HIV and SGBV
- National level meetings of regional and district health teams to share experiences in integrating SRHR, HIV and SGBV at facilities level
- Visits to newly integrating facilities by staff referred from experienced facilities in a different region of the country
- Policy briefs developed with UNFPA support distributed through existing national knowledge-sharing networks and forums.

In summary, at regional level in ESA and at country level in Namibia and Zambia (the country case studies where the linkage and integration agenda has been most advanced), UNFPA has been active in promoting knowledge generation, lessons learning and South-South information exchange on the practicalities of linkage and integration. The evaluation has not found, at least in recent years, that UNFPA has been able to replicate this level of knowledge development and dissemination at a global level.

4.3.7 Supply chains and comprehensive condom programming

In examining the question of UNFPA effectiveness in support of linking and integrating SRHR, HIV and SGBV, the evaluation focused on two assumptions relating to condoms: UNFPA support to improve supply chain management (SCM) for condoms and UNFPA support to promote and support comprehensive condom programming (assumptions 1.4 and 1.5).

With regard to SCM for condoms, the main differentiating factor in UNFPA support seems to be the presence (or absence) of the UNFPA Supplies Programme. In countries without a UNFPA Supplies Programme presence, the evaluation found little evidence of UNFPA support to strengthen SCM for condoms. In some countries, for example, Georgia and Namibia, the Global Fund provides both commodities and limited support to improve the SCM for condoms. In Namibia and in Zambia, UNFPA supports the national process for quantifying condom requirements but does not directly support SCM for condoms. This raises the question of how UNFPA can engage in efforts to

improve the SCM for condoms as an essential factor in the HIV response in countries that are not procuring condoms through the UNFPA Supplies Programme.

With regard to comprehensive condom programming, key informants interviewed at global level felt that UNFPA lacked a programmatic focus on HIV prevention through condom programming. Rather they felt that, in the HIV world at least, UNFPA is seen as promoting its “Condomize!” brand of demand-generation campaigns without a systematic approach to condom programming, despite the role played by UNFPA in the 20 by 20 initiative (see Section 4.1). To some extent, this reflects the high visibility of “Condomize!” as an awareness-building campaign, while other aspects of technical support to condom programming may be less visible.

At a regional level, UNFPA ESARO has used the *2gether 4 SRHR* programme to support two regional workshops in 2019 in order to “build the capacity of countries to undertake comprehensive condom programming and promote the exchange of knowledge amongst UNFPA technical focal persons”.¹¹⁶ However, with the exception of Zambia, there was little evidence in the case study countries of UNFPA support to CCP. In Zambia, the national CCP strategy expired in 2016 and is currently being revised with UNFPA support. A 2018 situation analysis of the CCP concluded that:

“Although comprehensive condom programming has been implemented for many years in Zambia, there have been challenges related to the supply chain that have made it difficult for condoms to be easily and consistently accessed by all those in need. Last mile distribution is still a challenge...In addition, the national comprehensive condom programming strategy that outlines key interventions for condom promotion and distribution expired in 2014 and has not yet been replaced.”¹¹⁷

In contrast to these findings, the respondents to the evaluation online survey were largely positive in their view of UNFPA efforts to strengthen SCM. Just over 86 per cent of respondents agreed or strongly agreed that “UNFPA has effectively contributed to national efforts to strengthen the management of supply chains for male and female condoms”.¹¹⁸ However, this response needs to be interpreted with care, since it reflects experience in many countries where the UNFPA Supplies Programme is supporting efforts to strengthen SCM, not necessarily as part of, or connected to, the national HIV response.

¹¹⁶ UNFPA/UNICEF/UNAIDS/WHO, *2gether 4 SRHR Mid-Year Review Year2 2019*. Regional Presentation July 22, 2019 (Power Point Presentation).

¹¹⁷ National AIDS Council of Zambia (2018). *Situational Analysis Report of the National Comprehensive Condom Programming in Zambia*.

¹¹⁸ Online survey, see Annex 5.

The area where respondents feel UNFPA has been most active has been in national condom policy, planning and coordination (78 per cent). It is notable, however, that 40 per cent of those responding felt that UNFPA was contributing to condom distribution to the “last mile” and over a third (34 per cent) noted that UNFPA contributes to demand generation. This latter point is consistent with the views of key informants interviewed during the case studies. Most often they pointed to campaigns supported by UNFPA under the “Condomize!” banner as examples of a UNFPA contribution to HIV prevention through condom use.

Evidence from the case studies indicates that UNFPA support to national condom planning, policy and (sometimes) distribution, is not integrated with or driven by efforts to promote HIV prevention. With the exception of “Condomize!” campaigns, UNFPA support to condom programming is more

often a stand-alone awareness-raising effort in support of family planning, which is itself not necessarily effectively linked to HIV prevention. The recent evaluation of the UNFPA Supplies Programme also noted that in some countries the supply chain for condoms used in the HIV response operates in parallel to the supply chain for family planning and, as a result, does not benefit from UNFPA support to SCM, which presents another challenge to UNFPA efforts to strengthen supply chains critical to the HIV response.¹¹⁹

The relative lack of support by UNFPA to SCM in most of the case study countries (which are not UNFPA Supplies Programme countries) can also undercut the rationale for awareness-raising campaigns like “Condomize!” and parts of the CSE curriculum. Generating increased demand in the context of weak supply chains and disruptions in supply is unlikely to lead to sustained behaviour change.

4.4 STRENGTHENING NETWORKS AND FORGING PARTNERSHIPS

Summary

UNFPA has been effective at regional level in EECA and ESA in forging partnerships and working with networks to develop strategies, frameworks, guidelines and training models on critical aspects of the HIV response; this has helped support advocacy and technical assistance in programme countries. UNFPA has also demonstrated a proven ability at country office level to foster strong relationships with organizations and networks led by adolescents, youth and KPs to support their capacity to engage in national dialogue and action in the HIV response. This work has helped to shape the design of programmes to better meet the needs of these groups, yet there is little evidence of their participation in processes holding programmes accountable for ensuring access and assuring quality. It is also questionable whether the capacity for strong participation by CSOs and networks fostered by UNFPA can be scaled or sustained, given the dependency on diminishing external resources. At global level, a lack of common understanding within the organization as to its HIV priorities appears to impair the capacity of UNFPA to fully execute its mandate in global leadership on HIV prevention. In particular, UNFPA has not maximized its role on important needs related to revitalizing the interface between condom programming and SRHR-HIV integration in the aftermath of the ECHO trial results, which highlights the need to integrate condom programming and triple protection for HIV prevention into family planning services.

For details of the evidence, supporting findings in Section 4 see the evaluation matrix (Annex 1): Assumptions 4.1, 4.2, 4.3 and 4.4.

4.4.1 Forging partnerships for a strategic response to HIV

The UNFPA strategic plan 2018-2021 highlights the importance of multi-stakeholder partnerships and of working to strengthen collaboration with governments, as well as with civil society and the private sector as a means of securing commitment, action and ownership in the pursuit of the SDGs. In general, UNFPA has been most effective in

forging partnerships and supporting networks at regional and national levels. The region and country level case studies provide the strongest evidence of UNFPA success in partnering for a strategic response to HIV, in part because UNFPA is better positioned through its field staff and structures to engage at regional and country office levels.

¹¹⁹ UNFPA, Mid-Term Evaluation of the UNFPA Supplies Programme 2016-2020, p.43.

Regional and national partnerships in ESA

In the ESA region, the strong presence of SADC and its subcommittee of health ministers, offers ESARO a valuable partnership for advocacy at regional and country levels. Because SADC health ministers work by consensus, when a strategy or policy is approved, it becomes a guiding document for all countries in the region. For example, the SADC strategy for addressing KPs in the HIV response provides a vision to be translated into national action by 2030:

“The strategic framework is not a strategic plan but a guiding framework for SADC Member States. It aims to provide details on how key populations are and remain more vulnerable to HIV than the general population. It further identifies the key barriers they face in accessing HIV and SRH services, and identifies steps Member States can take to address these obstacles and thereby lower the vulnerability of key populations to HIV and increase their access to HIV and SRH services.”¹²⁰

The SADC HIV strategy for KPs and the broader SADC SRHR strategy¹²¹ were both developed with the active support of UNFPA ESARO. They are especially valuable as advocacy tools within the region, as one key informant from the United Nations joint regional team on HIV noted, “No Ministry of Health or Ministry of Education wants to be left behind”.

At country office level, UNFPA Namibia, with the support of UNFPA ESARO, has been able to draw on the work of regional networks in the SADC and the EAC to further the development of strategies, guidelines and model laws on different aspects of the HIV response. AfriYAN, a youth and adolescent network, is supported by UNFPA at both regional and country levels. It builds on the ministerial commitments by SADC ministers of health, education and youth in relation to teenage pregnancy, SGBV and HIV and AIDS. UNFPA also supported the ongoing operation of the TWG on KPs with membership that includes the MoHSS and national NGOs representing the LGBTI community: Out-Right Namibia (ORN), Trans-Namibian Trust, Namibia Diverse Women and SFH. This forum offers TWG members an opening to have a rights discussion with the MoHSS.

In Zambia, platforms established by UNFPA at regional level, such as the Regional Programme Steering Committee for United Nations agencies and regional technical consultations, supported the sharing of information, implementation tools and lessons learned. Most importantly, it demonstrated to the Zambian Government successful examples of integration from countries with similar contexts.

120 Southern African Development Community, Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights Among Key Populations, 2018, p.11.

121 Southern African Development Community: Regional Strategy for Sexual and Reproductive Health and Rights (SRHR) 2019–2030. 2018.

Regional and national partnerships in EECA

UNFPA EECARO support for regional partnerships with KP networks has helped to address the needs of vulnerable populations, as well as to leverage other strategic partners and funding opportunities. For example, a successful partnership with IPPF has brought together government officials, community members and service providers from eight countries to influence country level work on HIV and YKPs and marginalized populations. EECARO also works with several other regional partners to advance evidence and knowledge sharing for effective advocacy in the region, including the Eurasian Network of Women with AIDS (EWNA) and Eurasian Coalition on Male Health (ECOM). For example, EECARO (represented by the Georgia country office) participated in a regional assessment conducted by the Regional Advisory Group on Strategic Information (RAGSI) for an ECOM Global Fund grant regarding HIV in MSM and trans-people. The grant was to further the understanding of the epidemic context and source options to alleviate the HIV burden and its impact among different populations.

Interviews with governmental and NGO partners paint a picture of UNFPA Georgia as an experienced and flexible broker of partnerships to advance SRHR issues, including the repositioning of HIV prevention as a critical issue. Interviews with stakeholders reflected an approach used by UNFPA Georgia to broker efforts around a particular issue. The steps in this approach were: 1) increase awareness of key national stakeholders through regional or South-South exchanges at conferences, meetings and workshops; 2) support the generation of evidence to support policy and strategy development; 3) support a consultative process with a wide range of stakeholders to participate and generate ownership; 4) provide technical assistance in the development of strategies, guidelines, standards and protocols; 5) develop curricula and reference materials based on the standards and protocols for use in capacity building; 6) support capacity building through collaboration with government and NGO partners. This process was used to advance policies and action related to comprehensive HIV prevention for KPs and was appreciated by a range of governmental and civil society partners.

Forging partnerships in Indonesia

In its role as Global Fund subrecipient, UNFPA Indonesia has solid relationships with several key actors in the nation's HIV programme. In particular, it created the opportunity for UNFPA Indonesia to collaborate closely and build the capacity of OPSI to engage at national level in policy dialogue and advocacy. UNFPA ensured wide participation of key groups when developing guidelines for FSW programme outreach. The FSW programme has close connections with other government and non-government actors and offers potentially wider opportunities to involve other KP groups. UNFPA also partnered with the Siklus Foundation in piloting UNALA, an innovative social franchising model to broker partnerships between civil society and private sectors to

deliver youth-friendly services and information for young people.

Partnership for HIV prevention at global level: room for greater UNFPA leadership

Among the stakeholders interviewed, UNFPA is not seen as maximizing its participation in key partnership platforms to offer leadership on global policy and advocacy issues related to repositioning HIV prevention as an essential component of SRHR. The Global HIV Prevention Coalition is one such partnership where it was noted that UNFPA was engaged in the beginning at very high levels, which helped to bring other major players on board such as BMGF, the Global Fund and PEPFAR. More recently, as one stakeholder noted, “we don’t see UNFPA very often at the global meetings and I don’t hear loud statements from them on rights issues”. Several key stakeholders expressed the opinion that HIV is critical in SRHR; therefore, UNFPA must be a visible and vocal champion within global and field level discourse on rights-based HIV prevention and SRHR-HIV integration.

UNAIDS is seen as providing leadership on issues of SRHR and HIV more broadly while there is a feeling that United Nations entities, including UNFPA, are “more diplomatic than brave” in bringing up publicly the difficult issues on HIV prevention with partner governments – an observation that is sometimes made at national level as well. Another civil society stakeholder noted, “GBV is becoming a more prominent issue at global level, but I haven’t seen UNFPA active on that, not in terms of concrete achievements”. Overall, there is a desire from stakeholders to see greater vision and leadership from UNFPA to address – in new ways – condom programming and integration. This is a critical area for UNFPA leadership in light of the findings of the ECHO trial, which highlighted the need for greater integration between HIV prevention services and family planning.¹²² These findings supplement those in Section 4.1 on the extent to which UNFPA fulfils its mandate and on its technical capacity to work on HIV prevention at global level.

4.4.2 Strengthening networks to influence national policy and programmes

While UNFPA has worked to develop strong partnerships and to support networks at regional and, to a lesser degree, global levels, it is at national level where the evaluation team found the most direct evidence of a strong contribution to engaging with networks to influence policies and change programmes. As already noted, the strength of this contribution is, in part, based on the work done at regional level.

UNFPA Namibia, for example, has engaged with several different networks and CSOs representing adolescents

and youth and KPs, which has led to these groups being active and able to engage meaningfully in the national dialogue on HIV. The Office of the First Lady (OFL) has been an important strategic ally in the process to create space for the participation of youth. This has helped the national Government to recognize the role that CSOs should play in ensuring that services are appropriate to the needs of adolescents and youth and KPs. As noted by civil society stakeholders, “UNFPA works hard to make sure that organizations representing adolescents and youth are ‘in the tent’ regarding the national dialogue on HIV and AIDS”.

Further, stakeholders noted that ongoing dialogue with parliamentarians on the part of UNFPA and other members of the United Nations Country Team (UNCT) had helped to create a better atmosphere among political leaders. As a result, these same leaders are now more willing to discuss HIV issues and to agree on a road map for future action. However, there is an ongoing concern whether CSOs supported by UNFPA (and other development partners) can sustain their capacity in light of their dependence on diminishing resources.

Similarly, UNFPA Zambia worked in collaboration with WHO and ILO on behalf of several NGOs representing persons living with disabilities to mobilize resources for improving access to comprehensive SRHR-HIV services. This involved establishing strong partnerships with national level key stakeholders, such as the Ministry of Community Development and Social Welfare, as well as with representatives from several key disabled people’s organizations; and conducting a consultation process to highlight discriminatory behaviours and experience with barriers to access.

UNFPA Georgia has also demonstrated a strong commitment to supporting networks to influence policy dialogue and programming. For example, in 2016 the country office supported a round-table and training exercise among professional networks and civil society activists in partnership with the Women’s Fund in Georgia, EWNA and others for the rights of women and girls to raise awareness on violence against women who live with HIV and AIDS, use drugs and practice sex work. UNFPA works in partnership with the Tanadgoma Centre for Information and Counselling on Reproductive Health (NGO Tanadgoma).

Through this partnership, UNFPA Georgia supports the meaningful participation of KPs in the design process, using participatory methods gleaned from the UNFPA MSMIT, SWIT and YKP tools. UNFPA Georgia also supports the Georgia Youth Development Agency to develop its capacity as a network for youth programming, as well as for participating in policy dialogue. According to those interviewed, meaningful participation remains a challenge. While stakeholders acknowledged the importance of participating in and providing input to the up-front design process of a

122 [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)31288-7/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31288-7/fulltext)

programme, they also called for greater attention to be placed on the accountability dimension of programming, i.e., whether and how plans were actually implemented and how the interventions were experienced by the youth, KPs and women affected. Resource constraints (and continued resistance from traditional community leaders) have resulted in the curtailment of youth activities and have stalled additional capacity development.

In Indonesia, the JUNTA decision to allocate attention to specific KP groups to each United Nations agency limits the potential to achieve a coherent approach to build the capacity of CSOs and strengthen their meaningful participation in policymaking. One senior manager of a CSO noted that, as subrecipients, many United Nations agencies work closely with governments, but they are not necessarily close to key communities and community groups in the HIV response.

This is particularly worrisome, as Indonesia is short of actors willing and able to engage in advocacy with the Government on sensitive issues of human rights and the role and value of the community in the HIV response. Nevertheless, UNFPA financial and technical support to OPSI has been greatly appreciated, including help to develop an advocacy plan in response to government action closing brothels, although this could be misconstrued as UNFPA supporting an NGO to oppose a national plan. UNFPA has relationships with many other coalitions and networks, although it was noted that these are primarily at staff level, rather than organized as part of the UNFPA country programme implementation.

In summary, UNFPA country offices have been generally active and successful in supporting networks and individual CSOs to “create space” for organizations representing KPs to participate in the national dialogue on SRHR generally and on the HIV response in particular.

4.5 COORDINATION AND SUSTAINABILITY

Summary

UNFPA is an active participant in mechanisms for coordinating support to the HIV response at global, regional and national levels. At global level, UNFPA staff participate actively in mechanisms and processes for budgeting and accountability of the UNAIDS joint programme and play a central role in the UNAIDS CCO. At regional level, on the other hand, the extent of UNFPA participation depends on the level of resources and the level of attention to the HIV epidemic by external partners and host governments alike. Meanwhile, at country level, UNFPA participates fully in existing mechanisms for coordination both within and beyond the UNCT. Although mechanisms for coordination (especially at regional and national levels) have been effective in avoiding overlap and duplication, they require significant investments of time and resources by UNFPA offices. At times, they are also narrow in scope and face important operational challenges. UNFPA, at both regional and country levels, has supported efforts to improve sustainability and encourage national investment alongside its United Nations partners and other sources of financial support. While some countries have made significant efforts to increase the share of HIV expenses covered by the national budget, they remain highly dependent on external sources of finance, especially for recurrent expenditures for staff and training.

4.5.1 UNFPA support and participation in coordination

The evidence from the case studies strongly supports the view that UNFPA has played an active and supportive role in mechanisms for coordinating external support (and local action) to the HIV response at global, regional and national levels – although the pattern varies from region to region depending on the resources available and the number of agencies participating.

Coordination at global level

At global level, a member of the UNFPA HIV team is currently chairing the UNAIDS Committee of Cosponsoring Organizations. The CCO reports directly to the Programme Coordinating Board (PCB). The PCB consists of representatives of 22 governments from all geographic

regions, the UNAIDS Cosponsors and five representatives of non-governmental organizations, including associations of PLHIV. Among other functions, the PCB has a responsibility:

- “To establish broad policies and priorities for the Joint Programme, taking into account the provisions of General Assembly resolution 47/199
- To review and decide upon the planning and execution of the Joint Programme. For this purpose, it is kept informed of all aspects of the development of the Joint Programme and considers reports and recommendations submitted to it by the Executive Director and the CCO

- To review and approve the plan of action and budget for each financial period, prepared by the Executive Director and reviewed by the CCO".¹²³

Key informants interviewed at global level including staff of other UNAIDS Cosponsors and staff of international CSOs were largely positive concerning the role played by UNFPA in the CCO and other international coordinating bodies. In their view, the staff of the small HIV unit at UNFPA headquarters work industriously to adequately represent UNFPA in the relevant HIV forums and coordinating bodies. Global level key informants also felt that UNFPA is well suited, in terms of comparative advantages, to the various assigned roles it has in its capacity as a UNAIDS Cosponsor.

Coordination at regional level

At regional level, coordinating mechanisms themselves and the role that UNFPA plays within them vary greatly depending on the profile of HIV as an epidemic in the region, the level of development partners' interest (and their financial support) for an HIV response and the attitude of national governments. Another critical factor is the institutional strength and interest of intra-regional bodies involved in coordinating policies, programmes and practise in SRHR.

Of the two case study regions, EECA features just a few notable mechanisms for coordinating regional action (and external support) to the AIDS response. The first is the regional committee on United Nations humanitarian affairs where EECARO is active. The second is the issue-based Coalition on Health and Well-Being. As noted in interviews with UNFPA EECARO staff and with other key informants in Turkey and Georgia, there is a strong reluctance on the part of national governments to publicly emphasize and recognize the extent of the epidemic, especially in relation to KPs, which argues against their participation in regional coordinating bodies for HIV.

Within the United Nations family in the EECA region, UNFPA is able to use its own Regional Intervention Action Plan as a tool for communicating its activities in support of the HIV response. In ESA, the UNFPA regional office has a much more complex and more structured set of intra-regional bodies to engage with. Within the United Nations family on HIV, UNFPA participates in the RATESA, which includes four technical working groups on prevention, treatment, social justice and integration. UNFPA ESARO is most active in the prevention, social justice and HIV/SRHR integration working groups. Interviews at regional level with RATESA members indicate that UNFPA ESARO has made a major effort to participate in the development of the joint UNAIDS programme in the region. ESARO does this not only through the work of regional HIV staff but also by providing the joint programme with access to staff in other technical areas.

Each UNAIDS Cosponsor has the freedom to develop its own work programme within the regional HIV programme. However, they also share a single joint work plan, which specifies, for each activity and result, which organizations are to be responsible, accountable, consulted or informed (the RACI planning model). There is also a regional steering committee for the *2gether 4 SRHR* programme, which includes representatives of participating governments, CSOs and the participating United Nations agencies (UNFPA, UNICEF, UNAIDS and WHO).

Finally, coordination work at the regional level in ESA is also strengthened by the consultative structures of SADC and the EAC, particularly the SADC Parliamentary Forum and the subcommittee of regional health ministers of both EAC and SADC. When faced with the need to develop a specific strategy or guideline in HIV or SRHR programming, SADC convenes working groups of three of its member states, chosen as needed, and supported by United Nations agencies to develop drafts to be reviewed and adopted by ministers. The *SADC Regional Strategy on Sexual and Reproductive Health*, published in 2018, followed this process and was developed with support from UNFPA at both regional and country office levels.

Coordination mechanisms at country level

As at regional level, the strength and complexity of coordinating mechanisms varies considerably depending on the level of resources dedicated to the HIV response and, especially, the willingness of national governments to participate publicly in structures that highlight issues relating to the needs of KPs. This is well exemplified by the diverse situations in Georgia, Indonesia and Namibia.

In Georgia, the Global Fund Country Coordinating Mechanism (CCM) is the main body of coordination for the national response to HIV and AIDS and TB. It has 28 members representing a range of government and non-governmental actors and is chaired by the MoH. Given that the Global Fund intends to phase out funding in Georgia by 2025, many key informants are sceptical of the durability of the CCM, although they do regard it as useful. At the level of the United Nations member agencies, prior to 2014, the United Nations Joint Team on AIDS was not seen as effective because UNAIDS was not present in Georgia after 2013. In 2014, UNFPA Georgia assumed the role of chair. Since 2014, UNFPA has effectively represented the JUNTA at the CCM and in the Policy Advisory Council.

In Indonesia, the situation for coordination is more complex, as there is no national AIDS coordinating body fulfilling the role of overall coordinator. There is currently no NAC, and the structures established to take up the roles it used to perform are not functional. As a result, the main functioning coordinating bodies are attached to the Global Fund-financed HIV programme. As in Georgia, the Global Fund CCM serves this role alongside a TWG-HIV. The difficulty

¹²³ Available at: <https://www.unaids.org/en/whoweare/pcb>

with this arrangement is the narrow and specific focus of the TWG-HIV. It focuses on the coordination of the Global Fund-financed programme of work, not the overall national HIV response. In addition, staff of agencies participating in the CCM in Indonesia indicate they are limited in their ability to use the mechanism as a forum for advocacy because of their reluctance to challenge the national Government.

UNFPA has also helped to create, and has participated in, other national coordination platforms on SRHR. For example:

- In 2016, UNFPA reported contributing to the “establishment of a national cross-sector coordination team for integrated rights-based family planning”.¹²⁴ Although directly referenced in the quote, respondents report that this initiative did not address rights issues relating to HIV, sexual health or sexuality
- UNFPA participates fully in the JUNTA and its contribution is greatly appreciated by UNAIDS and other agencies. The efficacy of the JUNTA is called into question, however, given the Division of Labour by KP group rather than according to UNAIDS guidance
- Since 2014, UNFPA has chaired the Interagency Network for Youth Development, which coordinates United Nations youth development initiatives across partners from UNICEF, UNAIDS, the ILO, UNDP etc. Building on this coordination role, UNICEF and UNFPA propose to develop and co-chair a new coordinating platform called the United Nations Youth Working Group.

In Namibia, UNFPA participates in a range of teams, task forces, coordinating committees and TWGs. For the sake of analysis, these can be grouped under five different, yet interlinked coordinating platforms:

1. The components of the National AIDS Executive Committee (NAEC), responsible for coordinating the operational aspects of the NSF. It includes both Technical Assistance Committees and TWGs. Importantly, the NSF draws an explicit link between coordinating mechanisms of the NAEC and the JUNTA. “The participation of the United Nations agencies is coordinated by UNAIDS through the United Nations Joint Team on HIV/AIDS.”¹²⁵
2. The Health and Education Task Forces, which operate at national level in all 14 regions and in each electoral constituency to coordinate the work of ministries, local authorities and development partners around health aspects of education. The national Health and Education Task Force has multi-sector participation including UNICEF/UNESCO/ UNFPA, the University of Namibia (for teacher training), the MEAC, the Ministry of Gender Equality and Child Welfare (MGECW), the MoHSS and the Ministry of Sport, Youth and National Service (MSYNS).
3. The coordinating mechanisms for the implementation of the National Gender Policy, which include implementation clusters for health, HIV and AIDS and for SGBV and human rights.
4. HIV coordinating mechanisms for the UNCT in Namibia. In the main, these consist of the JUNTA and the UNCT. The JUNTA meets monthly (one week before the monthly meetings of the UNCT) and is chaired by UNAIDS while the UNCT is chaired by the Office of the United Nations Resident Coordinator. The work of the JUNTA and the UNCT regarding HIV is reflected in the Joint Programme of Support for AIDS in Namibia.
5. The United Nations Partnership Framework (UNPAF), which has its own coordinating mechanism with, at its apex, the UNFPA Joint Steering Committee co-chaired by the Ministry of Economic Planning and the United Nations Resident Coordinator. At the operational level, it is supported by the meetings of the UNCT chaired by the Resident Coordinator. On matters of HIV and AIDS, the JUNTA provides input to the UNCT. In this way, the JUNTA is directly connected to the UNPAF coordinating mechanism, as illustrated in the governance structure and implementation mechanisms for the UNPAF. The UNPAF also has specific clusters of participating UNCT members organized around different programming areas.¹²⁶

124 UNFPA, Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to the Government of Indonesia (GOI) 2016–2020. Dated February 20, 2019. UNFPA. P.52

125 Republic of Namibia, Ministry of Health and Social Services, National Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22. 2017, p.59.

126 Government of the Republic of Namibia, United Nations Namibia, United Nations Partnership Framework (UNPAF) 2019-2023. (2019), p.15.

4.5.2 Effective mechanisms for coordination

In general, global level interviews and case studies at regional and country levels support the view that mechanisms for coordinating external support and national action in response to HIV have been effective (and well supported

by UNFPA). Table 17 outlines some of the positive elements and some of the challenges reported for coordination at different levels.

TABLE 17: Coordination mechanisms: strengths and challenges

Level of coordination	Strengths	Challenges to effective coordination
Global	UNFPA active in coordinating UNAIDS through the CCO and other bodies such as the GPC	Severe staff resource constraints on UNFPA participation/ leadership
Regional: EEAC	UNFPA plays an important role due to its active programming in the region	Limited interest on the part of national governments Declining investments by external partners reduces incentive for coordination
Country: Georgia	UNFPA plays a key role in coordinating the JUNTA, including representing the UN agencies on the CCM and Policy Advocacy Advisory Council	Role of the Global Fund-oriented CCM is critical but diminishing along with Global Fund financing with no ready replacement
Country: Indonesia	TWG on HIV and the JUNTA are active with a strong role in the JUNTA played by UNFPA	The CCM and its TWG-HIV are focused on Global Fund-supported programmes and not the overall national HIV response UNFPA role in the JUNTA approved Division of Labour limits CO ability to address needs of MSM and other priority KPS
Country: Namibia	Long-standing structures for coordinating action in HIV, health education and SGBV Some TWGs under the national structure are active and effective Effective JUNTA with clear links to the UNCT in Namibia	NAEC seen as lacking dynamism and failing to adequately promote a prevention agenda JUNTA is effective but, within the UNCT, there is some overlap in mandates for adolescent health (WHO), SRHR for adolescents and youth (UNFPA) and child health and development (UNICEF). Sometimes contributes to mixed messages from the UNCT members to national authorities

Respondents to the online survey were largely positive (73 per cent) in their responses when asked about the effectiveness of national platforms for coordinating the HIV response. While mechanisms for coordinating the response to HIV at global and regional levels (at least as reflected in the regional case studies) are viewed positively by stakeholders interviewed by the evaluation team, mechanisms at country level face significant challenges. In Georgia and Indonesia, the diminished importance and relatively narrow programme focus of the Global Fund CCM and its TWG present real challenges to effective coordination. In Namibia, while coordinating mechanisms are well established, they are complex and sometimes overlapping, imposing significant costs in staff time for participants from government, civil society and the United Nations team.

4.5.3 Sustainable investments

UNFPA operates within a difficult context for supporting sustainable investments in HIV prevention at both regional and national levels. At regional level, both EECA and Asia Pacific regions are confronted by declining levels of investment by the Global Fund (at least in the case study countries). The situation in ESA is less dire from an external resource point of view. In that context, ESARO has worked with other members of the RATESA to mobilize resources in support of integration through funding of the *2gether 4 SRHR* programme by Sweden. It has also encouraged national governments to mobilize their own resources. For example, a key component of the *2gether 4 SRHR* programme is “a transition strategy that demonstrates how the programme will be integrated within and funded through country plans by the end of 2021”.¹²⁷

At country level, the challenge of ensuring stable, or even increasing, investments in the HIV response is particularly acute, despite the efforts by some national governments to expand their share of HIV expenditures. In Georgia, for example, the national government reportedly finances 75 per cent of HIV expenditures with the other 25 per cent accounted for by the Global Fund. Similarly, in Namibia, the national government has recently increased its share of HIV expenditures to 64 per cent from a base of 39 per cent in 2013.

UNFPA has, however, tried to support efforts to improve the sustainability of financing for the HIV response at national level. The Namibia MoHSS is currently working (with support from UNFPA, UNAIDS and PEPFAR/CDC) to convene an SADC meeting on sustainable resources for HIV programmes in the region. In Zambia, UNFPA and UNICEF supported the MoH to develop and publish a discussion paper on sustainable financing of HIV prevention in 2017.

UNFPA is also constrained regarding both its funding and the types of activities it can support in upper middle-income countries using core funds because of the budget allocation formula used under UNFPA lines of business model. This is especially difficult in ESA where, in spite of very high levels of inequality, UNFPA country offices are very restricted in terms of access to core funding despite very low levels of national spending per-capita on health in UMIC countries, such as Namibia and South Africa.

Finally, it is important to recognize that many of the countries where UNFPA is supporting urgent actions in the HIV response remain highly donor dependent. In Georgia, for example, there are apparently plans in place for adequate funding of treatment through purchases of ARVs but prevention remains relatively neglected. Despite efforts to increase the national share of HIV expenditures, Namibia continues to be highly dependent on external funding for HIV staff compensation (55 per cent in 2017) and for training (95 per cent).¹²⁸

127 UNFPA/UNICEF/UNAIDS/WHO, Steering Committee Summary Presentation. *2gether 4 SRHR* programme (Power Point Presentation), slide 44-45.

128 Ministry of Health and Social Services, Namibia's Health and HIV Financing Landscape, 2015/16 and 2016/17: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercises, (August, 2018).



© UNFPA Namibia/Emma Mbekele. In 2015, UNFPA launched a 3D film on sexual and reproductive health, 'Don't be a Zula Zombie', that provides accurate information on sexual and reproductive health to adolescent and youth



© UNFPA Namibia/Emma Mbekele. UNFPA supporting delivery of accurate information on sexual and reproductive health to adolescent girls in Namibia

5

CONCLUSIONS

5.1 OVERALL STRENGTHS AND CHALLENGES OF UNFPA SUPPORT TO THE HIV RESPONSE

Building on the detailed theory of change (presented in Section 3.2), and based on the evaluation’s findings, one can highlight the key strengths of the UNFPA support to the HIV response as well as its limitations and the challenges it faces.

It is important to note the cross-linking nature of all UNFPA interventions (as depicted in Figure 9). For example, the

deployment of interventions pertaining to the areas 1, 2, 3, and 4 have synergetic effects since realizing rights, meeting needs and supporting participation by the marginalized and KPs can effectively contribute to, and benefit from, linking and integrating SRHR/HIV/SGBV services.

FIGURE 9: UNFPA support to the HIV response: focus on preventing sexual transmission

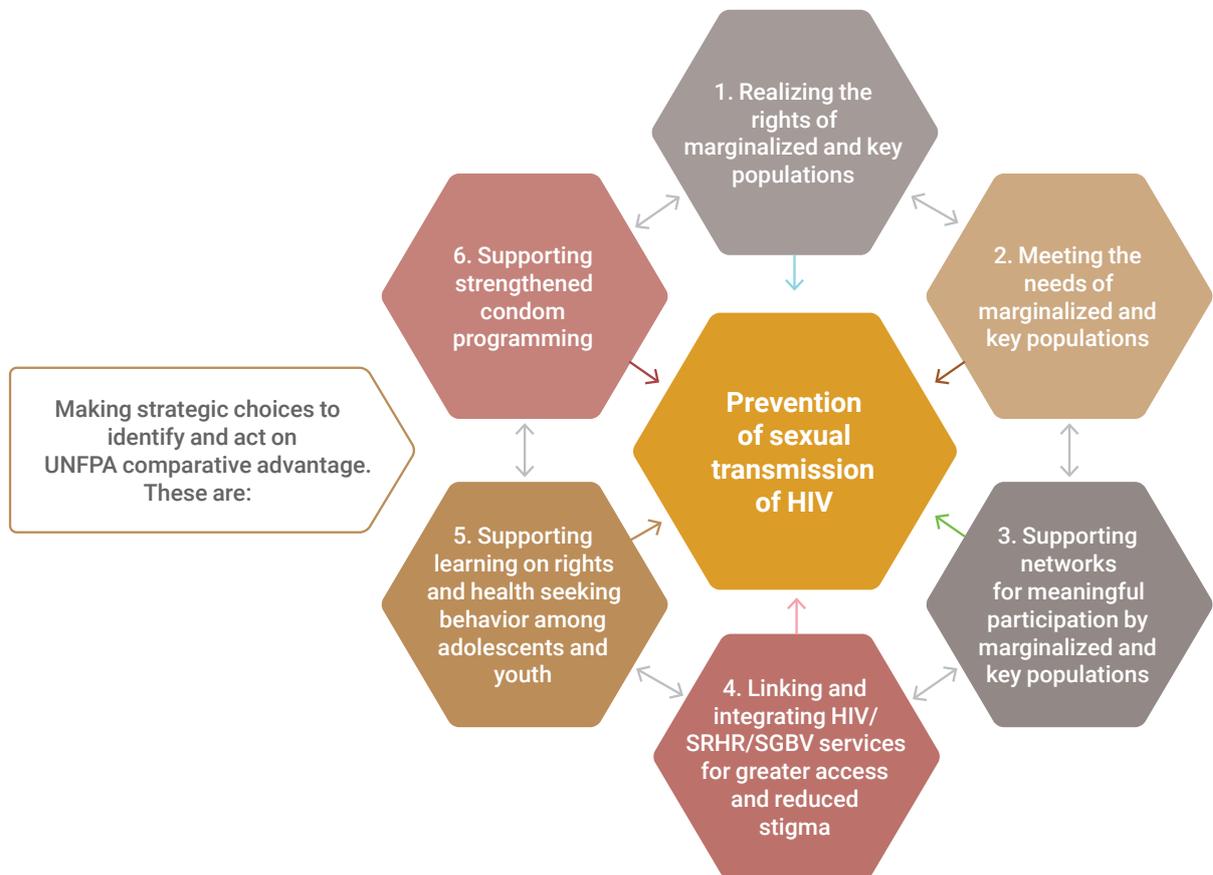


TABLE 18: Strengths and challenges in UNFPA support to HIV

UNFPA Actions	Strengths	Challenges
Strategic choices and realizing comparative advantage	<ul style="list-style-type: none"> • UNAIDS Division of Labour serves a guiding principle • Focus on LNOB and most vulnerable • Some ROs with identified strategic approaches adapted to different contexts • Some COs with strategic approaches appropriate to the national context. 	<ul style="list-style-type: none"> • Absence of an overall UNFPA strategy and theory of change for supporting the HIV response • Some missed opportunities for global, regional and national advocacy • Perceived de-emphasis of HIV in the current strategic plan • Human and financial resource constraints • Global agreements on the Division of Labour in HIV (UBRAF) not always carried through at country level, inhibiting UNFPA in realizing its comparative advantage
Realizing the rights of marginalized and KPs	<ul style="list-style-type: none"> • UNFPA recognized in selected countries as a “pioneer” in supporting rights of marginalized and KPs through advocacy and legitimizing their participation in policy process • Strong links to strategic partners advocating for rights of marginalized and KPs in some regions and countries 	<ul style="list-style-type: none"> • Interventions to address the rights/needs of marginalized and KPs constrained when UNFPA business model prevents engagement at service delivery level • Focus on the principle of ‘non-discrimination’ does not address the issue of recognition of rights and concrete equality • Only recent UNFPA attention to rights of persons with disabilities and indigenous groups
Meeting the needs of the marginalized and KPs	<ul style="list-style-type: none"> • Meeting needs of marginalized and KPs is a recognized comparative advantage and core mandate area for UNFPA • Demonstrated ability and willingness by UNFPA to support CSOs targeting services to meet the needs of marginalized and KPs. 	<ul style="list-style-type: none"> • Link between rights and meeting needs of KPs is not well recognized in some COs and by host governments • Reliance on CSOs for meeting the needs of marginalized and KPs poses issues of reach (i.e. national coverage) and sustainability despite their strengths as service providers to stigmatized and marginalized populations
Supporting networks for meaningful participation	<ul style="list-style-type: none"> • Active UNFPA support to key networks at regional and country levels • Evidence of meaningful participation of most vulnerable/KPs in national conversation on the HIV response • UNFPA is effective in advocating for participation of networks and CSOs in the policy process 	<ul style="list-style-type: none"> • Limited UNFPA financial and technical resources for capacity development of networks and CSOs • UNFPA business model constrains efforts to support service delivery by CSOs in key middle-income countries

UNFPA Actions	Strengths	Challenges
Linking and integrating SRHR/ HIV/SGBV	<ul style="list-style-type: none"> • Effective UNFPA advocacy and support of linkages and integration at global, regional and country levels • Tools for linkage and integration developed and in use • ROs develop strategies to support linkage and integration, which are appropriate to the regional context • Multi-country programme in support of integration creates a rich body of experience • Efforts to share local and national experience within and across regions 	<ul style="list-style-type: none"> • Despite communications efforts of the headquarters units, not all regions and countries are aware of the importance of linkages and integration in the HIV response • The lessons learned and challenges to be overcome in linking and integrating SRHR/ HIV/SGBV are insufficiently documented and disseminated
Supporting learning on rights and health	<ul style="list-style-type: none"> • UNFPA is a key partner in strengthening CSE in non-formal settings • Guidelines and curricula on CSE at regional and country level address SRHR for adolescents and youth, including rights of KPs • Cooperation between UNFPA and UNESCO on out-of-school CSE 	<ul style="list-style-type: none"> • CSE curriculum under life-skills programmes are often not given the same priority as 'examinable' subjects needed for school leaving certificates • Lack of research-backed knowledge on the effect of learning on behaviour of adolescents and youth
Strengthening condom programming	<ul style="list-style-type: none"> • High profile of UNFPA supported "Condomize!" campaigns at national level • RO and CO experience highlights the importance of supply chains and CCP • Advocacy for strengthened SCM with national authorities and partners 	<ul style="list-style-type: none"> • Sustainability of effects of "Condomize!" campaigns questionable in absence of a broader support to CCP • Lack of engagement by UNFPA in SCM outside of UNFPA supplies countries • UNFPA is not sufficiently acting on its perceived comparative advantage in condom programming

5.2 CONCLUSIONS

5.2.1 Strategic choices and comparative advantages

CONCLUSION 1

UNFPA has been able to utilize the UNAIDS Division of Labour to guide its support to the HIV response in a manner consistent with its comparative advantages. However, strategic plan 2018-2021 does not explicitly recognize the central role UNFPA should play in preventing sexual transmission of HIV and realizing the rights and meeting the needs of KPs. As a result, there is an imbalance between the outward-facing ambition of UNFPA to fill a leadership role in the global HIV response and the inward-facing attention and priority paid to this

responsibility. This imbalance, combined with the lack of an agreed UNFPA HIV strategy supported by a theory of change, and the lack of necessary financial and human resources, has limited the ability of UNFPA to use advocacy to shape the global agenda and ensure prioritization of comprehensive HIV prevention. There are countries where external resources are limited and the allocation of UNFPA core resources is constrained by the UNFPA business plan: these factors have contributed to an insufficient level of attention to HIV prevention in family planning and a lack of prioritization for CCP.

Based on findings for evaluation question five: see Section 4.1

5.2.2 Promoting rights and meeting the needs of key populations and the most vulnerable

CONCLUSION 2

UNFPA has made important contributions to realizing the rights and meeting the needs of the most vulnerable, including AGYW, and KPs. However, a number of factors inhibit the capacity of UNFPA to play its expected role in championing their rights and the ability of country offices to engage on sensitive issues in order to reform the broader legal and policy framework. The absence (at corporate level) of a transformative result conveying a strong priority for realizing the rights of, in particular, KPs, and the lack of an explicit strategy for UNFPA support to the HIV response both diminish the focus required for more effective action on rights.

This is further limited by a UNFPA business model that does not foresee service delivery as a mode of engagement in many countries. This constrains the capacity of country offices to address the ability of the most vulnerable and KPs to access quality services in HIV prevention, testing and treatment free of discrimination. These are often countries (as in EECA) where the pace of HIV infection is rising and is concentrated among KPs. Yet, support to rights promotion and meeting the needs of the most vulnerable is of limited effectiveness when not rooted in efforts to improve access to rights-based services.

Based on findings for evaluation question two and three: see section 4.2

5.2.3 Linking and integrating SRHR, HIV and SGBV

CONCLUSION 3

UNFPA support has demonstrated that linking and integrating SRHR/HIV/SGBV programmes and services is an effective approach to meeting the needs of AGYW, other vulnerable groups and KPs. UNFPA has also responded effectively to the proven link between sexual and gender-based violence and HIV infections among adolescent girls and young women by extending the integration agenda to include SGBV. UNFPA has made an important contribution to achieving quality, integrated services in SRHR/HIV/SGBV especially in countries taking part in the *2gether 4 SRHR* programme in ESA.

This can be attributed to access to consistent financial support for this large, multi-country project focused on linkages and integration, combined with a strong regional partnership with the Southern Africa Development Community, and sustained advocacy and technical support by UNFPA staff. However, the understanding, level and nature of support to integration varies widely across UNFPA regions and countries. Furthermore, the relative absence of UNFPA support to CCP in many countries can undermine some of the results obtained through linkages and integration of SRHR/HIV/SGBV.

Based on findings for evaluation question one: see section 4.3.

5.2.4 Supporting networks and forging partnerships

CONCLUSION 4

UNFPA has effectively forged partnerships and worked with networks at regional and country levels to promote meaningful participation of AGYW, KPs and other vulnerable groups in the policy process. UNFPA has also contributed to the effectiveness of networks and civil society organizations led by adolescents, youth and KPs. However, empowering these partners requires adequate and sustained investment over time in order to build their capacity to engage in advocacy and policy making to improve the HIV response, broader SRHR policies and the overall legal framework.

Yet, UNFPA support to networks is currently constrained by a lack of guidance on how to extend participation beyond the stages of programme design and implementation into accountability by partner governments for effectively realizing the rights of young people, KPs and other vulnerable groups. Furthermore, while reliance on and strengthening of civil society partners can be an effective approach, it presents important challenges due to the contrast between their potential contribution to the HIV response for young people, KPs and other vulnerable groups, and the factors that hinder their growth.

Based on findings for evaluation question four: see section 4.4.

5.2.5 Coordination and Sustainability

CONCLUSION 5

UNFPA participates actively in platforms and mechanisms for coordinating actions in support of the HIV response at global, regional and national levels. These platforms have successfully avoided duplication of efforts and conflicting messages from the United Nations Country Teams in host countries. UNFPA participation in coordinating mechanisms does, however, require a significant investment of time and resources.

In addition, coordination among partners with a view to increasing and sustaining investments in HIV prevention, testing and treatment has been limited, although the need is particularly acute in countries transitioning to upper middle-income country status where resource-allocation models for large-scale programmes can result in abrupt reductions in multilateral support. Reliance on external funding for key aspects of the HIV response by many countries presents a continuing risk to the sustainability of progress made.

Based on findings for evaluation question six: See Section 4.5.



6

RECOMMENDATIONS

RECOMMENDATION 1: Clarifying the role of UNFPA and its strategic orientations on HIV

While the UNAIDS 2018 Division of Labour helps to guide UNFPA interventions, it cannot replace a clear statement from UNFPA senior management regarding the roles and responsibilities of the organization in the HIV response. UNFPA, as a matter of organizational priority, should develop and adopt a strategy for its support to the HIV response, including matching human and financial resources, setting priorities, and accommodating the flexible application of the business model. It should be supported by a theory of change detailing the role of UNFPA at global, regional and national levels, aligning UNFPA responsibilities as a UNAIDS Cosponsor with UNFPA core mandate areas, and seeking synergies between UNFPA HIV programming and other internal strategies and programmes, in support of the transformative results of UNFPA strategic plan 2018-2021.

Based on conclusion: 1

Directed to: UNFPA Technical Division (SRH Branch), Resource Mobilization Branch, Policy and Strategy Division, regional offices, Office of the Executive Director

Operational requirements

- Develop a UNFPA HIV strategy and associated implementation plan, building on the UNFPA HIV draft framework of 2017, under UNFPA technical and executive leadership
- Develop an agreed theory of change for UNFPA

support to the HIV response, which is consistent with UNFPA strategic plan 2018-2021 and its role as a UNAIDS Cosponsor

- Ensure the implementation plan includes a monitoring framework on UNFPA leadership (with a focus on prevention and integration in HIV programming) and adequate human resources and programming budgets
- Mainstream the HIV strategy in the implementation of other UNFPA programming, such as, but not limited to: Essential Package for SRHR, the Youth Strategy, the GBV Strategy, Humanitarian Response, etc.

RECOMMENDATION 2: Meeting the needs of those left behind and promoting their rights

UNFPA needs to take steps to close the gap between rhetoric and action regarding its human rights-based approaches in SRHR. To this end, it should develop tools for operationalizing the UNFPA commitment to rights in different technical areas, including in contributing to the HIV response. This should include explicit programming tools placing the promotion of rights, including the rights of AGYW, KPs and other vulnerable groups, as a core strategic pillar of UNFPA work in support of the HIV response. It should also include efforts to promote rights literacy among UNFPA staff, service providers and communities. Finally, it should strengthen accountability mechanisms or other components related to the identification (and follow-up) of potential violations of rights, especially in relation to access to quality SRHR services.

Based on conclusion: 2

Directed to: Technical Division (SRH Branch, GHR Branch), Policy and Strategy Division, regional offices, country offices

Operational requirements:

- Ensure support to the HIV response incorporates and builds on elements of the UNFPA/WHO policy and guidelines on a human rights-based approach
- Ensure implementation of the existing UNFPA HRBA guidance at country level. This could include new indicators designed to capture UNFPA efforts to support rights-based HIV and integration programming
- Strengthen lessons learned and sharing of best practices, including through South-South cooperation, for advancing rights in the context of HIV across UNFPA regional and country offices and other technical units, as well as by host governments and implementing partners.

RECOMMENDATION 3: Linking and integrating SRHR/HIV/SGBV

Linking and integrating SRHR/HIV/SGBV services is key to an effective and sustainable national response to HIV. There is a need for UNFPA to build on lessons learned from the experiences in EECA, ESA and other regions, as well as from the ECHO trial results, in order to develop and strengthen guidance to regional and country offices on piloting and scaling linkages and integration at national level. This guidance should take stock of the diversity of contexts in which UNFPA operates, and should be communicated across all regional and country offices. The intent is to ensure that UNFPA maintains strong leadership on linkages and integration, and that country offices can be effective in supporting related programmatic actions at country level, with regional offices providing the advocacy and technical support as needed.

Based on conclusion: 3

Directed to: Technical Division (SRH Branch, GHR Branch), Resource Mobilization Branch, regional offices, country offices

Operational requirements:

- Emphasize the role of linkages and integration in the chain of effects in the UNFPA strategy for supporting the HIV response (and its accompanying theory of change)
- Strengthen South-South cooperation to accelerate

SRHR/HIV/SGBV linkages and integration, support operational lessons learned at regional and country office levels, and inform global advocacy

- Update guidance on operational aspects of piloting and scaling linkages and integration at national level
- Accelerate the implementation of the key population implementation tools and the Consolidated Guidelines on SRHR for women living with HIV
- Clarify the role of UNFPA towards providing technical support to scale up national linked and integrated SRHR/HIV/SGBV programmes for key populations (in all programme countries) and young women (in settings with high HIV prevalence) and their partners. This includes defining the UNFPA role at country level in support of programming, in particular throughout the new three-year Global Fund cycle.
- Strengthen the leadership role for regional offices (particularly those without HIV-dedicated staff) to ensure that support to the HIV response at country level includes needs identification, advocacy, and piloting and scaling linkages, and integration.

RECOMMENDATION 4: Asserting leadership in comprehensive condom programming

UNFPA should continue to assert the critical importance of CCP, as doing so realizes the role of UNFPA in championing triple protection (prevention of HIV, other STIs and unintended pregnancies). This should include providing support to condom programming (male and female condoms and lubricants) that is comprehensive and covers both supply and demand. Important elements of a comprehensive approach should include, in particular, further integration of condom programming into UNFPA support to family planning programmes. It should extend to strengthening supply chains (including in countries that do not currently benefit from the UNFPA Supplies Programme) and bolstering demand creation, especially among young people. A comprehensive approach to condom programming should also foresee the reinforcement of public-private-people partnerships for increasing access to and uptake of the use of condoms and lubricants.

Based on conclusions: 1 and 3

Directed to: UNFPA Technical Division (SRH Branch, CS Branch), regional offices, country offices

Operational Requirements:

- Bolster advocacy and technical support at global,

regional and national levels for strengthened condom programming, including supply, demand and stewardship, as a key element in HIV prevention and as an essential part of SRHR

- Further integrate condom programming within family planning programmes and services
- Reinforce and extend cooperation between the SRH Branch, the Procurement Services Branch, the Commodity Security Branch (and the UNFPA Supplies Programme), to provide support to those countries that do not participate in the Supplies Programme

RECOMMENDATION 5: Forging partnerships and supporting networks

UNFPA should increase support to the development of the community of regional and national networks by leveraging and allocating resources to strengthen the capacity of CSOs (particularly those catering for or led by KPs, adolescent girls and young people) to engage effectively in policy dialogue, and to access funding from national and international sources. UNFPA should also promote linkages between global, regional and national networks for advocacy and engagement of KPs, AGYW and other young people. Finally, UNFPA should explore collaboration with the Global Fund to support grant applications and the implementation of HIV prevention programmes, especially for programmes focused on AGYW and KPs.

Based on Conclusion: 4

Directed to: UNFPA Senior Management, SRH Branch, Resource Mobilization Branch, regional offices, country offices, Policy and Strategy Division

Operational Requirements

- Support the capacity development of, and service delivery by, CSOs, including in transitioning MIC and UMIC countries
- Coordinate support by regional and country offices to community networks operating at both regional and national levels to ensure investments in communities are working in synergy and in a mutually reinforcing manner
- Strengthen regional and country offices' advocacy efforts to enlarge the space for, and ensure meaningful representation and participation of, civil society, notably key populations, adolescent girls and young people in national dialogues

- Strengthen UNFPA advocacy with national governments and other partners in the HIV response, with a view to increasing and sustaining CSO financing, including through social contracting mechanisms and including within transitioning MIC and UMIC countries
- Strengthen the capacity of regional and country offices to support the application for and implementation of Global Fund grants

RECOMMENDATION 6: Coordination and sustainability

UNFPA should take action to address risks to the sustainability of the HIV response as part of its role as a UNAIDS Cosponsor participating in the Joint Programme at global, regional and country levels. UNFPA should also advocate and collaborate with other development partners to promote sustainable HIV programming, including transitioning from external funding and integrating HIV into national and sector development programmes. It should advocate for increased emphasis on prevention within HIV responses under national stewardship and support national strategies and plans for incorporation of the essential package of SRHR interventions, including on HIV/STIs, into universal health coverage (UHC) mechanisms. UNFPA should also consider technical assistance to national authorities developing proposals for external funding for the HIV response and ensure that the support to capacity development of health care providers for family planning and other SRHR services does incorporate rights-based HIV prevention, testing and links to treatment.

Based on conclusion: 5

Directed to: Technical Division, regional and country offices

Operational Requirements

- Increase efforts for sharing lessons learned in effective sustainability strategies at national level
- Develop regional and country offices' capacity in assessing the cost efficiency of HIV prevention and testing and links to treatment interventions
- Collaborate with WHO on efforts to move toward UHC and address the implications of this for the HIV response, including in the context of the SRHR essential package
- Emphasize efficiency gains resulting from linkages and integration of SRHR/HIV/SGBV programmes and services.



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