Agenda item 7

UNAIDS/PCB (47)/20.33

ANNEXES

Independent Evaluation of the UN system response to AIDS in 2016-2019

UNAIDS

15-18 December 2020 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
Issue date: 18 November 2020

Additional documents for this item: Annual Report on Evaluation (UNAIDS/PCB (47)/20.31), Independent evaluation of the UN system response to AIDS in 2016-2019 (UNAIDS/PCB (47)/20.32), and the management response to the independent evaluation of the UN system response to AIDS in 2016–2019 (UNAIDS/PCB (47)/20.34).

Action required at this meeting—the Programme Coordinating Board is invited to:

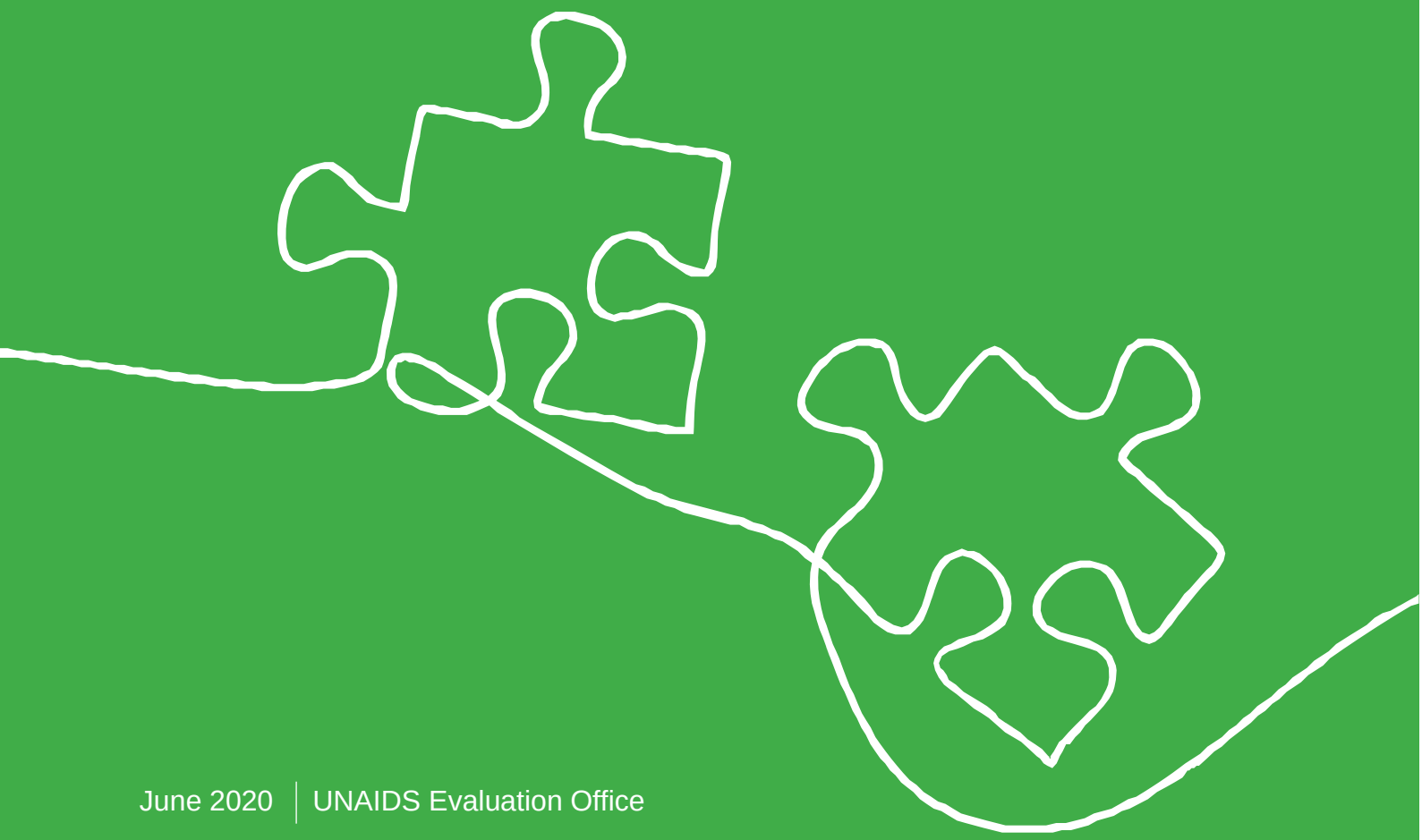
welcome the independent evaluation of the UN system response to AIDS in 2016–2019 (UNAIDS/PCB (47)/20.32) and *request* the Evaluation Office to report on follow up to the independent evaluation as part of its annual reporting the Programme Coordinating Board;

Cost implications for the implementation of the decisions: none

UNAIDS
EVALUATION REPORT

INDEPENDENT EVALUATION OF THE UN SYSTEM RESPONSE TO AIDS IN 2016–2019

Annexes



June 2020 | UNAIDS Evaluation Office

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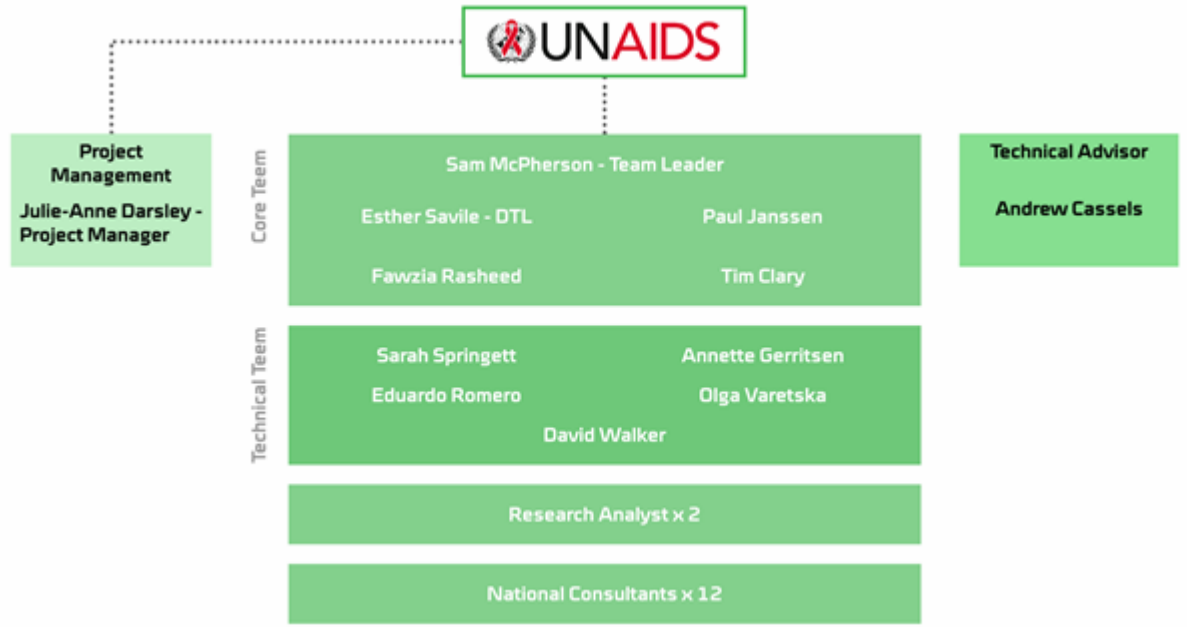
Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Drug
ART	Antiretroviral Therapy
CCM	Country Coordinating Mechanism
CBO	Community Based Organisation
CCO	Committee of Cosponsoring Organisations
CDC	Centers for Disease Control
CSO	Civil Society Organisation
DAC	Development Assistance Committee
DFID	Department for International Development
ECOSOC	UN Economic and Social Council
EMG	Evaluation Management Group
eMTCT	Elimination of Mother to Child Transmission
ERG	Evaluation Reference Group
EQ	Evaluation Question
FSW	Female Sex Workers
GAM	Global AIDS Monitoring
GBV	Gender Based Violence
GEM	Gender Equality Marker
GEWE	Gender Equality and Women Empowerment
GF	Global Fund
GF PR	Global Fund Principal Recipient
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+	Global Network of People Living with HIV/AIDS
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
IDP	Internally displaced person
INGO	International Non-governmental Organisation
KII	Key Informant Interview
KP	Key Population
JIU	Joint Inspection Unit
JPMS	Joint Programme Monitoring System
JUNTA	Joint United Nations Team on AIDS
LGBT	Lesbian, Gay, Bisexual, and Transgender
M&E	Monitoring and Evaluation
MENA	Middle East and North Africa

MoH	Ministry of Health
MOPAN	Multilateral Organisation Performance Assessment Network
MSM	Men who have Sex with Men
NGO	Non-governmental Organisation
NSP	National Strategic Plan
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan-American Health Organization
PCB	Programme Coordinating Board
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-exposure Prophylaxis
PWID	People who inject drugs
QA	Quality Assurance
RST	Regional Support Team
RAG	Red Amber Green
RFP	Request for Proposal
SDG	Sustainable Development Goal
SMT	Senior Management Team
SRA	Strategic Results Area
SRH	Sexual and Reproductive Health
TG	Transgender
ToR	Terms of Reference
UBRAF	Unified Budget, Results and Accountability Framework
UCO	UNAIDS Country Office
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJTA	United Nations Joint Team on AIDS
UNODC	United Nations Office on Drugs and Crime
UNSDCF	United Nations Sustainable Development Cooperation Framework
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women

USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WLHIV	Women Living with HIV
WSW	Women who have sex with Women

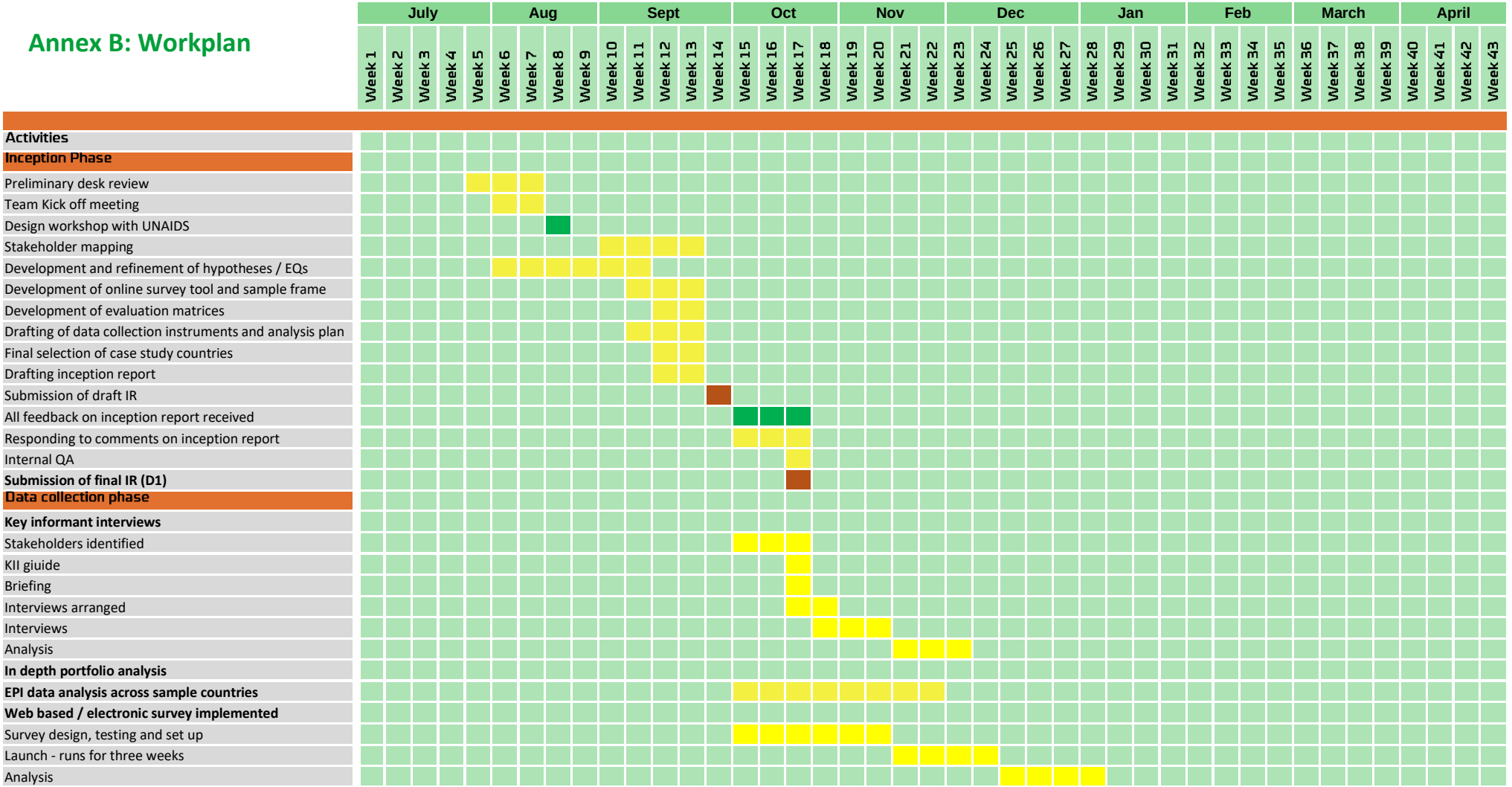
Annex A: Overview of the Evaluation Team

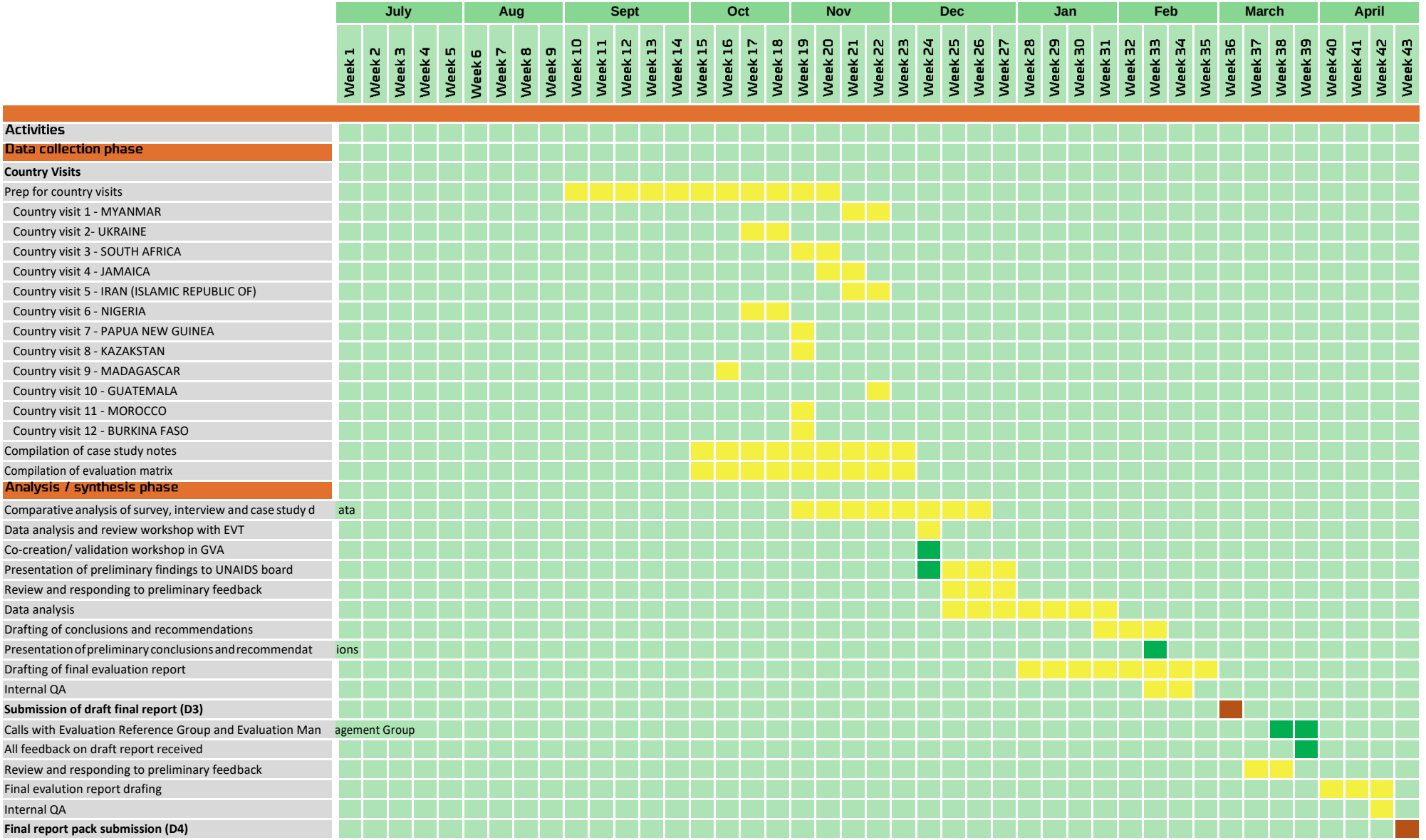


Name	Responsibility
Sam McPherson	Team Leader
Esther Saville	Deputy Team Leader Document review
Paul Janssen	Oversight of 'right things' Oversight of Evaluation Focus Area 'Joint partnership model' and 'Joint Programme in context of reform' Oversight of country case study Country visits x1
Tim Clary	Oversight of 'right way' Oversight of Evaluation Focus Area 'Mobilisation and leveraging resources' Country visits x1
Fawzia Rasheed	Oversight of KIIs Review of reports
David Walker	Oversight of Evaluation Focus Area 'Gender mainstreaming'
Julie-Anne Darsley	Programme Manager Coordination within team and point person with UNAIDS Evaluation Unit
Andrew Cassels	Technical Adviser and quality assurance (QA)
Annette Gerritsen	Oversight of 'right results' Country visits x1
Sarah Springett	Input into the document review
Olga Varetska	Input into Evaluation Focus Area 'Participation and inclusion' Country visits x1
Eduardo Romero	Input into Evaluation Focus Area 'Human rights approach' Country visits x2

Name	Responsibility
Krista Kruja	Research Analyst
Valeria Raggi	Research Analyst
Oladele Akogun	Country Visit - Nigeria
Pierre Huygens	Country Visit – Burkina Faso & Madagascar
Barbara Franklin	Country Visit – Papua New Guinea
Audrey Brown	Country Visit – Jamaica
Inna Shvab	Country Visit – Ukraine
Zaw Min Oo	Country Visit – Myanmar Local Consultant
Rhonda Morrison	Country Visit – Jamaica Local Consultant
Nastaran Moossavi	Country Visit – Iran Local Consultant
Cheikh Traore	Country Visit – Nigeria Local Consultant
Batyrbek Assembekov	Country Visit – Kazakhstan Local Consultant
Holitiana Randrianarimanana	Country Visit – Madagascar Local Consultant
Boureima Zida	Country Visit – Burkina Faso Local Consultant
Erika Stolz de Sobalvarro	Country Visit – Guatemala Local Consultant
Souad Rahibe	Country Visit – Morocco Local Consultant

Annex B: Workplan

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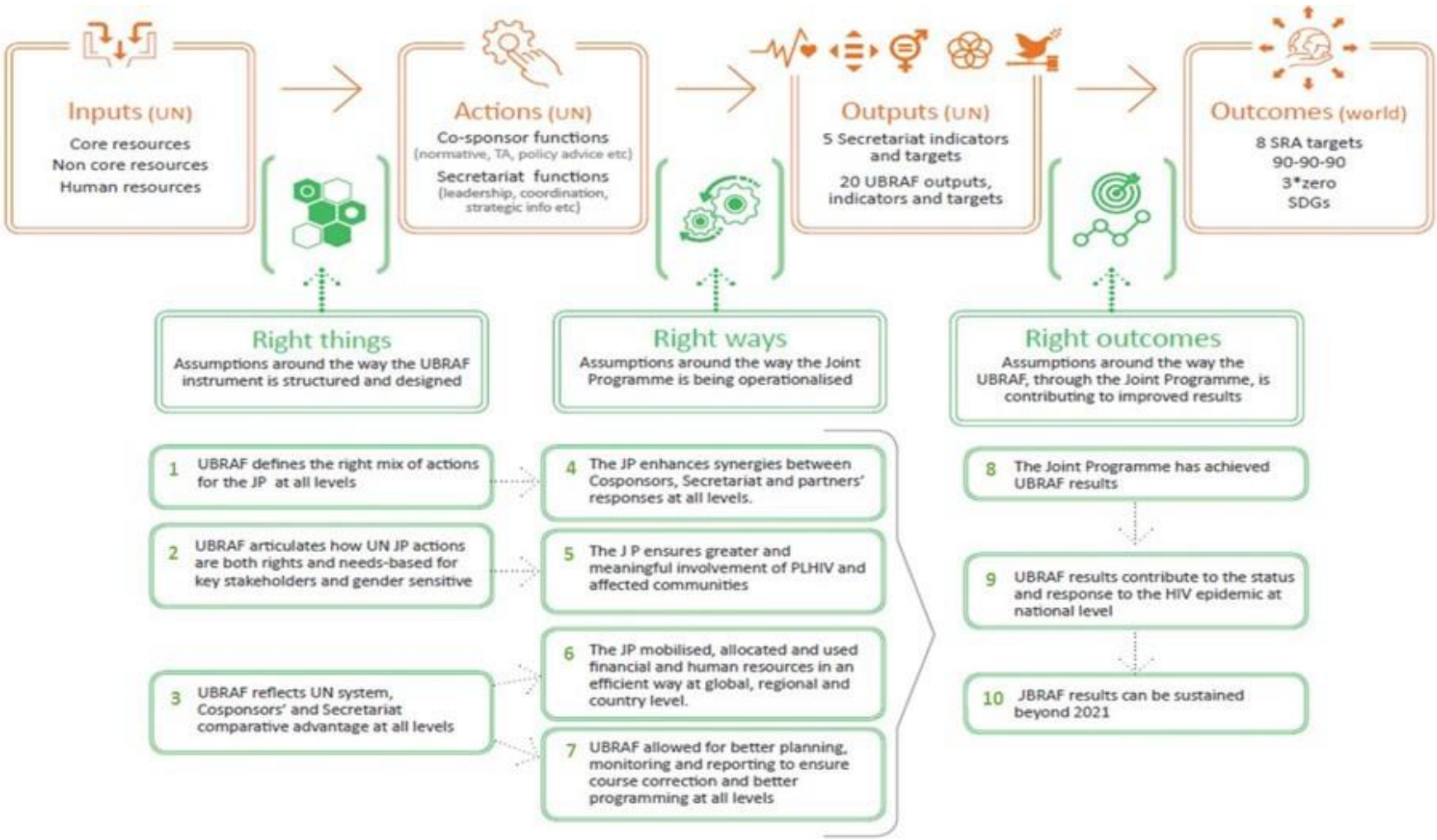
Activities
Data collection phase
Country Visits
Prep for country visits
Country visit 1 - MYANMAR
Country visit 2- UKRAINE
Country visit 3 - SOUTH AFRICA
Country visit 4 - JAMAICA
Country visit 5 - IRAN (ISLAMIC REPUBLIC OF)
Country visit 6 - NIGERIA
Country visit 7 - PAPUA NEW GUINEA
Country visit 8 - KAZAKSTAN
Country visit 9 - MADAGASCAR
Country visit 10 - GUATEMALA
Country visit 11 - MOROCCO
Country visit 12 - BURKINA FASO
Compilation of case study notes
Compilation of evaluation matrix
Analysis / synthesis phase
Comparative analysis of survey, interview and case study d
ata
Data analysis and review workshop with EVT
Co-creation/ validation workshop in GVA
Presentation of preliminary findings to UNAIDS board
Review and responding to preliminary feedback
Data analysis
Drafting of conclusions and recommendations
Presentation of preliminary conclusions and recommendat
ions
Drafting of final evaluation report
Internal QA
Submission of draft final report (D3)
Calls with Evaluation Reference Group and Evaluation Man
agement Group
All feedback on draft report received
Review and responding to preliminary feedback
Final evalution report drafing
Internal QA
Final report pack submission (D4)

Annex C: Overarching ToC for the Evaluation



Annex D: Evaluation Matrix and Questions

Workstream	Hypotheses	Evaluation questions	Link with Evaluation Focus Areas
Right things	1. UBRAF defines the right mix of actions for the UNAIDS Joint Programme globally, regionally and at country level	1.1. To what extent is there a coherent Theory of Change linking the actions of the Joint Programme to the goals and targets in UNAIDS Strategy? 1.2. To what extent are the actions defined in the UBRAF evidence-based? 1.3. To what extent are UBRAF designed to address broader social enablers and participation by stakeholders? 1.4. To what extent are the actions of the UNAIDS Secretariat and Cosponsors relevant at global, regional and country level? 1.5. To what extent are the defined actions at global, regional and country level realistic? 1.6. To what extent does UBRAF help guide prioritisation in case of reduced resources?	Joint Programme partnership model Human rights based approaches Gender mainstreaming
	2. UBRAF articulates how the UN Joint Programme actions are both rights and needs-based for key stakeholders (including key populations) and gender sensitive	2.1. What has been the process of engaging/including key stakeholders in identification of priorities? 2.2. To what extent has the UBRAF been informed by a comprehensive gender analysis? 2.3. To what extent have the needs of key populations/beneficiaries been assessed? How responsive/specific is the UBRAF to needs of key stakeholders? 2.4. To what extent have the needs of country-level counterparts/governments been articulated (in the UBRAF and regional and country plans)? 2.5. To what extent does UBRAF promote the greater and meaningful contribution of people living with HIV?	Joint Programme partnership model Human rights-based approaches Gender mainstreaming Participation and inclusion
	3. UBRAF reflects UN system, Cosponsors' and Secretariat comparative advantage at global, regional and country level.	3.1. To what extent are the roles and responsibilities reflective of the capacities and resources of the organisations? 3.2. To what extent is the external context reflected in UBRAF i.e. PEPFAR, Global Fund etc? 3.3 What is the added-value of the Joint Programme & UNAIDS Secretariat at global, regional and country level? 3.4 How does UBRAF articulate 'leaving no one behind', human rights and equity? 3.5. Does the organisational set-up reflect or respond to UN reform?	Joint Programme partnership model UN reform and AIDS landscape
Right way	4. The Joint Programme enhances synergies between Cosponsors,	4.1. How has the Joint Programme worked with the other major stakeholders at global, regional and country level?	Joint Programme partnership model UN reform and AIDS landscape

	Secretariat and partners' responses at global, regional and country level.	4.2. To what extent have partnership mechanisms been effectively used to ensure the delivery of the Joint Programme's goals (within recognized resource constraints)? 4.3. What is the relationship between UBRAF and UNSDCF, and how are they used at country level?	
	5. The Joint Programme ensures greater and meaningful involvement of people living with, at risk of, and affected by HIV in the AIDS response	5.1 How do Cosponsors and UNAIDS Secretariat engage communities and civil society in the Joint UN Programme? 5.2. How does the Joint Programme support community and civil society involvement in national HIV responses and in global policy development? 5.3 How does the UBRAF monitor and evaluate community and civil society involvement (disaggregated for various key populations)?	Participation and inclusion Human rights based approaches Gender mainstreaming
	6. The Joint Programme has mobilised, allocated and used financial and human resources in an efficient way at global, regional and country level.	6.1. To what extent have funds been mobilised as per plan? What have been the barriers? 6.2. To what extent has the UBRAF leveraged Cosponsor and other development partner resources for HIV programming? 6.3. How has the Joint Programme responded to reduced resources? 6.4. What has been the Joint Programme's capacity and adequacy of allocation of human resources? 6.5. How have country envelopes affected the overall budgeting process and/or the Joint Programme's ability to respond to emerging issues?	Joint Programme partnership model Mobilizing and leveraging resources
	7. The UBRAF has allowed for better planning, monitoring and reporting to ensure course correction and better programming at global, regional and country level	7.1. To what extent are the M&E systems fit for purpose in terms of the quality and quantity of data generated and reported? 7.2. To what extent are the M&E systems (and the information generated) used at all levels to inform planning, programming and course corrections? 7.3 How have the different Cosponsors and Secretariat reported on their contributions to UBRAF results?	Joint Programme partnership model
Right results	8. The Joint Programme has achieved UBRAF results	8.1. To what extent have UBRAF targets been achieved and what is the evidence by output 8.2. What is the evidence of differential performance between countries? 8.3 What is relative contribution of Cosponsors and the Secretariat to joint UN response? 8.4 What is the evidence that the Joint Programme has addressed social enablers at country level?	Participation and inclusion

	9. UBRAF results contribute to the status and response to the HIV epidemic at national level	9.1 What is the evidence to support a correlation between progress on UBRAF outputs and the status and response to the HIV epidemic? 9.2. To what extent can lack of correlation ("outliers") be explained? What lessons can be learned? 9.3. How does the UN Joint Programme contribute to the broader SDGs that are most relevant to the AIDS response: SDG 3, 5,10,16 and 17 (identified in the Strategy and UBRAF)?	Joint Programme partnership model Mobilising and leveraging resources
	10. UBRAF results can be sustained beyond 2021, including through sustainable financing for national responses	10.1. How sustainable are the efforts and results of the Joint Programme? 10.2. To what extent has the Joint Programme supported transition from external to domestic funding? 10.3. How has the Joint Programme informed and optimised the use of Global Fund, PEPFAR and other resources at the country regional and global level? 10.4. What is the evidence that the Joint Programme has contributed to stronger systems and capacities to sustain national and local AIDS responses?	Mobilising and leveraging resources

Annex E: Background Document Review

Itad received over 600 background documents for review, the evaluation team also conducted additional desk-based research to identify relevant Cosponsor evaluations. A scoping review was conducted across all the documents identified to categorise them, dividing them by hypothesis and workstream. The documents were then selected and prioritised by relevance to the evaluation, importance, key interest areas, countries and region. A short list of 93 documents was created for detailed systematic review.

The questions against which the documents were coded as part of the systematic review were the evaluation questions outlined in Annex D. A coding matrix was developed, as detailed in the inception report, and relevant data and information from the documents were extracted and placed within the matrix. Following this, the strength of evidence was assessed to convey the robustness of the findings.

The scale is presented in the rankings overview below.

Ranking	Description
1	Evidence is comprised of multiple data sources (good triangulation) which are generally of decent quality. Where fewer data sources exist, the supporting evidence is more factual than subjective.
2	Evidence is comprised of multiple data sources (good triangulation) of lesser quality, or the finding is supported by fewer data sources (limited triangulation) of decent quality but perhaps more perception-based than factual.
3	Evidence is comprised of few data sources (limited triangulation) and is perception based, or generally based on data that are viewed as being of lesser quality.
4	Evidence is comprised of very limited evidence (single source) or by incomplete or unreliable evidence. In the context of the preliminary findings reports, we might position resulting findings as more preliminary or emerging, with active and ongoing data collection to follow-up.

Once the document review was complete, the workstream leads conducted qualitative anaylsis on the data and included the findings in their overall findings for each hypothesis.

The remaining documents, not included in the systematic review, were categorised as per the scoping review and provided as background reading for consultants. In addition to this, over 300 documents were reviewed ahead of the country case studies. This involved each consultant on the country visit reading the documents that were listed as relevant to their country. These reviewed were used to support the identification of key interest areas, develop specific lines of enquiry and any findings from the documents that were deemed relevant were included in the country report.

The list of documents reviewed can be found below.

Global documents

- Corporate thematic evaluation of UN Women's contribution to governance and national planning, UN Women, 2019
- Fast-Track: Ending the AIDS Epidemic by 2030 (Brochure), UNAIDS, 2014
- Fast-Track: Ending the AIDS Epidemic by 2030, UNAIDS, 2014
- Global AIDS Update: Communities at the centre, UNAIDS, 2019
- Guidance on evaluating institutional gender mainstreaming, UNEG, 2018

- Integrating human rights and gender equality into UNAIDS evaluations, UNAIDS Evaluation Unit, 2018
- Innovation for impact: Refining the operating model of the UNAIDS Joint Programme – Action Plan.-
- Joint United Nations Programme on HIV/AIDS (UNAIDS): Institutional Assessment Report, MOPAN, 2016
- UNAIDS, 2017
- Key barriers to women's access to HIV treatment: A global review, UN Women, 2017
- Political declaration on HIV and AIDS: On the fast track to accelerate the fight against HIV and to ending the AIDS epidemic by 2030, UN General Assembly, 2016
- Review of the management and administration of the Joint United Nations Programme on HIV/AIDS (UNAIDS), Joint Inspection Unit, 2019
- WAD Report UNAIDS, 2014
- UNAIDS 2016-2021 Strategy: On the fast-track to end AIDS, UNAIDS, 2015

Joint Programme planning

- 2018-2019 UBRAF Budget: Country envelopes allocations, UNAIDS
- 38th Meeting of the UNAIDS PCB: 2016-2021 Unified budget, results and accountability framework, UNAIDS, 2016
- 39th Meeting of the UNAIDS PCB: Impact and implications of the budget shortfall on the implementation of the UNAIDS 2016-2021 Strategy, UNAIDS, 2016
- Fast-forward: refining the operating model of the UNAIDS Joint Programme for Agenda 2030, UNAIDS
- Refined operating model of the United Nations Joint Programme on HIV/AIDS (UNAIDS), UNAIDS PCB, 2017
- Refining & reinforcing: The UNAIDS Joint Programme model, Global Review Panel
- UNAIDS 2018-2019 budget: A dynamic, differentiated resource planning, mobilisation, allocation and accountability model, UNAIDS PCB, 2017
- Unified budget, results and accountability framework (UBRAF): Workplan and budget 2020-2021, UNAIDS PCB, 2019

Joint Programme reporting

- Checklist for planning and reporting on Human Rights and GEWE, UNAIDS, 2017

- Evaluation of The UNFPA Support To The HIV Response (2016-2019), Georgia
- Evaluation of The UNFPA Support To The HIV Response (2016-2019), Namibia
- Financial reporting: financial report and audited financial statements for the year ended 31 December 2016, UNAIDS PCB, 2017
- Financial reporting: financial report and audited financial statements for the year ended 31 December 2017, UNAIDS PCB, 2018
- Global AIDS Monitoring 2018: Indicators for monitoring the 2016 United Nations Political Declaration on ending AIDS, UNAIDS, 2017
- Global AIDS Monitoring 2019: Indicators for monitoring the 2016 United Nations Political Declaration on ending AIDS, UNAIDS, 2018
- JPMS 2018 country summary reports
- JPMS 2018 regional summary reports
- JPMS 2018 SRA reports by agencies
- JPMS 2018 SRA reports by outputs
- 2016 JPMS reports
- 2017 JPMS reports
- MOPAN 2015-16 Assessments Joint United Nations Programme on HIV/AIDS (UNAIDS) Executive Summary, MOPAN, 2017
- Performance Monitoring Reports (PMRs), Part I, UNAIDS, 2017
- Performance Monitoring Reports (PMRs), Part II, UNAIDS, 2017
- Progress in the implementation of the UNAIDS Joint Programme action plan: Strategic resource mobilisation plan 2018-2021, UNAIDS, 2017
- Progress on the implementation of the UNAIDS Joint Programme action plan: UNAIDS, 2018
- Quality Assurance Group Comments HQ, UNAIDS, 2017
- Quality Assurance Review Group -Comments, UNAIDS, 2017
- Quality Assurance Review Group -Comments (Management and Governance Branch), UNAIDS, 2018
- Quality Assurance Review Group -Comments (Programme Branch), UNAIDS, 2018
- Quality Assurance Review Group -Comments (RSTs), UNAIDS, 2018
- Raising the standard: the Multilateral Development Review, 2016
- TORs Quality Assurance Review Group, UNAIDS, 2018
- UNAIDS Secretariat Gender Equality Marker Guidance, UNAIDS, 2018
- UBRAF Indicator Report 2016-2019, UNAIDS 2019, draft

- UBRAF Updated Indicator Guidance, UNAIDS, 2017
- Unified budget, results and accountability framework (UBRAF): Financial reporting, UNAIDS PCB, 2019
- Unified budget, results and accountability framework (UBRAF) Performance monitoring report 2016: Organizational reports, UNAIDS PCB, 2017
- Unified budget, results and accountability framework (UBRAF): Performance monitoring report 2016, UNAIDS PCB, 2017
- Unified budget, results and accountability framework (UBRAF): Performance reporting, UNAIDS PCB, 2018
- Unified budget, results and accountability framework (UBRAF) Performance monitoring report 2016-17: Organizational reports, UNAIDS PCB, 2018
- Unified budget, results and accountability framework (UBRAF): Performance monitoring report 2018: Introduction, UNAIDS PCB, 2019
- Unified budget, results and accountability framework (UBRAF): Performance monitoring report 2018: Regional and Country Report, UNAIDS PCB, 2019
- Unified budget, results and accountability framework (UBRAF): Performance monitoring report 2018 strategy results area and indicator report, UNAIDS PCB, 2019
- Unified budget, results and accountability framework (UBRAF) Performance monitoring report 2018: Organizational reports, UNAIDS PCB, 2019

Evaluation reports

- Corporate Thematic Evaluation of UN Women's Contribution to Governance and National Planning, UN Women, 2019
- Final independent project evaluation of the HIV prevention, treatment, care and support in prisons settings in sub-Saharan Africa, Independent Evaluation Unit, 2017
- Independent evaluation of the partnership between UNAIDS & the Global Fund: Final Report, UNAIDS PCB, 2017
- Independent in-depth evaluation of the UNODC Global Programme on HIV/AIDS 2008-2012, Independent Evaluation Unit, 2014
- Independent project evaluation of the partnership on effective HIV/AIDS prevention and care among vulnerable groups in Central Asia and Eastern Europe – Phase II, Independent Evaluation Unit, 2017
- Review of the implementation of the UNAIDS Joint Programme action plan and revised operating model: Interim report, UNAIDS PCB, 2018

UNAIDS Secretariat documents

- 2016-2017 Summary Workplan La, Carb, UNAIDS, 2017
- 2016-2017 Summary Workplan MENA, UNAIDS, 2017
- 2016-2017 Summary Workplan WCA, UNAIDS, 2017
- 2018-2019 Workplans, Asia and Pacific, UNAIDS, 2018
- 2018-2019 Workplans, Eastern and Southern Africa, UNAIDS, 2018
- 2018-2019 Workplans, Eastern Europe and Central Asia, UNAIDS, 2018
- 2018-2019 Workplans, Executive Office, UNAIDS, 2018
- 2018-2019 Workplans, Latin America and Caribbean, UNAIDS, 2018
- 2018-2019 Workplans, Management and Governance, UNAIDS, 2018
- 2018-2019 Workplans, Middle East and North Africa, UNAIDS, 2018
- 2018-2019 Workplans, Programme Branch, UNAIDS, 2018
- 2018-2019 Workplans, West and Central Africa, UNAIDS, 2018
- AP 2016-2017 Summary Workplan, UNAIDS, 2017
- Country Data and UNAIDS Secretariat and Joint Programme Data (spreadsheet), UNAIDS, 2019
- EECA 2016-2017 Summary Workplan, UNAIDS, 2017
- End of year 2017 summary reports: HQ Divisions, extracted from ERP
- ESA 2016-2017 Summary Workplan, UNAIDS, 2017
- Guidelines Activity workplanning 2016-2017, UNAIDS, 2016
- HQ and Liaison Offices 2016-2017 summary workplan, UNAIDS, 2017
- Management Functions, UNAIDS, 2018
- Secretariat activity workplans in the Enterprise Resource Planning (ERP)
- Workplanning 2016-2017 - Quality Assurance (QA) of workplans, UNAIDS, 2017
- Workplanning 2018-2019, UNAIDS Planning Finance and Accountability department and Resource Planning and Management division, 2018
- UNAIDS Division of Labour: Guidance Note, UNAIDS, 2018

Burkina Faso

- 2018 JPMS Country Summary Report for Burkina Faso
- Anonyme. (2019, mai). Genre, VIH et Sida et Eglise : Etude de cas du Burkina Faso.

- BASP. (2017, novembre). Rapport de l'étude biocomportementale en milieur carcéral auprès des détenus hommes et femmmes du Burkina Faso.
- Berthé, A., Traoré, I., Somé, J., Berthé-Sanou, L., Salouka, S., Rouamba, J., … Méda, N. (2013). L'expérience burkinabè de constitution d'un Comité Consultatif Communautaire pour un meilleur accompagnement des projets de recherche sur le VIH. Santé Publique, 25(6), 829. https://doi.org/10.3917/spub.136.0829
- GARPR. (2015). Rapport d'activité sur le VIH sida au Burkina Faso (GLOBAL AIDS RESPONSE PROGRESS REPORTING (GARPR) 2015).
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- ICI Santé. (2017). Cartographie programmatique, estimation de la taille et enquête biocomportementale des populations-clés au Burkina Faso (p. 138).
- Ilse, J., & Simon, S. (s. d.). Sixteen days of activism against gender-based violence in Burkina Faso. 2.
- JUNTA. (2017). Joint Program Country report 2017_ Burkina Faso.
- JUNTA. (2018a). Country Approval on UNAIDS Joint Team enveloppe 2018.
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- JUNTA. (2018c). CR_réunion équipe conjointe 19/4/18.
- JUNTA. (2019a). CR_réunion équipe conjointe 11/4/19.
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- JUNTA. (2019c). Joint Plan 2018-2019-Burkina Faso xls.
- JUNTA. (s. d.-a). CR_réunion équipe conjointe 5/09/19.
- JUNTA. (s. d.-b). PolicyDashboard 3x90_.docx.
- JUNTA. (s. d.-c). PTA_ EC _2018 and 2019.
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- JUNTA. (s. d.-e). UBRAF output 2016-2018 Burkina Faso.
- Ky-Zerbo, O., Desclaux, A., Somé, J.-F., El Asmar, K., Msellati, P., & Makhlouf Obermeyer, C. (2014). La stigmatisation des PVVIH en Afrique : Analyse de ses formes et manifestations au Burkina Faso. Santé Publique, 26(3), 375. https://doi.org/10.3917/spub.139.0375
- OMS. (2016). Données TB 2016. Consulté à l'adresse www.who.int/tb/data
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- ONUSIDA. (2018a). BILAN PHYSIQUE_MEO_Pla nde Travail_EC_2018.
- ONUSIDA. (2018b). Rapport GAM 2018 du Burkina Faso.

- ONUSIDA. (2018c). Résultats de l'équipe Conjointe 2018.
- ONUSIDA. (2019). Focus sur le Burkina Faso. Consulté à l'adresse https://www.unaids.org/fr/20190402_country_focus_BurkinaFaso
- ONUSIDA. (s. d.-a). Rapport GAM 2017 du Burkina Faso.
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- WHO (12 January 2018) ‘Ukraine to finance expanded opioid substitution therapy programme’ (Accessed 23/07/2018)
- WHO Europe (2013) ‘HIV/AIDS treatment and care in Ukraine: Evaluation report’ [pdf]
- WHO/UNAIDS/UNICEF (2011) ,'Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access 2011'
- World Health Organisation Europe (2014) ‘Good practices in Europe: HIV prevention for People Who Inject Drugs implemented by the International HIV/AIDS Alliance in Ukraine’
- World Health Organisation Regional Office Europe (2013) ‘HIV/AIDS treatment and care in Ukraine: evaluation report’

Annex F: Key Informant Interviews

Key Informant interviews were conducted to enhance and complement the data, especially for areas that are were not well covered by existing documentation and/or that require more qualitative information. KIIs were carried out using a semi-structured interview protocol, recorded with the interviewee's permission before being transcribed and coded.

The approach to sampling was flexible and aimed at ensuring maximum coverage and representation of key stakeholders to cover the 10 evaluation hypotheses and EQs (see Annex D). During the inception phase of the evaluation, a stakeholder mapping exercise was conducted to ensure stakeholders from all relevant institutions were identified as well as those related to the specific Evaluation Focus Areas and hypotheses under investigation.

The long list of questions used for the KIIs is outlined below. A shortlist was developed according to each stakeholder prior to the interview, based on the allocation of specific hypotheses/Eval questions to the interviewee.

Long list of KII question:

Hypotheses	Evaluation questions
1. UBRAF defines the right mix of actions for the UNAIDS Joint Programme globally, regionally and at country level	1.1. To what extent is there a coherent Theory of Change linking the actions of the Joint Programme to the goals and targets in UNAIDS Strategy? 1.2. To what extent are the actions defined in the UBRAF evidence-based? 1.3. To what extent are UBRAF designed to address broader social enablers and participation by stakeholders? 1.4. To what extent are the actions of the UNAIDS Secretariat and Cosponsors relevant at global, regional and country level? 1.5. To what extent are the defined actions at global, regional and country level realistic? 1.6. To what extent does UBRAF help guide prioritisation in case of reduced resources?
2. UBRAF articulates how the UN Joint Programme actions are both rights and needs-based for key stakeholders (including Key Populations) and gender sensitive	2.1. What has been the process of engaging/including key stakeholders in identification of priorities?

	2.2. To what extent has the UBRAF been informed by a comprehensive gender analysis? 2.3. To what extent have the needs of key populations/beneficiaries been assessed? How responsive/specific is the UBRAF to needs of key stakeholders? 2.4. To what extent have the needs of country-level counterparts/governments been articulated (in the UBRAF and regional and country plans)? 2.5. To what extent does UBRAF promote the greater and meaningful contribution of people living with HIV?
3. UBRAF reflects UN system, Cosponsors' and Secretariat comparative advantage at global, regional and country level.	3.1. To what extent are the roles and responsibilities reflective of the capacities and resources of the organisations? 3.2. To what extent is the external context reflected in UBRAF i.e. PEPFAR, Global Fund etc? 3.3 What is the added-value of the Joint Programme & UNAIDS Secretariat at global, regional and country level? 3.4 How does UBRAF articulate 'leaving no one behind', human rights and equity? 3.5. Does the organisational set-up reflect or respond to UN reform?
4. The Joint Programme enhances synergies between Cosponsors, Secretariat and partners' responses at global, regional and country level.	4.1. How has the Joint Programme worked with the other major stakeholders at global, regional and country level? 4.2. To what extent have partnership mechanisms been effectively used to ensure the delivery of the Joint Programme's goals (within recognized resource constraints)? 4.3. What is the relationship between UBRAF and UNSDCF, and how are they used at country level?
5. The Joint Programme ensures greater and meaningful involvement of people living with, at risk of, and affected by HIV in the AIDS response.	5.1 How do Cosponsors and UNAIDS Secretariat engage communities and civil society in the Joint UN Programme? 5.2. How does the Joint Programme support community and civil society involvement in national HIV responses and in global policy development? 5.3 How does the UBRAF monitor and evaluate community and civil society involvement (disaggregated for various key populations)?
6. The Joint Programme has mobilised, allocated and used financial and human resources in an efficient way at global, regional and country level.	6.1. To what extent have funds been mobilised as per plan? What have been the barriers? 6.2. To what extent has the UBRAF leveraged Cosponsor and other development partner resources for HIV programming?

	6.3. How has the Joint Programme responded to reduced resources? 6.4. What has been the Joint Programme's capacity and adequacy of allocation of human resources? 6.5. How have country envelopes affected the overall budgeting process and/or the Joint Programme's ability to respond to emerging issues?
7. The UBRAF has allowed for better planning, monitoring and reporting to ensure course correction and better programming at global, regional and country level	7.1. To what extent are the M&E systems fit for purpose in terms of the quality and quantity of data generated and reported? 7.2. To what extent are the M&E systems (and the information generated) used at all levels to inform planning, programming and course corrections? 7.3 How have the different Cosponsors and Secretariat reported on their contributions to UBRAF results?
8. The Joint Programme has achieved UBRAF results	8.1. To what extent have UBRAF targets been achieved and what is the evidence by output 8.2. What is the evidence of differential performance between countries? 8.3 What is relative contribution of Cosponsors and the Secretariat to joint UN response? 8.4 What is the evidence that the Joint Programme has addressed social enablers at country level?
9. UBRAF results contribute to the status and response to the HIV epidemic at national level	9.1 What is the evidence to support a correlation between progress on UBRAF outputs and the status and response to the HIV epidemic? 9.2. To what extent can lack of correlation ("outliers") be explained? What lessons can be learned? 9.3. How does the UN Joint Programme contribute to the broader SDGs that are most relevant to the AIDS response: SDG 3, 5,10,16 and 17 (identified in the Strategy and UBRAF)?
10. UBRAF results can be sustained beyond 2021, including through sustainable financing for national responses.	10.1. How sustainable are the efforts and results of the Joint Programme? 10.2. To what extent has the Joint Programme supported transition from external to domestic funding? 10.3. How has the Joint Programme informed and optimised the use of Global Fund, PEPFAR and other resources at the country regional and global level? 10.4. What is the evidence that the Joint Programme has contributed to stronger systems and capacities to sustain national and local AIDS responses?

The following people were interviewed as part of the KII data collection.

Table 1: Key Informant Interview Respondents

Name	Title	Department / Organisation
GLOBAL LEVEL		
Alison Holmes Cristiana Baroglio	Director, Human Resources Management Chief, HR Operations	UNAIDS
Ariana Stahmer Christopher Castle	Project Officer, Education Sector Division for inclusion, Peace and Sustainable Development Section of Health & Education Focal Point for HIV and AIDS Focal point for HIV within Cosponsors	UNESCO
David Sunderland Elizabeth Benomar	Focal point for HIV within Cosponsors Chair of Cosponsors, Global Coordinator HIV/AIDS, Sexual and Reproductive Health Branch, Technical Division	UNFPA
Abigail David	Senior Planning and Monitoring Adviser, M&E and reporting for aspects on UBRAF monitoring	UNAIDS
Andy Seale	WHO Adviser and Global Coordinator for WHO interactions with the UNAIDS	WHO
Ann Burton	Chief, Public Health Section Senior HIV and Reproductive Health	UNHCR
Chewe Luo	Associate Director, Chief of HIV/AIDS Section, Programme Division	UNICEF
Christopher Fontaine	Senior Adviser, Policy and Reporting	UNAIDS
David Wilson	Global HIV/AIDS Program Director	World Bank
Deborah von Zinkernagel		ex UNAIDS (PEPFAR/Pangaea)
Eamonn Murphy	Regional Director Asia and the Pacific	UNAIDS /Region
Elena Kudravtseva Nazneen Damji	Programme Specialist UN Women's Gender Equality and HIV/AIDS Policy Advisor	UN Women
Fatiha Terki Michael Smith	Deputy Director Nutrition Division HIV Officer (HIV Focal Point)	WFP
Feng Zhao Marelize Gorgens Nejma Cheikh Sutayut Osornprasop	Program Leader, Human Development Programs in Belarus, Moldova and Ukraine Senior Specialist – Health and Human Development Programs Health Specialist in the World Bank's Health, Nutrition, and Population Senior Human Development Specialist in East Asia and the Pacific	World Bank
Hege Wagan	Senior Advisor - Prevention	UNAIDS
Joel Rehnstrom	Director, Evaluation	UNAIDS
Kathy Ward	Global HIV Focal Point	World Bank
Kofi Amekudzi Shauna Olney	Focal point for HIV within Cosponsors Director GED	ILO
Ludo Bok Mandeep Dhaliwal	Focal point for HIV within Cosponsors Director of HIV, Health and Development Team	UNDP
Patrick Brenny	Regional Director West and Central Africa	UNAIDS /Region
Riku Lehtovuori Fariba Soltani	M&E Adviser HIV/AIDS Section Drug Prevention and Health Branch, Division for Operations Sr Expert, Portfolio Manager HIV/AIDS Section	UNODC
Signe Rotberga	HIV Regional Adviser for Southern Africa	UNODC

Tatiana Shoumilina	Senior Adviser, Fast-Track Country Support	UNAIDS
External		
Ade Fakoya	HIV Specialist	Global Fund
Anders Nordstrom	Regarding 2.3, Was on PCB when Swedes withdrew funding	PCB Donor Sweden
Christine Stegling	Executive Director	Frontline AIDS
Cynthia Mwase	Head, Africa and Middle East	Global Fund
Danny Graymore Sarah Boulton	PCB Chair (UK Department for International Development (DFID)) during the period. Head, Global Funds Department, Global Health Funds Team Leader	DFID
David Ripin	CMO & EVP of ID Programming	CHAI
Edwin Huizing	Executive Director	HIVOS
Els Klinkert Jennyfer Imperator Monique Middelhoff	PCB Netherlands	Netherlands MoFA
Francois Venter	Professor	WRHI
Gaj Gurung		Youth Lead
Gillian Holmes	Director: Funding and Engagement	Frontline AIDS
Jen Kates	Senior VP & Director of Global Health and HIV Policy	Kaiser Family
Joseph Amon		Human Rights Watch (UNAIDS Reference Group on HIV and Human Rights)
Judy Chang	Executive Director	INPUD
Kate Thomspon	Head of Community, Rights and Gender	Global Fund
Lee Abdelfadil	UNAIDS Focal Point / HIV Advisor, Technical Assistance and Partnership Development Department	Global Fund
Mamadi Yilla	Deputy Global AIDS Coordinator	USAID/PEPFAR
Stein Erik Kruse	Independent Consultant	PCB Donor Norway
Peter Piot	Founding Executive Director of UNAIDS, ex Associate Director of the Global Programme on AIDS of WHO	LSHTM
Rico Gustav	Executive Director	GNP+
Sonal Mehta	CEO	Alliance India

Annex G: Country Case Study Sampling

Case study countries were selected during the inception phase using a two-stage process

Introduction and initial parameters

This paper presents the sampling method and a selection of 12 countries, for consideration by the UBRAF Evaluation Management Group and Reference Group. The following considerations apply:

1. The UBRAF evaluation aimed to assess progress towards UBRAF objectives by the Joint Programme in *all* countries. The country case studies serve mainly to document experiences on specific areas of interest as identified in the evaluation ToR and the evaluation proposal.
2. The sampling is *purposive* to include a variety of contexts, epidemics and responses. The proposed 12 countries provide a coherent balance. Suggestions for alternatives should consider the coherence of the *total* sample.
3. If any country could not be visited for logistical reasons, the Evaluation Team selected a comparable replacement.

Sampling stage 1

- One fast-track country per region.
- Additional criterion: UNAIDS investment (combination of UNAIDS total funds, envelope funds and Cosponsor presence in country).

Result:

Country	Region	UNAIDS 2018	Country envelope 2018	Cosponsors (indicative)
1. Myanmar	AP	$7,936,764	$300,000	7
2. Ukraine	EECA	$1,036,000	$300,000	8
3. South Africa	ESA	$3,036,608	$1,100,000	9
4. Jamaica	LAC	$1,406,600	$300,000	6
5. Iran	MENA	$373,200	$300,000	5
6. Nigeria	WCA	$3,139,300	$1,100,000	7

Sampling stage 2

- Of the remaining non-Fast Track countries, for each region:
- One non-fast track country per region.
- Intra-regional variation: LAC region 1x Caribbean, AP region 1x Pacific and MENA 1x African.
- Sufficient UNAIDS investment/presence but 1x non-envelope country.
- Additional criteria to ensure variation/complementarity in context, epidemic and response:
    - HIV prevalence, incidence and epidemic profile (Key Populations affected).
    - Service coverage (e.g. access to antiretroviral therapy (ART)).
    - Presence of PEPFAR/Global Fund funding.
    - Fragility/humanitarian issues.
    - Country income status (prospects for sustainability and transition).

Result:

Country	Region	Country envelope	Global Fund HIV 2017–19	PEPFAR 2018	HIV prevalence 2018	HIV increase 2010–18	PLHIV on ART 2019	Income 2019	Fragile
7. PNG	AP	Yes	$42m	$8.8m	0.8%	+26%	65%	LMI	
8. Kazakhstan	EECA	Yes	$60m		0.2%	+35%	58%	UMI	
9. Madagascar	ESA	Yes	$57m		0.3%	+193%	9%	LI	
10. Guatemala	LAC	Yes	$124m		0.4%	+6%	43%	UMI	
11. Morocco	MENA	No	$70m		<0.1%	-25%	65%	LMI	
12. CAR	WCA	Yes	$54m		3.6%	-40%	36%	LI	Yes

Special interest areas relevant for the evaluation (to be finalised)

Country	Inclusion and participation[1]	Human rights[2]	Gender[3]	Resource issues[4]	Fragility and humanitarian	UN reform[5]	Key Populations
Fast Track							
1. Myanmar	Yes	Yes		LMI			IDU/MSM/TG/SW
2. Ukraine	Yes	Yes		LMI			IDU/MSM
3. South Africa	Yes	Yes	GBV	Transition			SW/MSM
4. Jamaica		Yes	GBV	Transition		DAO	MSM
5. Iran		Yes		Transition			IDU
6. Nigeria	Yes	Yes		Transition			
Non-Fast Track							
7. PNC	Yes	Yes	GBV	LMI		DAO	SW/MSM/TG
8. Kazakhstan	?	?		Transition			
9. Madagascar	?	?		Sustainability		DAO	
10. Guatemala	?	Yes		Transition			MSM/SW
11. Morocco	Yes	Yes		LMI			MSM
12. CAR	?	?	GBV	Sustainability	yes		

Shortlist of countries (based on region, Fast Track status, UNAIDS/joint UN investment and epidemic parameters)

Country	Region	Fast Track	UNAIDS 2018	Country envelope 2018	Global Fund HIV 2017–19	PEPFAR 2018	Coponsors (indicative)	HIV prevalence 2018	Incidence trends 2010–18	PLHIV on ART 2019	Income classification 2019	Fragile
Fast Track countries												
Myanmar	AP	Yes	$7,936,764	$300,000	$314,309,788	$13,326,514	7	0.8%	-31	70	LMI	
China	AP	Yes	$1,564,016	$300,000	$323,230,664	-	9	...	...	0	UMI	
Ukraine	EECA	Yes	$1,036,000	$300,000	$362,804,694	$54,824,772	8	1.0%	-26	35	LMI	
South Africa	ESA	Yes	$3,036,608	$1,100,000	$553,493,737	$849,335,022	9	20.4%	-40	62	UMI	
Kenya	ESA	Yes	$2,313,177	$600,000	$639,786,372	$954,928,087	11	4.7%	-30	68	LMI	
Jamaica	LAC	Yes	$1,406,600	$300,000	$86,782,851		6	1.9%	-6	31	UMI	
Haiti	LAC	Yes	$1,105,084	$300,000	$210,422,460	$148,177,536	5	2.0%	-17	58	LI	Yes
Iran	MENA	Yes	$373,200	$300,000	$58,986,249		5	0.1%	-12	20	UMI	
Nigeria	WCA	Yes	$3,139,300	$1,100,000	$824,620,517	$480,499,656	7	1.5%	5	53	LMI	
DRC	WCA	Yes	$2,455,146	$300,000	$524,100,367	$116,700,225	7	0.8%	-39	57	LI	Yes
Côte d'Ivoire	WCA	Yes	$1,498,846	$300,000	$189,818,147	$206,857,076	9	2.6%	-33	55	LMI	
Non-Fast Track countries												
Cambodia	AP	No	$703,300	NO	$243,526,951	$14,338,116		0.5%	-62	81	LMI	
PNG	AP	No	$647,600	$200,000	$41,843,627	$8,810,126	5	0.8%	26	65	LMI	
Kazakhstan	EECA	No	$804,300	$150,000	$59,489,675		9	0.2%	35	58	UMI	
Kyrgyzstan	EECA	No	$334,854	$150,000	$59,987,664		5	0.2%	-49	43	LMI	
Swaziland	ESA	No	$890,500	$300,000	$192,644,814	$105,989,895	6	27.3%	-31	86	LMI	Yes
Rwanda	ESA	No	$582,129	$280,000	$922,438,183	$95,681,833	6	2.5%	-61	87	LI	Yes
Madagascar	ESA	No	$440,300	$220,000	$57,008,932			0.3%	193	9	LI	
Guatemala	LAC	No	$1,124,810	$152,000	$124,259,953		7	0.4%	6	43	UMI	
Argentina	LAC	No	$741,000	$180,000	$28,402,468		6	0.4%	2	61	UMI	
Sudan	MENA	No	$467,386	$200,000	$149,785,633		5	0.2%	-2	15	LMI	
Morocco	MENA	No	$438,800	NO	$70,479,864		8	<0.1%	-25	65	LMI	
CAR	WCA	No	$1,191,563	$264,000	$54,174,818		7	3.6%	-40	36	LI	Yes
Benin	WCA	No	$718,498	$150,000	$153,386,728		7	1.0%	-15	61	LI	
Burkina Faso	WCA	No	$583,200	$176,000	$157,652,042			0.7%	-49	62	4	

1 Important civil society response and/or private sector response and/or multi-sectoral issues
2 Countries with epidemic in Key Populations and/or criminalisation issues
3 Countries with high incidence among girls and young women, and/or gender-based violence
4 UMI countries: transition to domestic financing; LI countries: sustainable external funding
5 Countries with Delivering As One: https://undg.org/standard-operating-procedures-for-delivering-as-one/delivering-as-one-countries/

Table 2: People interviewed as part of the country case studies:

Name	Title	Department / Organisation
Burkina Faso		
Abayo A.O Hermann	Coordonnateur	ATJUD
Bamba Issiaka	Suivi évaluation	AED
Banhoro Sita	Assistante suivi évaluation	REGIPIV
Barbari Aboubacar	UNV	ONUSIDA
Baziono Ledie Charlotte	Personne ressource	DGAP
Bernatas Jean-Jacques	Conseiller régional santé mondiale	Ambassade de France
Ciowema Mathieu	Représentant résident	PNUD
Cisse Mireille	Chargé de programme	UNICEF
Conseiga Bibata	CPS	AED
Diallo Ramata	Personne ressource	SP/CNLS/IST
Diapa T. Edouard	Coordonnateur	CORAB
Diarra-Nama Alimata Jeanne	Représentante	OMS
Drabo Mansour	Chargé suivi stratégique	CCM
Gandema Tasséré	Membre	COCOFA
Gbenou Dina V.	Responsable technique SS	OMS
Gnoumou Agnès	CPS	AED
Guibleweogo Parfait	Chargé de programme	UNFPA
Hien Hervé	Directeur Général	INSP
Ilboudo Victoire	CPS	AED
Kabore André	Chargé informations stratégiques	ONUSIDA
Kabore David	Point focal droits humains	Min. Justice
Kabore Marguerite	Animatrice	AZET
Kafando Clementine	CPS	AED
Kambiré Arlette	IDE	REVS+
Kambou N.O. Emile	Personne ressource	SP/CNLS/IST
Kansolé Reine Nadege	Responsable Ressources humaines	REVS+
Ki Karidiatou	CPS	AED
Kompaore Adama	Membre	AAS
Konate Salimata	Médiatrice	AED
Kone Marceline	CPS	AED
Konseimbo Arnaud	HEAWA/FHI360	FHI360
Koura Claire	CMLS/ MFSNFAH	MFSNFAH
Millogo Brice	Chargé de programme	PNUD
Minougou Mariam	CPS	AED
Moyenga Laurent	Chargé de programme	OMS
Mubalama Jean-Claude	Chief Health/Nutrition Porgramme	UNICEF
Nana/Dahourou Alimata	Chargé de programme	DGAP
Ninon/Fofana Olga	Chargé de programme	PAM
Nitiema Mariam	CPS	AED
Nyemba Jacques	Membre	ANS
Ouedraogo Adama	Coordonnateur	REGIPIV
Ouedraogo Issa	Chargé communication et suivi évaluation	REGIPIV
Ouedraogo Landaogo S.L. Wilfrid	Secrétaire général	Ministère de la santé

Ouedraogo Mahamadi	Point focal communication	PNUD
Ouedraogo Nicolas	PROMACO	PROMACO
Ouedraogo Ramata	Médiatrice	AED
Ouedraogo Romain	Responsable HSH	AAS
Ouedraogo Théphile	Responsable suivi évaluation	PSSLS
Ouedraogo/Drabo Djeneba	Coordonnateur	Yerelon
Rajaonarivela Andriaamanana Miarisoa	CM/OASIS	AAS
Romba Saidou	Chargé de programme	SP/CNLS/IST
Rouamba Kassoum	Responsable OEV	AAS
Sagbohan Job	Directeur pays	ONUSIDA
Sangare Sarata	Médiatrice	AED
Sanogo Jacques	CMA DO	AED
Sanou Assita	Médiatrice	AED
Sanou Edouard	CPS	AED
Sara Bolliri	Premier Secrétaire	Ambassade Grand-Duché Luxembourg
Sawadogo Geoffroy	1er Vice Président	CCM
Sawadogo Mariam	Membre	AED
Senninger Joseph	Chargé d'affaires	Ambassade Grand-Duché Luxembourg
Sore Ibrahim	Médecin charé de la prise en charge	AED
Tapsoba Donatien	Membre	COCOFA
Tiendrebeogo Pascal	Responsable suivi évaluation	AAS
Tihao Bernadette	CPS	AED
Toure Fatimata	Médiatrice	AED
Traore Aboubacar	Responsable infirmerie	AAS
Traore Dabou Irene	Coordonnatrice UCPSE	SP/CNLS/IST
Traore Fatimata	CPS	AED
Traore Lassiné	Gestionnaire des bases de données	REVS+
Traore/Dermé Maimouna	CMLS/Justice	Ministère de la justice
Valea Raga	Membre	CORAB
Yaro Mariam	CPS	AED
Yelkouni Fatimata	CPS	AED
Zerbo Elisabeth	CPS	AED
Guatemala		
Alvar Pérez Méndez	Viceministro Técnico de Salud	Ministerio de Salud Pública y Asistencia Social
Andrea	Directora	OTRANS
Bertha Chete	Directora	Reunión Red Guatemalteca de Mujeres Positivas en Acción -ICW-
César Galindo	Director	Colectivo Amigos Contra el Sida - CAS-
Dilvia Samayoa	PNS	Ministerio de Salud Pública y Asistencia Social
Eduardo Arathoon	Director	Asociación de Salud Integral -ASI-
Ekaterina Parrilla	Representante de país	USG, USAID/Plan Internacional
Grethel Alvarado	PNS, monitoreo y evaluación	Ministerio de Salud Pública y Asistencia Social
Jessica López	Asistente técnica política	OMES
Licda. Erica Soto	PNS, Coordinadora y personal técnico	Ministerio de Salud Pública y Asistencia Social
Lucas Santos	PNS	Ministerio de Salud Pública y Asistencia Social
Maria Elisa Reyes	PNS, logística	Ministerio de Salud Pública y Asistencia Social
Mario Aguilar	Oficial de Programas	USG, USAID
Mario Gudiel	Gerente Subvención VIH/FM	INCAP (RP FM)

Rosa Elena Morales	Asesora de Atención y Tratamiento de la Oficina Regional de CA	USG, CDC
Rosemary Bertrán	PNS, área administrativa	Ministerio de Salud Pública y Asistencia Social
Silvia Ríos	PNS, prevención	Ministerio de Salud Pública y Asistencia Social
Victor Hugo Fernández	Coordinador de Incidencia	Reunión Red Legal y su Observatorio de DDHH, VIH y PEMAR
Yolanda Pajarito	PNS, prevención	Ministerio de Salud Pública y Asistencia Social
Alvar Pérez Méndez	Viceministro Técnico de Salud	Ministerio de Salud Pública y Asistencia Social
Andrea	Directora	OTRANS
Bertha Chete	Directora	Reunión Red Guatemalteca de Mujeres Positivas en Acción -ICW-
César Galindo	Director	Colectivo Amigos Contra el Sida - CAS-
Dilvia Samayoa	PNS	Ministerio de Salud Pública y Asistencia Social
Eduardo Arathoon	Director	Asociación de Salud Integral -ASI-
Ekaterina Parrilla	Representante de país	USG, USAID/Plan Internacional
Grethel Alvarado	PNS, monitoreo y evaluación	Ministerio de Salud Pública y Asistencia Social
Iran		
Alexander Fedulov	Country Representative	UNODC
AliAkbar Haghdoost	Director of the NASR	MOHME-National Agency for Strategic Research in Medical Education (NASR)
Alireza Vasigh	Strategic Information Adviser	UNAIDS - UCO
Bita Vahdani	Mental Health and Addiction Specialist	MOHME- AIDS Control Office
Claudio Providas	Country Representative	UNDP
Farahnaz Bahari	Administrative Assistant; Outreach Worker	Local Positive Club (associated to FHA)
Fardad Doroudi	UNAIDS Country Director	UNAIDS - UCO
Fateme Moradi	Expert	State Welfare Organization
Gelareh Mostashari	Expert on Drug Demand Reduction	UNODC
Hamed Safari	Expert	MOHME- AIDS Control Office
Hedieh Khaneghahpanah	Programme Manager	Global Fund
Hengameh Namdaritabar	Responsible Expert on M&E	MOHME- National AIDS Control Office
Leila Saiji Joudane	Country Representative	UNFPA
Mahdihe Khanbeygi	Social Health Specialist	Ministry of Cooperatives, Labour, and Social Welfare
Mandep O'brien	Country Representative	UNICEF
Maryam Soltanzadeh	Expert	UNESCO
Mehdi Ghambari Mohammadi	Expert	Iran Drug Control Headquarters
Mehrzad Tashakorian	General Director	Prisons Organization- Health Office
Minoo Mohraz	Chief at Iranian Research Center for HIV/AIDS (IRCHA)	Tehran University of Medical Sciences, Infectious Diseases
Mohammad Mehdi Gouya	Chief of Centre of Communicable Disease Control (CDC)	Ministry of Health and Medical Education (MOHME)
Mohammad Reza Seyed Ghasemi	Director	Chatra NGO
Nazanin Heidari	Expert	MOHME- AIDS Control Office
Omid Zamani	National Professional Officer-Communicable Diseases	WHO
Parvin Afsar Kazerooni	Director	MOHME- National AIDS Control Office
Saeedeh Azahed Anaraki	Expert	MOHME- AIDS Control Office
Sara Zamani	Education Planning Specialist	Ministry of Education

Shadrokh Sirous	National Professional Officer	WHO
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Stephanie Rinville	Senior Programme Officer	UNHCR
Ugochi Daniels	Resident Coordinator	United Nations
Vahid Jahanmiri Nejad	Director of MAHC; Board Member of SPASDI	Society for Protection and Assistance of Socially Disadvantaged Individuals (SPASDI); Mehr Adolescent Health Club (MAHC)
Zahra (Mojan) Majdfar	HIV Specialist	UNICEF
Zahra Bayat Jozani	Head of Tehran PC (and SHAMSA)	Positive Clubs (PCs); Association of SHAMSA (a network of PCs)
Zahra Mirniam	Expert	UNFPA
Zarrin Eizadyar	Expert	UNHCR
Jamaica		
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Alisha Robb-Allen	Director of Treatment, Care & Support	MOH/STI TB Unit
Bernadette Theodore-Gandi	PAHO/WHO RepresentativeJamaica, Bermuda & the Cayman Islands	Cosponsor Heads- PAHO
Bilen Getachew	Program Lead	USAID HRSA
Christopher Harper	Executive Director	JYAN
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Ivan Cruickshank	Chair	GFATM/Jamaica Country Coordinating Mechanism
Jaevion Nelson	Executive Director	Equality for All-J-FLAG
Jason Fraser.	Country Representative	USAID Jamaica
Jerome Edwards	Social Worker/Counsellor	Teen Hub
Joy Crawford	Executive Director	Eve for Life
Jumoke Patrick	Executive Director	Jamaica Network of Sero-Positives
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Anna Kozlova		NGO Revanche
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Haja	Centre Hospitalier de District	Assistante Sociale
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Jude Padayachy	UNAIDS	Country Director
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Mananarisoa Ravelohanta	Ainga Aides	Coordinator
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Mohad El Gaabouri	Fédération Internationale des Associations des Etudiants en Médecine (IFMSA)	Vice-ésident des Affaires Externes
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Aye Aye Shwe	Sex Worker in Myanmar Network	EC member
Aye Ayue Nyein	CDC	Public Health Specialist (HIV)
Bhudi Setiawan	UNICEF	Maternal and Child Health Specialist Team Leader of MNCH, HIV, HSS Programme
Brigadier General Nyunt Shwe	Health, Sport and Culture Committee, Amyothar Hluttaw	Member of Parliament
Catherine	Myanmar Interfaith Network on AIDS (MINA)	EC member
Chit Ko Ko	Myanmar MSM and Transgender Network	Vice chairperson
Esia Hamid	UNOPS, PR Global Fund	M&E and HSS Advisor
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Htwe Htwe Myint	Myanmar Positive Women Network	Chair person
Karan Cavanaugh	USAID	Director, Office of Public Health
Khawn Taung	Myanmar Interfaith Network on AIDS (MINA)	Secretary
Khin Zarli Aye	PSI	Advisor, TOP Business Unit
Kyaw Ngwe	Health, Sport and Culture Committee, Amyothar Hluttaw	Member of Parliament
Kyaw Than Tun	Health, Sport and Culture Committee, Amyothar Hluttaw	Member of Parliament
Kyaw Htin Soe	Access to Health Fund	Programme Team Leader
Kyaw Myo Thant	Department of Social Welfare	Director
Lin Wai Phyo Latt	Health, Sport and Culture Committee, Amyothar Hluttaw	Member of Parliament
Lu Lu	Myanmar Positive Group	Chair person
Lwi Zar	Health, Sport and Culture Committee, Amyothar Hluttaw	Member of Parliament
Mai Ohn Khaing	Health, Sport and Culture Committee, Amyothar Hluttaw	Member of Parliament
Man Tun Kyaing	Health, Sport and Culture Committee, Amyothar Hluttaw	Member of Parliament
Min Thet Phyo San	Myanmar Youth Stars Network	Network Coordinator
Myat Yi Lwin	UNOPS, PR Global Fund	Programme Management Specialist

Myint Naing	Health, Sport and Culture Committee, Amyothar Hluttaw	Member of Parliament
Myo Set Aung	Save the Children, Global Fund Principal Recipient	Deputy Programme Director
Naw Saw Mu Htoo	Health, Sport and Culture Committee, Amyothar Hluttaw	Member of Parliament
Nay Myo Min	Myanmar Positive Group	Vice chairperson
Oussama Tawil	UNAIDS	Country Director
Phyu Phyu Swe	PSI	Deputy Director
Sai Aung Kham	National Drug User Network	Chair person
Sai Win Kyaw Het Aung	Access to Health Fund	Programme Analyst
Sai Wun Hlaing Kham	Health, Sport and Culture Committee, Amyothar Hluttaw	Member of Parliament
San Maung Maung	Health, Sport and Culture Committee, Amyothar Hluttaw	Secretary
San San Aye	Department of Social Welfare	Director General
Sid Naing	Marie Stopes International	Country Representative
Soe Naing	Alliance (Maharmate)	Executive Director
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Win Mar	UNODC	National Programme Specialist (Drug and Health)
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Win Zaw	Health, Sport and Culture Committee, Amyothar Hluttaw	Member of Parliament
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Akpan Ioise		NASCP
Bilkisu I Jibrin		Ass/ Director Art
Cheik Traore		ITAD
Deborah Odoh		Deputy Director Treatment Branch
Ekanmian Gatien		Adviser UNAIDS
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Joel Rehnstrom		UNAIDS Geneva
Nwokennaya Peter		SMO/ TCS
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Ogbeke Gerffrey		SSO
Okorie Chidi		PP
Oladele Akogun		ITAD
Ologun Taiye Joseph		D D/ Logistics
Oloyede Y.A		Director
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Richard Amenyah		Adviser, UNAIDS
Sugay Helu		UN/ WHO
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Angela Kelly-Hanku		PNG Institute of Medical Research
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Anup Gurung		WHO
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David Bridger		Country Director, UNAIDS
Delma Yaki		KP Consortium PNG / Igat Hope
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Heather McLeod	Country Director	World Vision
Iru Tau		KP Consortium PNG /Kapul Champions
Kester Maniaul		World Vision
Lady Roslyn Morauta		Global Fund Board
Lesley Bola		Coordinator, KP Consortium PNG
Nick Dala	Director	National AIDS Council
Paison Dakulala	Deputy Secretary of Health	
Paula Kongua		UNICEF
Steven Paniu		UNFPA
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South Africa		
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Anne Githuku-Shongwe	African Regional Advisor for HIV and gender	UN Women
Brian Chirombo	Acting Country Representative	WHO
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Nomakhosi Gxagxisa	Head	eThekwini DoH
Hope Ngobese	Senior Programme Manager	eThekwini DoH
Jacqueline N Ngozo	Director TBCP and HAST	KZN Province
Jacqueline Utamuriza-Nzisabiro	African Regional Advisor for HIV and gender	UN Women
Jacques Lloyds	Sector Leader for Disability	SANAC
Jill Hanass-Hancock	Disability sector KZN	
Linda Naidoo	Provincial Officer KZN	UNFPA
Mariame Sylla	Chief Health and Nutrition	UNICEF
Matome Kganakga	Deputy Chairperson	SANAC Men sector
Mbulawa Mugabe	Country Director	UNAIDS country office
Tlangelani	Assistant Representative	UNFPA
Patrick Mdletshe	Representative	PLHIV sector civil society KZN
Sandile Buthelezi	CEO	South African National AIDS Council (SANAC)
Sanjay Wijesekera	Chief Health and Nutrition	UNICEF
Tryphinah Ngweny	Director TBCP and HAST	KZN Department of Health
Yogan Pillay	Deputy Director-General	National Department of Health
Zhuldyz Akisheva	Regional Representative	UNODC
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Andriy Klepikov		Public Health Alliance
Andryi Chernyshov		LGBT community
Andryi Nagirnyak		Ukrainian Greek-Catholic Church
Artem Kravchenko		Seventh-day Adventist Church
Darren Dorkin		GF
Eleonora Gvazdzeva		Regional office of UNAIDS

Galyna Mescheryakova		UN Women
George Sakvarelidge		GF
Ihor Kuzin		Centre of Public Health
Iryna Chibisova		MOH
Iryna Koroeva		CCM Secretariat
Iryna Soroka		Centre of Public Health
Julia Novak		UNFPA
Kateryna Denisova		UNDP
Larysa Savchuk		ILO
Lubov Kravets		CCM Secretariat
Lyna		Tradeunions of sea transport Odessa
Martin Donahue		WHO
Natalia Salabai		UNAIDS
Oleh Alyohin		LGBT community
Oleh Dymaretskyi		PWID community
Olena Heilo		UNICEF
Olena Stryzhak		Positive Women
Olena Volkova		Judge, Yuzhnoukrainsk
Olesia Pohorelova		Centre of Public Health
Osnat Lubrani		UN Resident Coordinator
Roman Hailevych		UNAIDS
Sergiy Dmitriev		100% of life
Sergiy Revelent		Eleos Ukraine
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Volodymyr Kurpita		Centre of Public Health
Zhannat Kosmukhamedova		UNODC

Annex H: Country Notes

Country notes have been developed following the country visits. The country notes reflect the findings of the country visits undertaken in the context of the Evaluation the UN System Response to AIDS in 2016-2019. The aim of the twelve country visits was to explore country-level lessons on cross-cutting areas[6] as well as achievements of the UN Joint Programme in implementing the UBRAF. The UNAIDS Country Office and the evaluation team jointly selected priority cross-cutting issues described in each country case study. Methods included document review and in in-depth interviews with key informants.

6 1) UN reform and the UN Joint Programme; 2) Resource mobilisation & optimisation; 3) Partnership model; 4) Human rights; 5) Gender mainstreaming; & 6) Participation and inclusion of affected communities

Annex I: Web Survey

Background

An anonymous online survey was conducted to increase the breadth of the data collection. This was designed to gather data from the widest possible group of UBRAF stakeholders, thereby complementing the data collected through the KIIs, country case studies, and portfolio review by allowing access to the views of a wide range of respondents.

The survey was distributed via email to stakeholders at a global, regional, and national level. This included the key stakeholder categories of UN agencies, other multilateral and bilateral agencies and donors, civil society, national government, and the private sector.

Survey structure

The main sections of the survey are outlined below with notation.

Introduction section: This section was utilised to introduce the purpose of the survey with a brief overview of the UBRAF/Joint Programme independent evaluation. It also included additional information regarding the structure of the survey, the range of the number of questions (additional information provided below), the approximate range of time to complete the survey and contact information in case respondents have questions regarding the survey.

Confidentiality statement: In order to ensure that respondents are forthcoming with information, a confidentiality statement was included which assured respondents that any data/answers provided will only be seen and reviewed by the Evaluation Team.

Survey questions: A mix of both quantitative and qualitative questions were utilised. This allowed the Evaluation Team in its analysis not only to provide descriptive statistics (and possibly display information graphically) but also to provide qualitative information such as direct (unattributed) quotes, thematic testing and word clouds.

The first set of questions collected respondent profile information (e.g. gender, age, place/country of employment, UN affiliated organisation, length of employment, management level). For some questions, respondents were given the ability to opt out of providing information, or providing additional information if the options listed do not sufficiently reflect their profile.

The survey was structured around the evaluation's themes, hypotheses and questions. This forms the bulk of the subsequent questions. In other words, as respondents proceeded through the survey, a heading will appear (e.g. 'Mobilisation, allocation and use of human and financial resources') and respondents could either opt in or opt out of answering the subsidiary questions corresponding to that heading depending on their level of knowledge and relevance to their position.

End of survey: Respondents were thanked and contact information was again be provided in case there are any questions or concerns regarding the survey.

Timing

Respondents were given approximately four weeks to complete the survey after the initial introductory email was sent. This four-week time period allows for weekly reminders to be sent without becoming overbearing to potential respondents.

To maximise participation the following strategies were adopted:

- Selection of a user-friendly online platform that works on multiple devices
- Creation of English, French, Spanish, Russian, and Mandarin language versions
- Clear, concise, and easy to understand questions
- Communicating in a targeted, concise manger about the purpose of the survey

Sample

The initial list of respondents was collated from contact information provided by UNAIDS, this master list included the following types of respondents:

Type of Respondent	Approximate Number of Respondents
JPMS users: Cosponsor staff at country level	880
UNAIDS senior staff at HQ and regional level	60
UNAIDS staff at country level	120
PCB 44 participants, excluding support staff and UN	350
Participants to previous PCBs (41, 42, 43 PCB), Member States, NGOs, excluding supporting staff and UN staff	400
External stakeholders suggested by UNAIDS HQ staff/departments and Liaison offices	225
External stakeholders suggested by UNAIDS staff at regional and country level	1,080
Respondents suggested by GCs	110
Approximate Total	**3,225**

After duplicates and incorrect emails were removed, the survey was initially sent to a total of 3,124 respondents by email. These original respondents identified a further 300 respondents who were also sent the survey, providing an overall sample size of 3,424.

Responses

In total, 1,102 people completed the web survey, equating to an overall response rate of 32.2%. The sample and respondents are summarised below:

Respondents identified through UNAIDS	3,124
Additional respondents identified through the survey snowball effect	300
Total sample	3,424
Total completed surveys	1,102

Summaries of the respondents who completed the survey are provided below:

Do you work in:	Freq.	Percent
UNAIDS Secretariat (HQ, regional, country)	87	7.89
UN organisation (i.e. a Cosponsor)	358	32.49
Donor organisation/development partner	91	8.26
National or local government	197	17.88
International NGO	89	8.08
National NGO or community-based organisation	180	16.33
Choose not to disclose	12	1.09
Other	88	7.99
Total	**1,102**	**100**

Are you based at the global/HQ level, a regional office, or within a specific country?	Freq.	Percent
Global/HQ level	198	18.17
Regional office	101	9.27
Specific country	753	69.08
Choose not to disclose	50	4.54
Total	**1,102**	**100**

Type of organisation / Level of work	Choose not to disclose	Global	Regional	Country	Total
Choose not to disclose	20	3	0	1	24
Other	8	22	8	49	87
UNAIDS Secretariat (HQ, regional, country)	4	18	8	57	87
UN organisation (i.e. a Cosponsor)	6	36	39	273	354
Donor organisation/development partner	1	31	10	47	89
National or local government	6	35	7	147	195
International NGO	2	46	18	22	88
National NGO or community-based organisation	3	7	11	157	178
Total	**38**	**198**	**101**	**753**	**1,102**

Language	Freq.	Percent
Chinese	20	1.81
English	769	69.78
French	136	12.34
Russian	31	2.81
Spanish	146	13.25
Total	**1,102**	**100**

How many years have you worked in the HIV response?	Freq.	Percent
3-10 years	288	27.35
Choose not to disclose	31	2.94
More than 10 years	629	59.73
Up to 2 years	105	9.97
Total	**1,053**	**100**

Limitations

The following limitations to the approach used for the Web Survey were identified:

Sampling
Due to a number of constraints of the evaluation a convenience sampling approach was used. This method was the most applicable under the circumstances given that it provides a quick, easy, readily-available and cost-effective sample. A list of contacts was provided by UNAIDS, which was supplemented by the evaluation team, as well as respondents to the survey.
It is acknowledged that this method does not provide statistical rigour and can lead to sampling error and a lack of representation. However, this was the best option for reaching a large number of people within the short timeframe.

Non-response bias
This issue occurs when respondents included in the sample do not respond to the survey. Unfortunately, this type of bias is all but impossible to avoid when conducing web surveys, particularly as the evaluation team were only able to contact respondents through the email addresses provided by UNAIDS. Adjusting for this bias is also difficult, particularly when the population groups are unknown, as in this case.
To mitigate the impact of non-response bias, the evaluation team deployed a series of strategies, including:

- Pretesting the survey to ensure it works smoothly and does not contain errors
- Selection of a user-friendly online platform that works on multiple devices
- Creation of English, French, Spanish, Russian, and Mandarin language versions
- Keeping the survey short and simple, and containing only clear, concise, and easy to understand questions
- Allowing respondents approximately four weeks to complete the survey
- Communicating in a targeted, concise manger about the purpose of the survey. This included sending reminders to sampled participants, including deadlines, motivation for participating, and details of the objectives and benefits of the survey
- Ensuring confidentiality of responses by keeping the survey anonymous

For this survey, the highest response rate was among the UNAIDS Secretariat sample, with 48% of this group responding to the survey. This drops to 40% for UN Cosponsors, and 30% for other external stakeholders. It is acknowledged this as a potential source of bias in the survey results and this should be factored into considerations of the web survey results.
However, it is also worth noting that of the 21 evaluation questions answered by UNAIDS Secretariat and Cosponsor respondents, only 4 were also answered by other external respondents.

Response Rate

The overall response rate for this survey was 32.2%. This is comparable to, and indeed exceeds, the response rates in other web-based surveys, particularly those involving external stakeholders.[7]

Questionnaire Tool

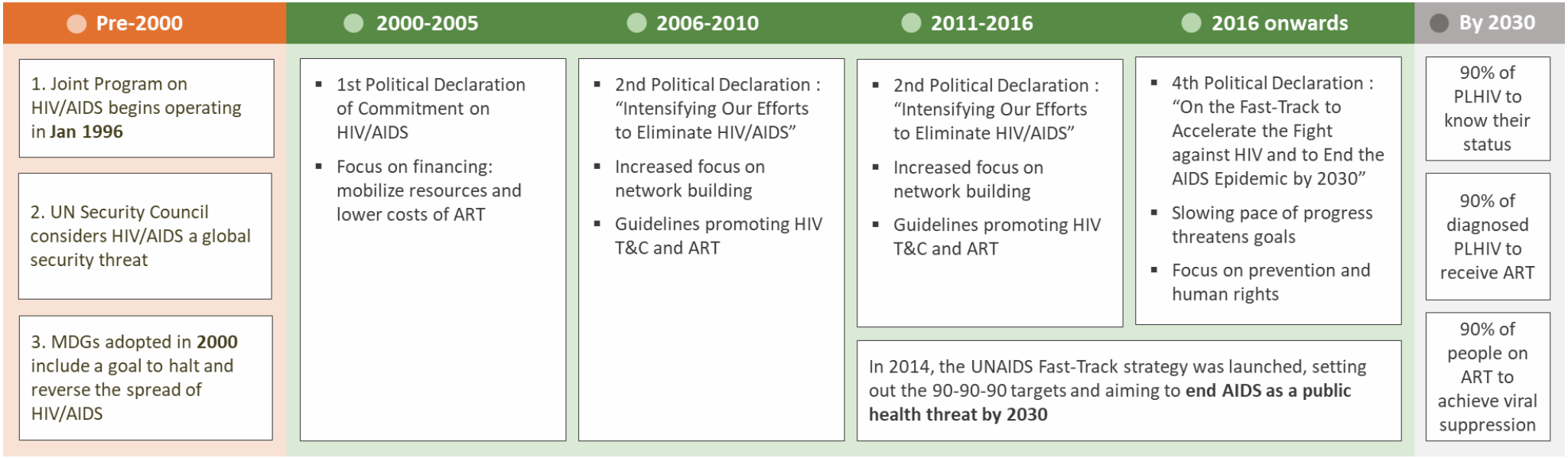
In addition to collecting background information about the participants and the work they do; the following questions were asked to respondents:

Questions in bold were asked to all respondents, those in plain text were asked only to respondents from UNAIDS Secretariat and other UN Organisations.

1. Do you know what the overall plans and targets are for the Joint Programme?
2. On a scale from 1 to 10 (1 = Not at all, 10 = Completely) to what extent do you believe the actions of the Joint Programme have been evidence-based?
3. On a scale from 1 to 10 (1 = Not at all, 10 = Completely) how realistic have been the actions defined within the Joint Programme?
4. **How relevant are the actions of the Joint Programme at the level at which you work?**
5. How well have key stakeholders been engaged in prioritizing activities which the Joint Programme has undertaken at the level at which you work?
6. To what extent has the Joint Programme addressed issues of gender (promoting gender equality, empowerment, actions against GBV, etc.) at the level at which you work?
7. How well have the needs of counterparts been reflected in the work of the Joint Programme?
8. How well is the organisational set-up of the Joint Programme responding to UN reform?
9. **How well has the Joint Programme worked with the other major stakeholders (e.g. the Global Fund, PEPFAR, etc.)?**
10. How well has the Joint Programme responded to priorities identified in the UNDAF/UNSDCF in the country/region in which you work?
11. **How well has the Joint Programme engaged with communities and civil society?**
12. How well has the Joint Programme promoted the involvement of communities and civil society in the HIV response and policy-making?
13. How well has the Joint Programme leveraged other donor resources for HIV programming?
14. How well is the Joint Programme performing in the context of constrained resources?
15. How well has the Joint Programme allocated human resources (reduced or otherwise)?
16. **To what extent do you use the data and information generated by the Joint Programme at the level at which you work to inform planning, programming and course corrections?**
17. To what extent have Fast-Track targets been achieved for your programme?
18. Do you believe that some agencies (the Secretariat and/or any individual Cosponsor) contribute more/less to achieving targets and results (keeping in mind roles, responsibilities, and resources)?
19. How well have the actions of the Joint Programme contributed to broader development goals (SDGs, multi-sectoral, self-reliance, etc.)?
20. How well has the Joint Programme supported transition from external to domestic funding for the HIV response?
21. **How much do you think the Joint Programme has contributed to stronger health systems and capacities to sustain national and local HIV responses?**

7 For example, Nulty, D (2008) The adequacy of response rates to online and paper surveys: what can be done?, Assessment & Evaluation in Higher Education Vol. 33, No. 3, June 2008, 301–314
Sinclair et al (2012) Comparison of response rates and cost-effectiveness for a community-based survey: postal, internet and telephone modes with generic or personalised recruitment approaches. BMC Med Res Methodol 12

Annex J: Timeline of UNAIDS Joint Programme



Annex K: Summary of Reviews and Evaluations to Date

Table 3 summarises the key evaluations and reviews implemented during the period assessed.

This table highlights that there have been no UNAIDS evaluations, and few Cosponsor evaluations on specific aspects of the UBRAF[8] and none of the independent assessments have specifically looked at the attribution of the reported results to the Joint Programme efforts.

Table 3 Summary of key reviews/evaluations relating to Joint Programme

Review	Key findings	Joint Programme impact assessed?
Review of the Implementation of the UNAIDS Joint Programme Action Plan and Revised Operating Model, Interim Report 2018 (carried out by UNAIDS, not independent)	The country processes of the Action Plan (country capacity assessments, Joint Plans and envelopes) are highly relevant to the SDGs and the UN Reform process. They represent a practical example of joint programming directly linked to UNDAFs and country priorities. Making funds available at the country level has increased ownership and targeted the use of UBRAF resources to meet country needs. In all six countries, engaging civil society and key populations are considered as a key role for the Joint Programme. Civil society respondents recognize Joint Programme efforts to ensure that the Global Fund also considers their needs. The Action Plan is contributing to reinvigorate the Joint Programme at regional and country levels. Although there are exceptions, and competition or challenges in joint implementation in some instances, most respondents believe that the country envelopes have improved strategic planning and coherence of UN support around country priorities. There are examples of increased engagement of Cosponsors that were less active in recent years at the country level. Although the situation varies across countries, the commitment to and quality of joint planning, based on evidence, and looking at areas of synergy and complementarity, has improved. Some challenges remain around prioritizing plans and envelope funds, and more work is still required on SMART (Specific, Measurable, Achievable, Realistic, Time-bound) deliverables. Limitations that were cited by global respondents include: the short time frame for planning, consultation and implementation; uneven interpretation of guidance (while exceptional, some instances of "pass-through"[9] funding between the Cosponsors at country level still occurred); lack of clarity on decision-making in some countries; and increased transaction costs at a time of already reduced resources for Cosponsors. some respondents reported that communication from the regional level to the country level was inconsistent and that there is need to streamline communication coming from the Cosponsors and Secretariat headquarters to countries. Most respondents believe that the joint planning process and envelopes are strengthening ownership and accountability, since envelope funds are received and managed at country level and tied to specific deliverables. The country processes have brought transparency regarding	The primary purpose of the review was to assess progress in the implementation of the Joint Programme Action Plan at country level. The Review has an Action Plan showing the Action Areas assessed and the Results. The word 'Impact' is mentioned a couple of times along the Review especially when talking about the future and funding: "Country respondents believe that funding constraints limit the potential impact of interventions", "Due to scarce resources and staff, the extent to which this process will be able to impact country footprints remains unclear".

9 Regional UNODC programme evaluations UNODC

	responsibilities and funding allocated to each Cosponsor at the country level. Joint Teams in the six countries visited stressed the importance of decision making on the allocation of funds occurring at the country level. Available funds are insufficient and there are many unfunded priorities for the Joint Programme. More needs to be done to use the Joint Plans as the basis for resource mobilization and to leverage funds from Cosponsors, as well as connect HIV- specific funding to the broader health and development agenda. For the most part, coordination and collaboration among the Cosponsors and Secretariat were perceived to be good at the regional and country levels, with a somewhat differing view at the global level. The short time frame for completing the assessment, planning and envelope processes were perceived as the main shortcomings, along with some delays in the receipt of funds. Roles and responsibilities at different levels could be clarified further and communication could be improved and streamlined. The guidance provided to countries could be clarified in certain respects, for example regarding the possibility for one agency to manage funds for a cluster of agencies (through pooled funding or similar arrangements in line with UNDAFs); the formulation of deliverables and use of results-based language; the use of funds for recruitment of staff; monitoring, performance-based release of funds, reprogramming, reporting requirements and timelines; and simplification of templates, where possible. Engagement of national stakeholders varies, but the priorities of the Joint Plans on AIDS have generally been developed in close collaboration with national and international partners, including civil society. Engaging civil society and key populations remains a key role for the Joint Programme. Looking ahead, more systematic engagement of civil society, especially people living with HIV and key populations, is needed. Most respondents, across regions, are of the view that implementation of the Joint Programme Action Plan is contributing to gender equality, women's empowerment and human rights related to HIV. Nonetheless, across Joint Plans and envelopes, gender equality and human rights have uneven prominence. Joint Teams are calling for more guidance, capacity and tools so that gender and human rights issues can feature more prominently in design, implementation and monitoring.	
Review of The Management and Administration of the Joint United Nations Programme on HIV/AIDS (UNAIDS), 2019	UNAIDS funding has been uneven, and the resource mobilization strategy has been unrealistic and overly ambitious. Cosponsors and the UNAIDS Secretariat have experienced a reduction in funding and a subsequent reduction in staff devoted to the HIV/AIDS response. However, with ambitious plans that are typically underfunded and targets that are not met across the health spectrum, strategic planning should be among the highest priorities of UNAIDS. The collaboration between the Secretariat and Cosponsors has been strained by, among other issues, funding and staffing challenges. In the process of developing its long-term strategy, the roles and responsibilities of Cosponsors, once considered as “co- owners” of UNAIDS, need to be revisited and the “joint” nature of UNAIDS needs to be reassessed.	Not specifically. The document looks at what has worked or not at the management and administration level.

	JIU claims that deficiencies in governance – and specifically the lack of oversight and accountability by the Programme Coordinating Board – have been mentioned in at least four independent assessments of UNAIDS, although they have not been substantively addressed. In the recent past, the Secretariat's human resources management was criticized due to issues related to decisions on recruitment, selection and mobility, inconsistent grading of positions, and insufficient training and coaching for managers. Relatedly, according to JIU Secretariat staff appear to be "over-graded" compared with other health-issue- focused United Nations organizations with a large field presence. This can create a disparity, especially in the field, in terms of coordination and collaboration with Cosponsors. Based on interviews with key UNAIDS stakeholders, there are frustrations at various levels about coordination and communication, programme delivery, funding, and reporting processes. The most substantive rift seems to be between the Cosponsors and the Secretariat in addressing how UNAIDS is delivering at various levels, what it will look like in the future and how it will be staffed to meet its future needs. The original intent in the design of UNAIDS was for Cosponsors to be "co-owners" of UNAIDS. As a 2007 JIU report stated: "Since each Cosponsor is accountable only to its own independent governing/executive board, neither the UNAIDS Secretariat nor PCB has any controlling organizational authority over the Cosponsors. Consequently, little can be done to exert pressure to bear on the Cosponsors to become effective partners within UNAIDS." There is still a significant number of new HIV infections worldwide and the risk of not meeting the target set for 2020, not to mention Goal 3 of the Sustainable Development Goals (SDG), with its target of ending the HIV/AIDS epidemic, as well as other related targets, by 2030. As the report concludes: "Current projections show that many health-related SDG indicators ... will require a concerted shift away from what might have driven past gains ... towards multisectoral, prevention-oriented policy action and investments to achieve SDG aims. Notably, several targets, if they are to be met by 2030, demand a pace of progress that no country has achieved in the recent past.	
MOPAN 2015-16 Assessments of Joint United Nations Programme on HIV/AIDS (UNAIDS)	MOPAN claims that there are signs of considerable progress from the last MOPAN assessment in 2012, as well as areas where attention is still needed. The continued commitment by UNAIDS to organisational development has brought further positive changes in terms of a shift to a more field-based organisation, reductions in overall staffing levels, and systems that ensure greater individual accountability for results. Considerable progress has been made in moving to more results-based reporting and, particularly, in the use of performance indicators, baselines and targets. However, progress is needed to ensure that evaluative and more analytical data are both available and used in programmatic decision-making. Similarly there is evidence that UNAIDS' structure has been further developed to ensure mutual accountability, for example through the development of the Joint Programme Monitoring System. However, tensions remain and have been exacerbated by the current financial crisis, raising some concerns about the Secretariat's commitment to participatory decision making.	No. The document highlights a lack of an independent evaluation function.

	UNAIDS has a strong strategic focus and financial framework, but its organisational architecture is not yet fully congruent with its vision and operating model. In terms of normative frameworks: human rights and good governance are central principles of UNAIDS' work and gender is strongly reflected in its corporate commitments and the current strategic plan. However, there is only limited evidence that it is made explicit in developing interventions. For example, human rights are not set out in the criteria for formal assessment processes for interventions. While the Secretariat has human and financial resources for advancing human rights as a cross-cutting issue, these resources have been reduced over time. Courses are available to staff but are not mandatory. Environmental sustainability and climate change, moreover, are not integrated into the organisation's strategic plan or corporate objectives. UBRAF provides a clear overarching statement, setting out the criteria and proposed country resource allocations. However, the criteria do not explicitly refer to the Cosponsors and their capacities in-country. There are perceived concerns: the degree of transparency in resource allocation to Cosponsors; the proposed discussions on joint planning and joint resource mobilisation, as well as with discussions on the sustainability and predictability of funding, have not materialised. UNAIDS applies results-based approaches across the organisation. The Programme Coordinating Board has played an active role in both encouraging UNAIDS to develop this approach and accompanying systems and in ensuring that the corporate strategy has a sound logic. While it is clear in several areas that UNAIDS uses lessons learned and best practices in planning and programming and has a system for tracking performance, the organisation lacks an independent evaluation function and has carried out few evaluations of its role and approach. This gap, alongside coverage weaknesses and a lack of systems to ensure evaluation quality and follow up, has prevented systematic and rigorous assessment of its results.	
DFID Multilateral Development Review, 2016.	The Multilateral Development Review systematically assessed the performance of 38 multilateral institutions that the UK funds through DFID. Multilateral partners ensure that UK development reaches more people, saves more lives and lifts more countries out of poverty, while The UK continues to give these agencies strong support, while pressing for even higher standards. A third of agencies' performance was mixed. This includes many humanitarian agencies and several UN development agencies. All of these agencies have one or more organisational weaknesses. The UK will work even more closely with these agencies to ensure maximum value for money for the UK's investment. UNAIDS focuses on political advocacy, protection of human rights, data, research and technical support and DFID, therefore, provides funding to UNAIDS centrally. According to DFID, UNAIDS plays a key role in countries where the state is weak and protect the rights of minority groups all over the world. UNAIDS's scored good as a match with UK development objectives, and scored weak as organisational strength. DFID will work closely with them, and with other countries, to raise their performance. DFID will link	No. The document measures UNAIDS's alignment with DFID's objectives and its organisational strength but does not go into much details.

	up to 30% of their funding to UN development and humanitarian organisations to improved results.	
UNFPA HIV programme evaluation (ongoing) 1. Evaluation of The UNFPA Support To The HIV Response (2016-2019), Namibia	Since 2011, UNFPA has taken a lead role in supporting the process of first linking and then integrating SRHR/HIV and, since 2018, SGBV services in Namibia. Working closely in support of the MoHSS, UNFPA has assisted in preliminary assessment of linkages, developing and pilot testing the Namibia model of integration and subsequently rolling the model out to the national level. Through this process, UNFPA has worked to ensure that integration is a country-led process consistent with the SADC commitments, national strategies and priorities. Since 2017, with continued and significant support from UNFPA, MoHSS has made important progress in scaling the Namibia model of integration to many health centres and clinics across all 14 regions. However, progress has been uneven due to significant organizational and operational challenges. The Namibia model places considerable demand on the skills and experience of health professionals in the newly integrated sites, which are already affected by frequent staff rotations. There is evidence that health centres that have implemented the Namibia model of integration have been able to improve client care, reduce wait times and reduce stigma for people living with HIV and for adolescents and KPs. The primary reason for this is the enhanced trust and a stronger relationship between clients and service providers. Health professionals working in the integrated sites also report improved job satisfaction and the ability to maintain a broader range of skills. The processing of taking the Namibia model of integrating SRHR/HIV/SGBV to scale at a national level has generated significant resistance. This resistance is, at least, partly grounded in miscommunication or lack of communication between the DSP of the MoHSS, responsible for disease-specific programmes including HIV treatment and the DPHC. UNFPA has worked effectively with the MoHSS, MEAC, MSYNS and MGECW to ensure that national strategies and priorities reflect the need to provide effective HIV prevention and treatment services to adolescents and youth and to KPs, especially the LGBTI community. Efforts to address the HIV and SRHR needs of people with disabilities (including adolescents and youth) are limited or in very early stages of development. Importantly, interventions aimed at meeting the needs of the LGBTI community do not address broader socio-economic issues, which impact their access to prevention and treatment services, including retention on ART. UNFPA has been strategic in developing partnerships and supporting networks engaged in promoting the rights of adolescents and youth and advocating for the rights of KPs. In particular, the OFL has been an effective partner in this work. However, UNFPA and its partners have found it difficult to effectively advocate for progress from a rights model, which emphasizes non-discrimination to one, which directly recognizes the right of LGBTI, people to competent, professional SRHR/HIV/SGBV services which meet their needs.	The evaluation shows some results of the pilots that have implemented the Namibia model of integration, such as improvement of client care, reduced wait times and reduced stigma for people living with HIV and for adolescents and KPs. The evaluation also highlights some key informant views on the process of policy development at regional levels and its impact in programming but says that the impact results should be reached and seen by 2020. The evaluation due to constraints in time and resources did not conduct client satisfaction surveys or exit interviews during the mission to Namibia.

2. Evaluation of The UNFPA Support To The HIV Response (2016-2019), Georgia	Mechanisms and platforms for coordinating action in response to HIV in Namibia are complex, multi-faceted and overlapping. While UNFPA continues to participate and make a positive contribution to many committees and working groups, there is a general recognition among stakeholders that overlap among different coordinating bodies can and should be reduced. While the Government has made a consistent effort to increase its share of total investment in the HIV response, it remains highly dependent on development partners for funding key recurrent expenditures, particularly for staff compensation (including incentive payments) and for training. The Evaluation claims that the Country Office (CO) has played a leading role in the repositioning of HIV prevention as a priority health intervention in Georgia. It has contributed in a number of important ways. It has led the revitalization of the UN response to address the need for HIV prevention efforts in light of increased incidence of infection among KPs. The CO has supported key strategic exercises to prepare for the upcoming transition from Global Fund to state funding. It has skilfully advocated and facilitated the development of strategies and policies, and corresponding standards, protocols and curricula to address the needs of most at-risk and KPs. The CO has smartly used its limited UBRAF resources and adapted existing UNFPA tools, MSMIT, SWIT and the YKP package as a platform for country efforts in HIV prevention for these KPs without having to "reinvent the wheel". As such, the CO contribution to the HIV response seems outsize in comparison to its (quite) small budget through the timely and strategic leveraging of its limited resources. Nevertheless, this work has not yet moved the needle for the establishment of a national strategy and plan in support of integration, and there are many missed opportunities for establishing SRHR-HIV linkages across parallel structures and programmes. Programmatically, insufficient attention has been paid to demand-side issues, given the context of low HIV testing coverage and uptake, resulting in late diagnosis and treatment. Individuals not aware of their status continue to engage in high risk behavior and unknowingly transmit the virus, leading to increased number of infections. The UNFPA business model for middle income countries is also a hindrance which prevents the CO from supporting demand-related interventions. The CO embraces and integrates a human rights-based approach in its programming. In particular, it has concrete efforts to address stigma and discrimination, gender equality, access to quality and dignified healthcare, and participation youth and KPs so that they have voice in the policies and programmes meant to serve them. Its work under the Joint Programme for Gender Equality is potentially an important contribution for improving the environment for rights. However, these efforts are nascent and there is a long way to go to ensure the availability and accessibility of quality, rights-based services that can address the specific needs of youth and KPs.	The document pays particular attention to the contribution of UNFPA to the HIV-related outcomes, particularly to the prevention of sexual transmission of HIV, the linking of HIV with other aspects of SRHR and the promotion of gender equality and human rights in the context of HIV (Outcome 1,2,3, 4).

	Working at the level of policy and advocacy can only go so far if not backed up by interventions to support the gap between policies and implementation. As noted above, working within the construct of the UNFPA business strategy constrains the types of interventions that can be undertaken, and limits holistic and comprehensive programming. In particular, demand efforts are very limited and hamper efforts to support awareness of the benefits of testing and services. Further, the loss of USAID and UNFPA support for condom procurement has resulted in a lack of attention for this important aspect of HIV prevention programming.	
UNODC HIV programme evaluation (2014)	The UNODC Global Programme on HIV/AIDS (Global Programme) has grown significantly from a single project, GLOG32, in 2002 to a portfolio of 34 on going or operationally complete projects by the end of 2012. The overall findings indicate that the Global Programme is relevant and contributing to the overall priorities within the UN system of progressing country needs and reaching beneficiaries needs with the types of projects and programmes that UNODC is best placed to implement. The Global Programme has not been as relevant with civil society participation at the global level and a more open, meaningful and participatory approach is required to re-establish strong linkages with civil society at the global and regional level. There are concerns about how country-level projects are designed, such as unsuitable output, outcome and impact indicators to measure implementation, effect and impact effectively and without the required baseline data that can help to ensure a project's success. There are also concerns about the sustainability of the Global Programme and individual project sustainability which has evidenced that many projects are either pilots or terminate once the funding period ends. This has not allowed for integration into national programmes that can sustain and scale-up successful models implemented by the Global Programme. The evaluation findings reveal strong evidence of projects that are gender sensitive and equitable. Many projects in the portfolio are targeted toward hard-to-reach populations such as women who inject drugs, young people and refugees. There are concerns that UNODC is not using its influence and convening power in protecting human rights, and specifically in countries that continue to incarcerate PWID into forced detention centres, and in settings where primary components of the comprehensive harm reduction package are illegal. A standardised set of core indicators that will determine both the effect and impact of programmes could be used for all projects would enable managers and advisers to more accurately measure the impact of interventions. The continuing alignment of planning and reporting within the UBRAF at the country level is important and will support UNODC in ensuring that the projects it is implementing continue to be relevant within UBRAF priorities.	The document reports concerns about how country-level projects are designed, such as unsuitable output, outcome and impact indicators to measure implementation effect. The document reports that overall the programme is performing well and individual projects have clearly had impact, particularly in the areas of policy support, training of a wide range of stakeholders in different aspects of HIV prevention, treatment and care for PWUD, advocacy, particularly with policy makers and some innovative programmes reaching hidden populations such as street children and female drug users. There is a whole chapter about the Impact (p.31), they also claim that the programme management structure of the Global Programme

		does not systematically measure impact and annual reporting is focused more at the activity and outcome levels and does not provide information on measurement of impact at the objective level.
UNDOC 2 -regional evaluations 1. Independent project evaluation of the Partnership on Effective HIV/AIDS Prevention and Care among Vulnerable Groups in Central Asia and Eastern Europe – Phase II (2017) 2. Final Independent Project Evaluation of the HIV Prevention, Treatment, Care and Support in Prisons Settings in Sub Saharan Africa (2017)	UNODC project XCEA01 – «Partnership on Effective HIV/AIDS Prevention and Care among Vulnerable Groups In Central Asia and Eastern Europe – Phase II» aimed to improve availability, coverage and quality of HIV services for injecting drug users and prisoners in community and prison settings in Central Asia. The scope of the project was very ambitious content wise and geographically although the chosen design was built on and logically stemmed from the success of the Phase I and therefore was appropriate to meet the project´s objective and its outcomes. However, the initial design had a number of issues such as lack of flexibility and freedom to adapt the regional initiatives to the diverse characteristics and unique conditions of the individual countries of the region. Moreover, the project suffered from intervals of interrupted and reduced funding and this has led to substantive cuttings in the project activities. Due to significant reduction of donor funds (CDC), the outcomes related to the national M&E mechanisms and model on integrated services were removed. These fund cuts, shortages and interruptions made the project to overcome inefficiencies of the first half of the project and plan activities in a thoughtful and efficient manner with implementation rate reaching 100%. The sustainability of the HIV services remains unsure with the exception of Kazakhstan. Other countries of the region although made some steps to institutionalize harm reduction continue to rely on donor funding currently leaving the region. Introduction of harm reduction and MMT programme in custodial settings remain the challenge in Uzbekistan and Kazakhstan respectively. Human rights and gender issues, although not systematically addressed nor explicitly stated in the project's documentation, have been included in the project's implementation. UNODC used every opportunity to make the national partners more aware of human rights obligations and gender issues, especially the respective needs of most-at-risk populations including women and those in detention. XSS V02 was designed with a clear awareness of and in the line with national and regional priority needs, HIV focus in prisons, as well as UNODC regional programming. The design informed an integrated, networked and top down regional and national response at policy level, prison system level and prison institution health provider level.	The Evaluation doesn't give too much details about impact but it claims that the impact of the project is visible in the region although varies across the countries. Harm reduction and particularly Methadone Maintenance Therapy (MMT) remain a challenge in the region. It claims that the anti-methadone movement in Central Asia poses a threat to the MMT program in the region and its future impact. The Evaluation claims that XSS V02 stimulated a collective response to HIV/AIDS in

	XSS V02 was very relevant in terms of responding to identified national and regional priority needs relating to both inmates and staff within prison settings, and sustainable development goals in terms of combatting HIV/AIDs and other diseases. Promotion of human rights within prisons and other closed settings was prioritised. Its design and implementation was also relevant to reaching decision makers and influencing strategic policy, practice and service delivery changes around inmate health and HIV/AIDS in prisons. XSS V02 strongly supported the development of regional and national networking, collaborations and partnerships. Coordination at regional and national levels increased through establishment of steering committees and technical working groups, signing of Memorandum of Understanding (MoUs) with various non-governmental organisations (NGOs), and improved collective planning between prison staff, prison health services and partners at operational levels. XSS V02 was efficient and implemented using available resources and in line with country specific and regional programme work plans. Resources and inputs were converted to outputs in a cost-effective manner, but timelines were hampered due to the complexity of work plan approval and procurement systems. XSS V02 was very effective with its interconnected broad areas of programming and related activities fast-tracking attainment of the majority of outcomes, while adequately addressing identified gaps in HIV, AIDS and prison health in benefitting countries. Challenges included economic/ political instability, legislative hurdles, low political buy in, the Umoja system, prison environments (overcrowding), and lack of available clinical equipment, nutrition and medicines. Prisoners are entitled to the highest attainable standard and delivery of health care when incarcerated. Human rights are strongly implied in the design of XSS V02. Gaps in programming and areas for further development include initiatives targeting women and children, injecting drug users (IDUs), men who have sex with men (MSMs), those affected by mental health issues, sexual minorities and juveniles.	prisons, addressed critical HIV/AIDS issues and programming gaps, and facilitated a more holistic view of human rights to HIV PTC&S in SSA prisons. However, factors affecting sustainability centre on challenges in coordination, staff and inmate turnover, service provision, prison conditions and infrastructural needs constrain the impact. The Evaluation has a chapter called 'Impact' and it claims that Impact in the form of awareness raising is visible by the increasing numbers of inmates and prison staff accessing HIV and AIDS services and the increasing knowledge around HIV and AIDS prevention, reduction of stigma, and advocacy for those with the disease in terms of health care. HIV and AIDS is now part of the agenda of the prison leadership and managers and is seen as a top priority when discussing health in prisons.
UN Women evaluation of WLHIV involvement/needs Corporate Thematic Evaluation	UN Women has shown exceptional ability to align GNP work, including in the area of HIV/AIDS, to partner government priorities, thereby enabling governments to make progress against their global commitments on gender equality. This has required tenacity and flexibility, given the changing national and global con- texts, including changes in governments, priorities in different sectors, changes in budgeting contexts and particularly the transition to the SDGs. At both global and national levels, UN Women has created channels for the voices of women	The document has a chapter about Impact of UN Women and it shows indicators and measurements (p. 55). Refer to Findings from n. 4 to 16 as

Of Un Women's Contribution To Governance And National Planning, Final Report 2019	and girls to influence priority setting. Long-term partnerships with civil society organizations (CSOs) have been key. This approach has been particularly consistent and prioritized in UN Women's work to promote gender- responsive HIV/AIDS national planning. However, in most cases these channels have not yet been securely institutionalized and therefore the extent to which CSOs are positioned to hold governments to account for their gender equality commitments remains uncertain. Improvements to UN Women's regional architecture have brought some positive dividends for its GNP work, including in HIV/AIDS, primarily in strengthening internal capacity to support partners at country level. Partners confirmed that UN Women's technical support is largely of high quality and there is evidence that the support enables them to make GNP, including in the area of HIV/AIDS, more gender responsive. However, partner support needs are extensive and meeting these needs is an ongoing challenge. Challenges in the financial resourcing of UN Women's GNP work, including in HIV/AIDS, are keenly felt by UN Women Country Offices and headquarters. Not only have available resources reduced in the period 2011– 2017 from US$ 15.4 million in 2015 to US$ 12.6 million in 2017, but the reliance on non-core funding exposes GNP work to the effects of changing donor priorities and the challenges of short-term funding to support long-term change processes. UN Women is increasingly recognizing and addressing intersectionality to benefit marginalized women. However, the extent to which this has been applied to its GNP work to facilitate policy and financing that specifically addresses the issues of marginalized groups appears variable (although it is more obvious in HIV/AIDS work, which consistently emphasizes the involvement of WLWHIV). Impact: FINDING 4: UN Women's influencing of global normative frameworks both builds on its country-level GNP experience and contributes to creating an enabling environment for further national-lev- el action to promote gender-responsive GNP. This is also true of UN Women's HIV- focused work. FINDING 5: UN Women's coordination with other UN agencies on GNP has been strategic. There are new opportunities for UN coordination at global and national levels on GNP, which could enhance country-level results and contribute to improved UN coordination. FINDING 6: UN Women has effectively coordinated with other UN partners through the Joint UN Programme on HIV/AIDS to strengthen the normative framework for gender and HIV/ AIDS and to enhance the enabling environment for gender-responsive national HIV/AIDS strategies. FINDING 7: Output and outcome level results at country level have been significant and striking in several countries. But achievements against targets reveal only a small part of the geo- graphical scope of IA 5. FINDING 8: Significant progress has been made in building the architecture to sustain gender responsiveness in GNP. In most cases, this progress does not completely cover a full cycle of pol- icy-plan-budget-execution-M&E and displays vulnerable areas.	they are explored in the effectiveness and impact chapter. The evaluation also highlights the difficulty of building a solid evidence base of UN Women's gender-responsive GNP work in the area of HIV/AIDS.

	FINDING 9: Progress towards enabling partners to make the national HIV/AIDS response more gender- responsive shows a different approach than that used to promote gender-responsive GNP more broadly. FINDING 10: UN Women's technical support to partners is largely of high quality and there is evidence of it enabling partners to make GNP, including HIV/AIDS, more gender-responsive. FINDING 11: While the reconstructed ToC offers a good foundation for conceptualizing the full array of GNP processes and results, it also reveals weaknesses reflecting the evolution of GNP work. This suggests that in the future GNP de- sign and monitoring would be better guided by a re-envisaged ToC. FINDING 12:UN Women's work is necessary, but – as is implicit in a partnership approach – it is not sufficient alone to progress establishing gender-responsive GNP, and its contribution is complex because many stakeholders are involved. FINDING 13: There are four key dimensions of UN Women's added value in GNP: creating spaces; creating connections; creating trust; and carrying the GNP flag. FINDING 14: Engaging women as rights holders and creating channels for their voices to be heard in decision-making is a core dimension of promoting gender equality and human rights, operationalized by UN Women in GNP processes, including in the area of HIV/AIDS. FINDING 15: Global-level GNP work, including in HIV/AIDS, reflects substantive human rights and gen- der equality approaches. At country level, the language of women's human rights is more strongly evident in UN Women's interaction with CSOs than with government stakeholders. FINDING 16: There are good levels of recognition of intersectionality issues in UN Women approaches, but it is variable how far these perspectives have been applied through GNP interventions, including in the area of HIV/AIDS.	
Independent Evaluation of the Partnership between UNAIDS and the Global Fund, and Cosponsors' HIV programme/project reviews	The UNAIDS – Global Fund relationship is highly relevant at country and regional levels as the organizations work together in priority countries and through national multi-stakeholder systems. Through UNAIDS participation in the Country Coordination Mechanisms (CCM) and periodic Global Fund attendance of CCM meetings, the two organizations are better able to ensure that the ways in which they are working together remain relevant to the countries and regions they work in. However, some UNAIDS stakeholders consulted during field visits were critical of the concept of UNAIDS and Global Fund having a bilateral relationship at the country level, increasing the possibility of skirting national coordination systems. UNAIDS-Global Fund cooperation at all levels of the organizations resulted in a number of achievements that enhanced the effectiveness of Global Fund assisted programs. The majority of achievements are not systematically reported on by the two organizations, in a way that attribution can be given the UNAIDS – Global Fund relationship. At the country level, both partners are perceived to be fulfilling their responsibilities for the relationship, as described in the Cooperation Agreement. UNAIDS provides valuable support to the Global Fund and the broader HIV response to foster a country-driven, cohesive and inclusive Global Fund grant cycle.	No. The document focuses on the relationship between UNAIDS and the Global Fund. It mentions that UNAIDS collaborates with Global Fund to assess the impact of national responses using modelled incidence and mortality estimates. It also says that UNAIDS supports impact workshops where countries can develop scenarios of varying programmatic mixes to determine which mix has the greatest impact, and in some

	The Global Fund was to establish a Partnership Management Committee, which would be responsible for the UNAIDS – Global Fund relationship (amongst others), but this was never fully implemented. As a result, the relationship is governed and managed through: 1) multi-stakeholder mechanisms at the global, regional and country level and 2) informal meetings between partnership counterparts at the global and country level. The UNAIDS-Global Fund relationship is operating without many of the relationship management tools and structures recommended for working in partnership, such as corporate guidance, joint work planning, joint monitoring and reporting and feedback mechanisms. The Cooperation Agreement, the main relationship management document, is not well known within the two organizations, nor is it regularly used by staff to guide the relationship and it has limited utility for assisting with managing the relationship. The greatest future threat to the relationship is the decline in funding for HIV and the changes to the broader aid architecture. Development partners and national stakeholders emphasized the role of UNAIDS and the Global Fund at the global level to continue to advocate for funding and demonstrate the ongoing relevance and results the organizations are generating to end the HIV epidemic.	cases, the greatest efficiency.

Annex L: Examples of Joint Programme Outputs that have Contributed to Changes in HIV Responses at the Country and Global Level

The report found that there is ample anecdotal evidence of outputs that can be attributed to the Joint Programme and that have contributed to changes in HIV responses at the country and global level.

Narrative reports in the Joint Programme Monitoring System (JPMS) contain many examples of activities conducted, along with Cosponsor evaluations and other documentation, Key Informant Interviews and country case studies.

Key areas where UN contribution can be seen from the above sources include:

1. Global guidance through policy development, tools and networks (such as the Global HIV Prevention Coalition).
2. Support to country strategy development and investment cases, based on strategic information (relating national targets to global).
3. Sustaining the focus on human rights, gender and the inclusion of civil society, even in challenging environments.
4. Catalytical support to service delivery, such as UNICEF, WFP and UNDP proving vital procurement services in countries under trade sanctions or where capacity is low.

The text below provides more details of these examples.

1. Global guidance through policy development, tools and networks.

There are significant examples of UN agencies providing support to policy development and the establishment of networks to guide collaborative strategic and technical guidance.

• A Global HIV Prevention Coalition (GPC) Secretariat was established at UNAIDS in Geneva to track progress of the HIV Prevention 2020 Road Map implementation, provide technical support to national HIV prevention coalitions and strategies, and help advocate for adequate investments in HIV prevention.[10] By mid-2018 this had translated to the country level as 19 of 25 countries participating in the Global HIV Prevention Coalition reported they had established national HIV prevention coalitions or assigned the responsibility to equivalent existing bodies with wide representation, thereby strengthening coordination and oversight of prevention efforts.

• A Global Partnership for action to eliminate all forms of stigma and discrimination was launched in 2018 with UNDP, UN Women, the UNAIDS Secretariat and the Global Network of People Living with HIV (GNP+) as co-conveners,[11] while the Global Commission on HIV and the Law established by UNDP in June 2010, on behalf of the UN joint team, continued to highlight global and national priorities for addressing law and human rights for vulnerable and key populations, to end AIDS and TB by 2030.

• Another key policy initiative during the period under review was the implementation of WHO 'Treat All' guidelines produced in 2016. There is ample evidence within the JPMS reports of support from WHO and other Cosponsors to ensure uptake and implementation of these

10 [Implementation of the HIV Prevention 2020 Road Map, First progress report March 2018, https://www.unaids.org/sites/default/files/media_asset/jc2927_hiv-prevention-2020-road-map-first-progress-report_en.pdf
11 UNAIDS 2018 PMR Strategy results and indicator report, 2019

recommendations supporting the achievement of SRA 1, with multiple countries noting support from UN teams to develop national guidelines and protocols. To give some examples:

a. In Kazakhstan UNAIDS, UNICEF and WHO have strongly advocated for and supported the government with the approval and implementation of the Test and Treat All policy to fast track the AIDS response.
b. In Kenya the UNJT supported the scale up in ART.[12]
c. In Moldova, protocols aligned to Treat All were approved by the government through support from the Joint Team.[13]

• Another Joint Programme initiative was to revise the International technical guidance on sexuality education. The guidance was prepared with input from a global comprehensive sexuality education advisory group with the participation of the Joint Programme (UNESCO, UNDP, UNFPA, UNICEF, UN Women, WHO) and other stakeholders, including civil service organizations and young people.[14] JPMS reports note support from UN agencies to translate global policy and technical guidance to country level through national policy development and technical assistance supporting training of relevant health personnel and civil society,[15] and survey respondents noted technical assistance provided as one of the main strengths of the Joint Programme.[16]

2. Support to country strategy development and investment cases, based on strategic information (relating national targets to global).

UN agencies have supported the development and evaluation of national strategic plans, investment cases and the development of national targets in line with global targets.

> *"UNJTA provided Government with strategic information through guidance and technical assistance to ensure evidence-based discussions on transitioning and sustainability of the AIDS response and effectiveness and efficiencies within the response." KII Respondent*

• JPMS Reports note support from UN Joint Teams on developing new National Strategic Plans, (e.g.: In Ecuador the UN joint team provided technical support for the whole process). Both JPMS and KIIs detailed examples of joint work through assessments and the use of strategic information which helps to focus investments so programmes are targeted, to where they will have the greatest impact. Contributing to SRA 7, JPMS highlights support to the development of an investment case in Kazakhstan,[17] and the development of an HIV expenditure analysis study with support to the NAC from the World bank jointly with UNAIDS.[18] This strategic information and focused investment also supported proposal development to the Global Fund, such as in Jamaica for example, where the UNJT provided technical support and strategic information through the Country Coordinating and other mechanisms to inform national planning and financing of the response, to access USD12 Million from the Global Fund.[19]

12 JPMS Report, Kenya, 2018
13 JPMS Report, Moldova, 2018
14 [International technical guidance on sexuality educations. An evidence-informed approach. UNESCO,2018 https://www.unaids.org/sites/default/files/media_asset/ITGSE_en.pdf]
15 JPMS Reports – multiple eg: Pakistan WHO supporting capacity building and operational planning; Guidelines for the operationalization of the HIV Prevention Roadmap and the development of the 100 days HIV prevention acceleration plan in Kenya; UNICEF provided technical assistance for revision of relevant policies and regulations for the young KAP program in Indonesia; UNAIDS and WHO supported the updating of HIV treatment guidelines in Fiji.
16 4 mentions as the main legacy of the Joint Programme; 25 mentions as a main strength of the Joint Programme
17 JPMS, Kazakhstan, 2018
18 JPMS, Botswana, 2018
19 Note also Kazakhstan and Morocco where the Joint program help to mobilize funding from Global Fund grants and the UCO participates in proposal design, planning, implementation and monitoring & evaluation

"The joint UN supported initiative of investment framework has been the single most important contribution of UNAIDS – especially effective at country level, to help access GF funds and focus the response." KII Respondent

• The UNAIDS Secretariat delivers several sources of strategic information related to the AIDS response, to support NSP development and investment cases, including Global AIDS Monitoring, Key Populations Atlas, Financial Dashboard, National Commitments and Policy Instrument (NCPI) (component of GAM), GPC scorecards. At global level this is considered a key strength of the Secretariat,[20] although at country level the M&E support has been reported as variable.[21]

• External stakeholders assess UNAIDS Secretariat support for strategic information systems as useful and of good quality. Traditionally, the Joint Programme significantly contributes to generation of good quality data on HIV at the country level to inform programs and policies, by promoting Global AIDS Monitoring reporting, as well as through providing technical support for routine data collection, studies and surveys. This area came out as a key strength of UNAIDS Secretariat in the MOPAN assessment. KIIs and web-based survey respondents rate highly the comprehensiveness and usefulness of the data generated with the help of UNAIDS worldwide. The majority of web survey respondents said they frequently use the data and information generated by the Joint Programme, ranging from 52% among the Cosponsors to 70% among UNAIDS Secretariat staff.

"*UNAIDS data is a core piece of global knowledge of the epidemic and response; …information … is the basis of actions in the field with beneficiaries." - Survey Respondent*

"…the main data produced by the Joint Programme such as the AIDS progress monitoring and the global AIDS update reports are usually the basis for policy and strategy formulation." - Survey Respondent

Strategic Information from the joint team enabled Burkina Faso to have national reports (GAM, sectoral reports, etc.) and to review the National Strategic Plan 2016-2020,[22] while one KII noted that strategic information is being used elsewhere, and some countries have taken the approach of AIDS and using it across other issues.[23]

3. Sustaining the focus on human rights, gender and the inclusion of civil society, even in challenging environments.

The Joint Programme is contributing to progress on reforms of laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support, contributing to the achievement of multiple SRAs (3, 4, 5 and 6).

"There will be something that needs to be preserved, Joint Programme or no Joint Programme. And those are related to human rights, gender inclusion with all the dimensions of inclusion, and civil society as a development player, community as a development actor, these are the dimensions that the Joint Programme brought in and that should be maintained."- KII Respondent

20 [EXT_USAID_1, INT_UNESCO_1]
21 [EXT_USAID_1]
22 JPMS< Burkina Faso, 2018
23 KII Respondent

• UNDP has taken a lead role in promoting human rights, gender equality and enabling law, rights and policy frameworks for health, including for vulnerable and key populations[24] (partnering with UNAIDS Secretariat, UNODC and WHO etc.) to develop international guidelines on human rights and drug policy to support efforts to advocate for human rights-based drug policies, development planning and poverty-reduction efforts.[25]

• This focus on human rights at the global level has put human rights, stigma and discrimination on national agendas. For example, in Burkina Faso UNDP, UNFPA, UNICEF have been crucial to push and maintain human rights and gender mainstreaming in the agenda at operational level, with UNAIDS and UNFPA directly credited for development of a plan including GBV control mechanism with focal points at the police and the tribunal;[26] UNAIDS supported the Kazakhstan AIDS Centre and the Kazakhstan Union of PLHIV to develop and sign a National Plan to Reduce Stigma and Discrimination in the context of HIV for 2018-2019,[27] while in Jamaica, following continued advocacy by the UNJT and partners, a review of four Acts was carried out; the Sexual Offences Act, Offences Against the Person Act, Domestic Violence Act and the Child Care and Protection Act, containing recommendations for legislative and policy reform that will improve administration of justice and promotion and protection of human rights.[28]

• In collaboration with the UNAIDS Secretariat and other Cosponsors, UNDP supported the Global Fund initiative Breaking Down Barriers, which provides resources, including US$45 million in additional funds, to 20 countries to scale up evidence-based programming to reduce human rights-related barriers to HIV, TB and malaria services. The Global Fund has completed baseline assessments in most of these countries to determine the interventions to be implemented to address human rights barriers and to identify gaps.[29]

• The Joint Programme has developed and piloted tools and guidance notes, to help countries measure and strengthen the gender sensitivity of their national AIDS plans and strategies. The Gender Assessment Tool (first introduced in 2014) was updated to reflect the 2016 Political Declaration commitments and integrate new science and knowledge on ensuring a gender-responsive approach to HIV,[30] along with UNDP's capacity development for health toolkit, with a critical enablers section on gender equality and human rights.

4. Catalytical support to service delivery, such as UNICEF, WFP and UNDP proving vital procurement services in countries under trade sanctions or where capacity is low.

Whilst some Cosponsors do some direct service delivery (e.g.: UNHCR providing HIV testing to refugees), most Cosponsors provide catalytic support to enable government bodies or civil society groups to implement vital services.

• WFP, UNICEF and UNDP all carry out large procurement for countries in challenging environments or those with a lack of capacity, whilst in some countries providing new and innovative approaches to tackling chronic constraints in supply chains.[31] To illustrate this, in Iran UNDP procures significant health products for the government implemented programme due to sanctions, while in other countries UN supported procurement has led to significant savings (e.g. in Ukraine through 'Prozzoro'), or filled essential gaps to support SRA1 (UNICEF

24 https://www.undp-capacitydevelopment-health.org/en/legal-and-policy/undps-role/]
25 (UBRAF575 p41)
26 Country visit
27 JPMS, Kazakhstan, 2018
28 JPMS, Jamaica, 2018
29 UNAIDS 2018 PMR Organisational Report, 2019

31 UNAIDS2018 Performance Monitoring Report 2016-2017: Organizational Reports

procured USD 1.3m of ARV and OI drugs for the government of PNG to fulfil treatment commitments). UNDP works to strengthen the capacity of national counterpart's quantification, warehousing and supply chain systems to develop and sustain public health procurement capacity.[32]

• Catalytic support also includes UNDP's work on social contracting, with the move to more sustainable domestic funding and decreased donor support there is a need for governments to be able to directly provide funds to civil society groups, something not commonly in place, especially in Eastern Europe or Asia. UNDP, working closely with the Global Fund and OSF have supported the development of social contracting and other mechanisms in support of state funding allocations for HIV.[33]

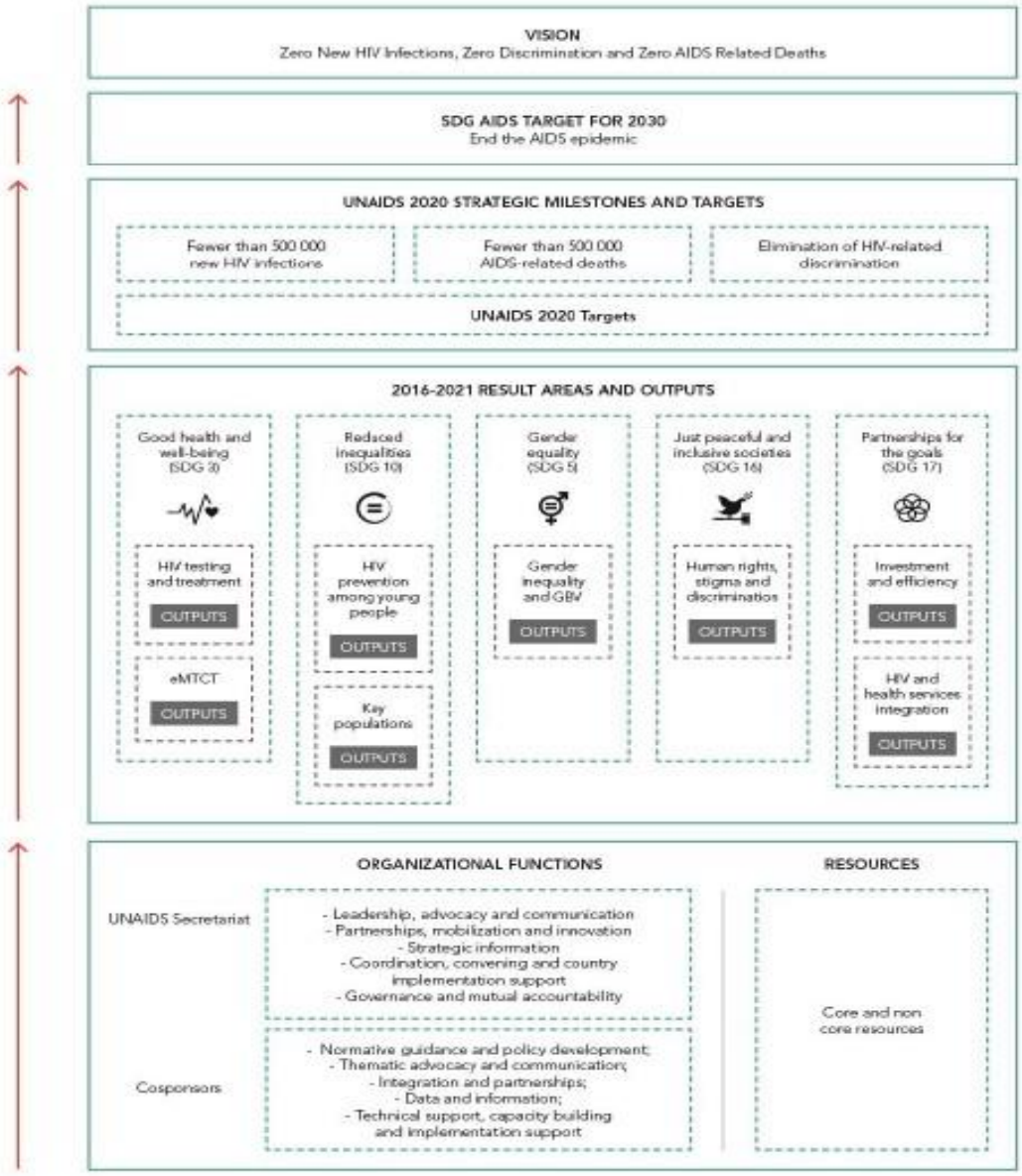
• Finally, the Joint Programme supports change through enabling innovation. For example, in Belarus, envelope funds allow WHO to support the implementation of HIV self-testing at decentralized levels, with the engagement of community organizations, and UNFPA have assessed the feasibility of introducing PrEP for gay and other men who have sex with men. In Iran, innovative services include self-testing, public-private partnerships in delivering eMTCT services, peer-led education to improve the recruitment rate of people who inject drugs for HIV services, and an online phone-based application in the ART programme.

32 UNAIDS Performance Monitoring Reports (PMRs), Part II, 2017
33 E.g.: Kazakhstan, Belarus

Annex M: ToC and the Contribution Gap

The UBRAF Theory of Change does not articulate how activities of the Joint Programme contribute to the goals and targets in UNAIDS Strategy. One of the innovations of the UBRAF is "a theory of change linking UBRAF outputs to higher-level results and the SDGs, explaining how the Joint Programme contributes to outcomes and impact". The UBRAF results framework on page 8 indeed visualises the contribution of the Joint Programme to the objectives of the UNAIDS Strategy.[34]

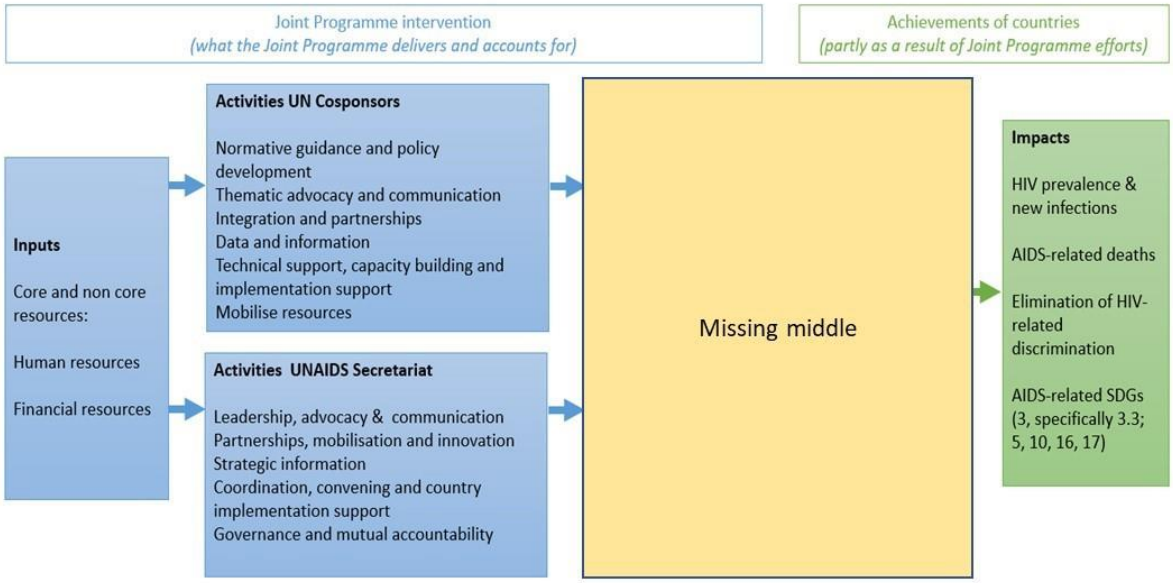
As such it presents the logic between UN core functions (e.g. policy advocacy), UBRAF outputs (e.g. adoption of supportive policies), strategic result areas (e.g. reduced transmission), global fast track targets and ultimately SDGs[35] (see figure 1). Eight theories of change provide further detail on the link between country level outputs and global goals.



The fundamental challenge of the current reporting system that is intended to speak to this overarching Theory of Change is that UBRAF outputs relate to country level change (typically the percentage countries with a certain policy, strategy or programme in place) which is mostly not directly or exclusively the result of support by the UN system.

Therefore, the UBRAF result framework cannot determine contribution (or, of course, attribution)[36] of the UN system as it intends: There is a 'missing middle' or a contribution gap between Joint Programme activities and the results (outcomes) at country level. Specifically, there is a missing set of 'intermediary' indicators (outputs) in core function areas that can be attributed to the Joint Programme and based on that the contribution to country level outcomes can be established,[37] for example WHO normative guidance or policy options that contribute to quality and coverage of HIV treatment services.[38]

Figure 1: 'Missing middle' in the UBRAF Theory of Change

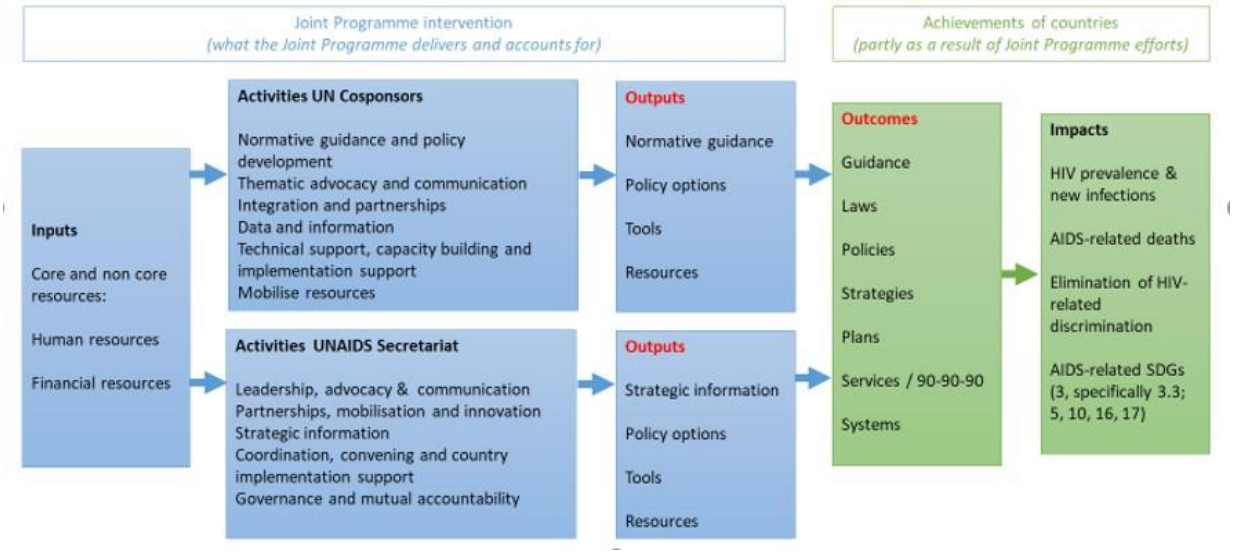


In order to address this (and as flagged in Recommendation 5) it is proposed that the UBRAF reporting system is modified to more systematically and directly capture the data relating to the Joint Programme implementation at country level.

Specifically, in line with Results chains developed by e.g. WHO[39] and UNFPA[40] a revised UBRAF Framework (Figure 2 below) is proposed, which better articulates this missing "middle". In this model the outputs are all the responsibility of the Joint Programme (i.e. attributable to the Joint Programme). The outcomes on the other hand are the result of contributions of the Joint Programme, but also the country itself and other partners.

36 Attribution implies the change is caused by does the from Joint Programme influence or intervention. Contribution implies the change is only in part due to the Joint Programme influence or intervention under consideration.
37 Outputs are considered to be direct results of the Joint Programme activities, while outcomes are changes at country level (due to outputs from the Joint Programme, but also from other stakeholders).
38 The challenge of inferring causation was recognized in the first draft of the UBRAF [PCB Working Group to Review and Further Develop the Results and Accountability Framework of the UBRAF, note for the record 2-3 March 2016; UBRAF, pg10 Fast-forward: refining the operating model of the UNAIDS Joint Programme for Agenda 2030]
39 WHO. Twelfth General Programme of Work 2014–2019. Not merely the absence of disease. 2014 https://apps.who.int/iris/handle/10665/112792
40 UNFPA. Evaluation handbook - how to design and conduct a country programme evaluation at UNFP. 2019 https://www.unfpa.org/sites/default/files/admin-resource/UNFPA_Evaluation_Handbook_FINAl_spread.pdf

Figure 2: Revised ToC framework with Joint Programme outputs and outcomes specified



The WHO document does, however, not actually specify what these output indicators should look like and many of the output descriptions/indicators that are articulated in the UNFPA strategic plan are not easy to present as indicators and/or it is questionable whether these are the sole responsibility of UNFPA.[41]

Hence, defining output indicators at global/aggregate level will be difficult (and is outside the scope of this assignment). Some suggestions, however, are made below the framework, using existing UBRAF indicators (Table 4).

Table 4 - Examples of Joint Programme output and country outcome indicators

Example	Country Joint Programme Output indicators	Country Outcome indicators
1.	a. Country Joint Programme provided input into national strategies in line with global guidelines on comprehensive packages of services for key populations. b. Country Joint Programme created new partnerships to work on key population service provision. c. Country Joint Programme mobilized funding for key population programmes.	Percentage of countries with comprehensive packages of services for key populations defined and included in national strategies (Current UBRAF Output indicator 4.1)
2.	a. Country Joint Programme provided input into a national policy / strategy on gender quality / norms. b. Country Joint Programme was part of the team that conducted a country gender assessment. c. Country Joint Programme presented their approach to gender equality and norm transform presented in national forums.	Percentage of countries with national HIV policies and strategies that promote gender equality and transform unequal gender norms (Current UBRAF Output indicator 5.1)

41 UNFPA. Indicator metadata strategic plan 2018-2021. 2018. https://www.unfpa.org/sites/default/files/admin-resource/Indicator%20metadata%20strategic%20plan%202018-2021.pdf

Annex N: Key Findings Relating to the UBRAF Reporting System

The key finding in the report relating to the UBRAF reporting system was as follows: While there has been recent good progress in streamlining and rationalising the UBNRAF reporting system it is still widely considered to be suboptimal.

Below more detailed analytical content to support and explain this finding is provided:

A web-based tool, the Joint Programme Monitoring System (JPMS) was introduced in 2012 to facilitate collecting, collating and analysing of performance information of the Joint Programme. It includes narrative/qualitative reports on implementation achievements, as well as data on 20 UBRAF outputs consisting of 92 indicator measurements that measure if policies, strategies, guidelines and programmes are in place[42.]

The resources allocated to the UBRAF reporting system have not been adequate. It has been noted that contrary to the GAM process, the UBRAF monitoring and reporting function has been allocated significantly less staff and resources at all levels, and especially at global level (one full-time person has been in position starting 2019). At the same time, interpreting Joint Programme data and triangulating with global AIDS response indicators is a difficult task that requires effort and resources.

Indicators are not sensitive or specific enough for reporting. One of the main critiques of the monitoring system that was raised by many informants is that measurement questions under each indicator mainly refer to the existence of policies/strategies and require a yes/no answer, which does not allow for a more granular representation of the progress the Joint Team is achieving in countries, and is not sensitive enough to capture change that is happening (e.g. a policy in place with zero coverage would have the same reported result as a well-functioning nation-wide programme).

For certain areas, such as prevention or stigma and discrimination, the questions under indicators are not specific enough, (e.g. “Any mechanisms in place to record and address cases of discrimination in relation to HIV”), and are left pretty much for interpretation at the country level.

Some of the web survey respondents felt that in order for UBRAF data to become more useful and actionable, a move from annual to quarterly reporting should be considered. At the same time, changing reporting regularity without addressing the content of what is being reported is not likely to change much, as for many of the UBARF indicators their values do not change from one reporting cycle to another even with annual reporting.

Lack of clear attribution to the Joint Programme activities and contribution to country and global results.[43] The contribution gap is discussed in more detail in annex M.

Concerns about the validity of ‘self-reporting’. Although Step 4 in the Quality Assurance process of Annual Performance Monitoring and Reporting through JPMS foresees external data validation, most stakeholders interviewed who reported on the validity of this tool highlighted that the PMR is based on self-reported data by the Joint Programme, with no or very limited external validation. This questions the reliability of the reported data, and emphasises the need of an independent data source to triangulate the results. It is not clear whether annual reporting data are routinely triangulated with other data sources, such as GAM data (especially the National Commitments and Policy Instrument data)[44] and external evaluations, and if so where and how are the results used. However, the (draft)

42 (More detailed information can be found in the 2016-2021 UBRAF indicator guidance. [UBRAF3])
43 Unified Budget, Results and Accountability Framework: On the Fast Track to end AIDS
44 The NCPI is an integral component of GAM that aims to measure progress in developing and implementing policies, strategies and laws related to the HIV response.

UBRAF Indicator Report 2016-2019 indicates that internally at the UNAIDS Secretariat a process was undertaken to validate data entries by country [UBRAF Indicator Report 2016-2019, UNAIDS 2019, draft]. For this purpose, a task force was created with participation of Cosponsors and the following was done: 1) Data triangulation with other databases (GAM, including NCPI); 2) Data validation (inconsistencies between responses).

Concerns about the Annual Joint Programme reviews. Annual Joint Programme reviews take place at country, regional and global levels are one of the key instruments for UBRAF data sharing and use. However, KIIs felt that the extent to which these reviews are useful to end users/beneficiaries varies significantly.

While at country level reviews could actually be useful, had there been better analysis and more thorough discussion, at the global level the reviews are not programme specific, or at any level of detail. Due to the nature of data collected and reported, the reviews mainly focus on the global/ regional /national AIDS response issues, and not on the specificity of the Joint Programme's response.

> *"The UBRAF captures absolutely everything and provides little direction, particularly in resource constraints contexts, which is sorely needed…. improvements are needed in terms of reporting/use of the data."* --KII respondent

Stakeholders feel that the UNAIDS Performance Monitoring Report is fragmented and does not tell a clear story. An annual performance monitoring report (PMR) is the primary tool used to report to the PCB on results against the UBRAF. It is a comprehensive document composed of an introduction, regional and country report (narrative on achievements, challenges and future actions for each region and each country), strategy results and indicator report (includes narrative on the achieved results and indicator analysis by SRA), and organizational report for each of the 11 Cosponsors and the UNAIDS Secretariat.

While very comprehensive in nature, the background document review indicated that the PMR lacks the description of how the activities implemented by the Joint Programme lead to change. For example, PMR 2018 states that: "The remarkable progress made in expanding access to quality HIV testing and treatment services shows the impact of collaborative efforts across the Joint Programme",[45] and does not give any explanation of what specific activities of Joint Programme and to which degree contributed to achieving these results.

At the country level, lack of lower level output indicators directly linked (attributed) to Cosponsors workplans and budgets is viewed by the Joint Programme as a drawback. Stakeholders at country level highlighted the lack of instruments for easy monitoring of workplan implementation by Cosponsors and quick reaction in case of deviation (outcome level UBRAF indicators do not give this possibility).

Further, a significant number of UBRAF indicators were not viewed as relevant at country level, and frequently it was believed that the ones that were relevant and thus reported do not tell a comprehensive story. For example, for Indicator 3.1 "Percentage of countries with combination prevention programmes in place" a "yes" response means that "Quality-assured male and female condoms are readily available universally, either free or at low cost". At the same time, in certain countries it was felt that while female condoms are not socially accepted and, thus, available, combination prevention programmes are in fact in place, and their negative response to the indicator although correct per the definition, does not accurately correspond to the actual situation.

Quality of reports and how contributions are expressed differs by country and agency. There is lack of unification of the planning, monitoring and reporting system across the UN agencies. KIIs frequently indicated that the quality of UBRAF reporting is not consistent, for example, "Extensive reporting is

45 Performance Monitoring Report 2018 Strategy Result Area and Indicator Report, p.10

done, but the quality differs a lot. How the contributions are expressed vary country by country. While some countries focus more on activities (e.g. related to VMMC policy), others quantify these in results achieved in the country (e.g. increase in number of VMMCs done)." Further, while development of indicators was a collaborative process that involved all Cosponsors, KIs believed that after the indicators were finalised, approved and data had to be collected, there was (and continues to be) a lot of criticism and pushback from various agencies; also as one stakeholder noted, "…some cosponsors developed indicators and then couldn't provide the data". This led to a challenge in getting buy-in for the data obtained and interpretation of the results at the regional level and at the level of the Cosponsors' headquarters.

Issues with who takes credit. It was also mentioned by some Cosponsors at both the global and country level that the UNAIDS Secretariat takes credit for the work under UBRAF that was implemented by 'them'. On the other hand, some Secretariat informants also highlighted that in their reports Cosponsors promote their respective agencies and not that of the Joint Programme.

Lack of unification across reports. Cosponsors frequently noted the lack of unification between UBRAF reporting and that of their respective agencies in terms of content, timelines, and platforms used, which considerably increases the reporting burden. In general, it was felt that agencies spend too much time on planning and reporting, as opposed to implementing their workplans.

Annex O: Terminology Guide

Please note that this is a working document used by Itad and not an official UNAIDS document.

Term	Definition/Description
AIDS	Acquired immunodeficiency syndrome. See the Terminology Guide by UNAIDS for further information.
AIDSinfo	AIDSinfo is a data visualization and dissemination tool intended to facilitate the use of AIDS-related data, both within individual countries and globally. AIDSinfo is populated with multisectoral HIV data from a range of sources, including WHO, UNICEF, UNAIDS and Measure DHS. The data provided by UNAIDS, for instance, includes AIDS spending, epidemiological estimates, information on policies, strategies and laws, and other country-reported data from government and civil society. The tool's visualization capabilities allow for the rapid production of charts, maps and tables for presentations and analysis. For more information, contact aidsinfo@unaids.org or see http:// aidsinfoonline.org.
Behaviour change communication (BCC)	Behaviour change communication promotes tailored messages, personal risk assessment, greater dialogue and an increased sense of ownership of the response by the individual and the community. It is developed through an interactive process, and its messages and approaches use a mix of communication channels to encourage and sustain positive, healthy behaviours.
Beneficiaries	The beneficiaries are mainly people living with HIV and people affected by the virus. Moreover, UNAIDS charts paths for countries and communities to get on the Fast-Track to ending AIDS and is an advocate for addressing the legal and policy barriers to the AIDS response. See: https://www.unaids.org/en/whoweare/about
Civil Society	Civil society refers to the space for collective action around shared interests, purposes and values, generally distinct from government and commercial for-profit actors. Civil society includes charities, development NGOs, community groups, women's organizations, faith-based organizations, professional associations, trade unions, social movements, coalitions and advocacy groups. However civil society is not homogeneous and the boundaries between civil society and government or civil society and commercial actors can be blurred. There is certainly no one 'civil society' view, and civil society actors need to contend with similar issues of representativeness and legitimacy as those of other representatives and advocates.
Client-initiated testing and counselling (CITC)	Client-initiated testing and counselling (CITC) involves individuals actively seeking HIV testing and counselling at a facility that offers such services. CITC is one of three principal modalities of HIV testing—the other two modalities being provider-initiated testing and counselling (PITC) and HIV self-testing (HIVST). CITC can be undertaken or carried out in community or special purpose settings.
Co-creation of recommendations	Process that the Evaluation Team facilitated after presentation of the Draft Final Report highlighting findings and conclusions from the evaluation whereby primary users formulate their own recommendation with the evaluators' support. The rationale is that primary users are more likely to feel ownership and hence put into practice recommendations if they are deeply involved in their formulation. The recommendations are also more likely to be useful (and hence used) if formulated by those who are the closest to the subject at hand rather than by external evaluators. This is in line with the principle and theory of Utilisation-Focused Evaluation.
Cosponsors	11 Cosponsors: UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN WOMEN, ILO, UNESCO, WHO, the World Bank. https://www.unaids.org/en/aboutunaids/unaidscosponsors
Community-based Organisation	Community based organizations (CBO's) are nonprofit groups that work at a local level to improve life for residents. The focus is to build equality across society in all streams - health care, environment, quality of education, access to technology, access to spaces and information for the disabled, to name but a few.

Community systems	There is no singular understanding of community systems, but one way of defining them is as “community-led structures and mechanisms used by communities, through which community members and community-based organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities” (4). Community systems can be informal and small-scale, or they can be extensive networks of organizations.
Community systems strengthening (CSS)	The term community systems strengthening (CSS) refers to initiatives that contribute to the development and/or strengthening of community-based organizations. This is done in order to increase knowledge of (and access to) improved health-service delivery, and it usually includes capacity-building of infrastructure and systems, partnership-building and the development of sustainable financing solutions. CSS promotes the development of informed, capable and coordinated communities and community-based organizations, groups and structures. In other words, it is the capacity-building and the actions that are needed to ensure that the community response can be delivered through community systems. CSS should reach a broad range of community actors, enabling them to contribute to the long-term sustainability of health and other interventions at the community level, including creating an environment in which these contributions can be effective. As a systems approach, CSS aims to strengthen the role and effectiveness of key populations, community actors and organizations in the following areas: design, delivery, monitoring and evaluation of HIV and related services and activities; advocacy and policy; organizational management and development; capacity strengthening; engagement in decision-making processes; and accountability and transparency.
Core funds	The core funding in the UBRAF for the Cosponsors plays a key role in catalysing and influencing significant amounts of other contributions mobilized by the Cosponsors for the response to AIDS. It helps position, build and maintain strong HIV programmes within the Cosponsors under the SDG framework, and provides funding for essential coordination functions internally as well as within the Joint Programme. Since 2008-2009, UNAIDS core budget has remained constant at US$ 485 million in nominal terms, which means a significant reduction in real terms. During this period, UN Women has joined the Joint Programme as the 11th Cosponsors or and the core allocations of the Cosponsors have been increased to enable the Cosponsors to strengthen their internal capacities and mobilisation of resources for HIV-related activities. The Secretariat raise (about 180 USD million a year currently). About 140 are used for the Secretariat (everything, from electricity to staff to programmes); and 44 transferred to the Cosponsors. See page 47 of UBRAF document for more details.
Core Team	A subset of the Evaluation Team comprising the team leader, the three workstream leads, the civil society organisation (CSO) expert, the evaluator and the technical advisor.
Correct terminology for referring to HIV, AIDS, PLHIV etc	With reference to people living with HIV, it is preferable to avoid certain terms. For instance, AIDS patient should only be used in a medical context (most of the time a person with AIDS is not in the role of patient). These terms imply that the individual in question is powerless, with no control over his or her life. Referring to people living with HIV as innocent victims (which often is used to describe HIV-positive children or people who have acquired HIV medically) wrongly implies that people who acquire HIV in other ways are somehow deserving of punishment. People should never be referred to as an abbreviation, such as PLHIV, since this is dehumanizing. Instead, the name or identity of the group should be written out in full. Abbreviations for population groups can, however, be used in charts or graphs where brevity is required. The preferred terms are people living with HIV and children living with HIV as they reflect the fact that persons with HIV may continue to live well and productively for many years. The term people affected by HIV encompasses family members and dependents who may be involved in caregiving or otherwise affected by the HIV-positive status of a person living with HIV. The expression HIV/AIDS should be avoided whenever possible because it can cause confusion. Most people with HIV do not have AIDS. The expression HIV/AIDS prevention is even more unacceptable because HIV prevention entails correct and consistent condom use, use of sterile injecting equipment, changes in social norms and so on, whereas AIDS prevention entails antiretroviral therapy, cotrimoxazole, good nutrition, isoniazid prophylaxis (INH), etc. It is preferable to use the term that is most specific and appropriate in the context. For example: people living

	with HIV, HIV prevalence, HIV prevention, HIV response, HIV testing, HIV-related disease, AIDS diagnosis, children made vulnerable by AIDS, national AIDS programme, AIDS service organization. HIV epidemic and AIDS epidemic are acceptable, but HIV epidemic is a more inclusive term. See the 2015 UNAIDS Official Terminology Guide for more definitions and guidance on the preferred term.
Country Coordinating Mechanism (CCM)	The Country Coordinating Mechanism was established by the Global Fund to fulfill its commitment to local ownership and participatory decision-making. These country-level partnerships develop and submit grant proposals to the Global Fund based on priority needs at the national level and also monitor the implementation of the said proposal once funded.
Country envelope	Please refer to the 2020-2021 UBRAF Budget document for full explanation. Basically, it is a new way to allocate money to Cosponsors (only) – decisions are made at the country level (by UN Country Teams or Joint Teams on AIDS) based on country priorities. Once information from all countries has been compiled and aggregated, funds are transferred by the Secretariat to the relevant Cosponsors (before funds were allocated to Cosponsors, like 5 million to UNICEF HQ that decided how to allocate to its offices, now about 50% of funds, 22 million in 2018 and 22 million in 2019 are allocated differently: ex: the Joint Team in Gabon decides that UNICEF should get 20 000 USD – we sum all these amounts up and the transfer is made by UNAIDS Secretariat to UNICEF together with all other country envelopes). The envelope allocation at country level is part of the joint planning process at country level: key informants in the UNAIDS Secretariat are Abigail David and Tatiana Shoumilina.
CSO Constituency	
Division of labour	Mandates, roles and responsibilities of the Secretariat and each Cosponsors in the AIDS response – to guide Joint Programme work: https://www.unaids.org/sites/default/files/media_asset/UNAIDS-Division-of-Labour_en.pdf
Enterprise Resource Planning (ERP)	The World Health Organisation (WHO) developed a Global Management System (GSM) Enterprise Resource Planning (ERP) that integrates data and processes into a unified planning, budgeting and monitoring system. UNAIDS adopted WHO/GSM from its go-live in 2008, first at HQ level, and progressively at regional and country levels.
Evaluation Steering Committee	This is a reference group set up to oversee the evaluation.
Evaluation Team	The team contracted by Itad for the purposes of this evaluation and comprising the Core Team, the Project Management Team and the national consultants.
Fast Track	Intensified action on AIDS through a Fast-Track approach, i.e. doing things at an accelerated pace, which applies to all countries. Accordingly all countries have Fast-Track targets – but 33 countries (plus USA and Russia) are called “Fast-Track” countries because of they account for such a large part of the disease burden (over 80 per cent of new infections): please refer to page 44 for a list of Fast-Track Countries. We say Fast-Track approach (for all countries), Fast-Track countries, and to “fast track” the response See also: https://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf Countries that are not “Fast-Track” countries should not be referred to as “non Fast-Track countries”, but rather “other countries”, if there is a reason to talk about “Fast-Track” and “Other” countries separately.
Greater involvement of people living with HIV/AIDS3 (GIPA)	In 1994, 42 countries called upon the Paris AIDS Summit to include the greater involvement of people living with HIV/AIDS principle (GIPA) in its final declaration. For more information, see http://data.unaids.org/pub/BriefingNote/2007/JC1299_ Policy_Brief_GIPA.pdf.

HIV-related social protection	This term refers to programmes that are designed for the general public but that tend also to address HIV. Examples include social protection programmes that target older people (over the age of 60 years) in high-prevalence countries, which also will reach older caregivers who face specific HIV caregiving burdens.
HIV-sensitive social protection	Under an HIV-sensitive approach, people living with HIV and other vulnerable populations are provided with services together; this prevents the exclusion of equally needy groups. HIV-sensitive social protection is the most preferred approach, as it avoids the stigmatization that can be caused by focusing exclusively on HIV. Approaches to HIV-sensitive social protection include the following: financial protection through predictable transfers of cash, food or other commodities for those affected by HIV and those who are most vulnerable; access to affordable quality services, including treatment, health and education services; and policies, legislation and regulation to meet the needs (and uphold the rights) of the most vulnerable and excluded people.
HIV-specific social protection	This term refers to programmes that focus exclusively on HIV and people living with and affected by HIV. Under HIV-specific programmes, HIV services are provided for free, and financial incentives are offered to encourage access to them. Examples of this might include cash refunds to address the opportunity costs of accessing services and free food and nutrition for people living with HIV on antiretroviral therapy or tuberculosis treatment in order to encourage adherence to treatment.
HIV testing services (HTS)	HIV testing is the gateway to HIV treatment and care, and it is critical in the scale-up of universal access to HIV prevention, including in the context of male circumcision, elimination of new infections among children and antiretroviral medicine based prevention approaches (including pre-exposure prophylaxis or post-exposure prophylaxis). The term HIV testing services (HTS) is used to embrace the full range of services that should be provided together with HIV testing. HIV testing should be undertaken within the framework of the 5Cs: consent, confidentiality, counselling, correct test results and connection/linkage to prevention, care and treatment.
Human rights-based approach (HRBA)	A human rights-based approach is a conceptual framework for the HIV response that is grounded in international human rights norms and principles, both in terms of process (e.g. right to participation, equality and accountability) and outcome (e.g. rights to health, life and scientific progress). HRBA addresses discriminatory practices and unjust distributions of power that impede progress in the HIV response by strengthening the capacities of rights-holders to claim their rights and the ability of duty-bearers to meet their obligations.
In-depth case study	A case study that entailed a country visit, as conducted in Burkina Faso, Chad, Ghana, Guinea, Kenya and Pakistan.
Key Populations	UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people and people who inject drugs as the four 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. Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. The term key populations also is used by some agencies to refer to populations other than the four listed above. For example, prisoners and other incarcerated people also are particularly vulnerable to HIV; they frequently lack adequate access to services, and some agencies may refer to them as a key population. 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. In addition to the four main key populations, this term includes people living

	with HIV, seronegative partners in serodiscordant couples and other specific populations that might be relevant in particular regions (such as young women in southern Africa, fishermen and women around some African lakes, long-distance truck drivers and mobile populations).
Mother-to-child transmission (MTCT)	MTCT is the abbreviation for mother-to-child transmission. PMTCT, the abbreviation for prevention of mother-to-child transmission, refers to a four-prong strategy for stopping new HIV infections among children and keeping their mothers alive and families healthy. The four prongs are: helping reproductive-age women avoid HIV (prong 1); reducing unmet need for family planning (prong 2); providing antiretroviral medicine prophylaxis to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding (prong 3); and providing care, treatment and support for mothers and their families (prong 4). PMTCT often is mistakenly used to refer to only prong 3— the provision of antiretroviral medicine prophylaxis. Some countries prefer to use the terms parent-to-child transmission or vertical transmission as more inclusive terms to avoid stigmatizing pregnant women, to acknowledge the role of the father/male sexual partner in transmitting HIV to the woman and to encourage male involvement in HIV prevention. Still other countries and organizations use the term elimination of mother-to-child transmission (eMTCT). The UNAIDS preferred terminology for the four programmatic prongs is eliminating (or stopping/ending) new HIV infections among children and keeping their mothers alive. It has no abbreviation. WHO guidelines on the use of antiretroviral medicines for treating and preventing HIV infection in 2013 recommends two options for pregnant and breastfeeding women: (1) providing lifelong antiretroviral therapy to all pregnant and breastfeeding women living with HIV, regardless of CD4 count or clinical stage; and (2) providing antiretroviral therapy for pregnant and breastfeeding women living with HIV during the mother-to-child transmission risk period, and then continuing lifelong antiretroviral therapy for women who are eligible for treatment for their own health. These treatment options are commonly still referred to as Option B+ and Option B, respectively. Option A, which provides prophylaxis for mothers who are not yet eligible for ART for their own health (rather than treatment for both mother and infant), is no longer formally recommended by WHO, although it is still used in some countries.
Non-core funds	In the context of the UBRAF defined as the HIV-related budgets of the Cosponsors mobilised internally and the additional funds that Cosponsors and the Secretariat raise at country, regional and global levels. Basically, this refers to funds that Cosponsors raise by themselves. See page 47 of UBRAF document.
Strategy Result Area (SRA)	The 2016-2021 UBRAF is structured based on the eight result areas in the UNAIDS 2016-2021 Strategy and the five SDGs that are most relevant to the AIDS response. Strategy results are basically outcomes. See UBRAF document.
Stakeholders	A stakeholder is either an individual, group or organisation who is impacted by the outcome of a project. They have an interest in the success of the project, and can be within or outside the organization that is sponsoring the project. See the UBRAF Document for further info.
UBRAF	The UBRAF operationalises the Strategy: what the Joint Programme does to contribute to the Strategy. It is a document and a framework defining budget, allocations, outcomes, outputs, actions. Of course, it needs to be translated into more specific plans at the regional and country level, but it should guide their development. It is a guidance document. For people who are very familiar with it (PFA staff in UNAIDS, Global Coordinators, many PCB members …) it ended up to mean: “all that the Joint Programme does on AIDS, but for other it is simply the name of a “document” that they might need or not need to read (“the same way, for example, not all teachers read – or need to read –the ministerial educational plans for the year in order to perform their jobs”) Please note that every two years there is a new Budget approved by the PCB (2016-2017 is part of the UBRAF document, then 2018-2019, and 2020-2021); these used to be called Budgets but they are “mini-UBRAF” meaning they also include outputs, actions and so on, these are full planning framework (the 2020-2021 explains this better in its title, although it is not a workplan in its true sense). The Budgets for 2018-2019, and 2020-2021 are available in the shared folders and they should be USED TOGETHER WITH THE UBRAF DOCUMENT.

	To understand and assess the Joint Programme, the 2016-2021 UBRAF and the 2018-2019 and 2020-2021 Budgets need to be considered. http://www.unaids.org/sites/default/files/media_asset/20160623_UNAIDS_PCB38_16-10_Revised_UBRAF_EN.pdf
UNAIDS Joint Programme	It means the Secretariat AND the Cosponsors. It may mean the entities (12: 1 Secretariat plus 11 Cosponsors) but also the "Programme": what these entities do on AIDS at all levels: global, regional, countries.
UNAIDS Secretariat	The Secretariat: with its 700 or so people, in the Geneva HQ, 5 regional offices (RSTs) 3 liaison offices, and 78 country offices (UCOs).
UNAIDS Strategy	https://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf This is a GLOBAL strategy, what UNAIDS recommend the world (and the Joint Programme as part of it, to do)
UNAIDS	UNAIDS is a model for United Nations reform and is the only cosponsored Joint Programme in the United Nations system. It draws on the experience and expertise of 11 United Nations system Cosponsors and is the only United Nations entity with civil society represented on its governing body. 'UNAIDS' can have two meanings: - UNAIDS Secretariat (in common use) - A synonym of the Joint Programme, in more formal use (like in PCB documents)
UNGASS Declaration of Commitment on HIV/AIDS	In June 2001, the Special Session of the United Nations General Assembly on HIV/AIDS adopted the Declaration of Commitment on HIV/AIDS, in which Member States made a commitment to provide regular country progress reports. The UNAIDS Secretariat is entrusted with the responsibility of developing the reporting process, accepting reports from Member States and preparing a report for the General Assembly.
Vulnerability and Vulnerable communities	Vulnerability refers to unequal opportunities, social exclusion, unemployment, or precarious employment and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk and may be outside the control of individuals. These factors may include: lack of the knowledge and skills required to protect oneself and others; accessibility, quality, and coverage of services; and societal factors such as human rights violations or social and cultural norms. These norms can include practices, beliefs, and laws that stigmatize and disempower certain populations, limiting their ability to access or use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.
Young key populations (see also key populations)	The term specifically refers to young people aged 15 to 24 years who are members of key populations, such as young people living with HIV, young gay men and other men who have sex with men, young transgender people, young people who inject drugs and young people (18 years and older) who sell sex. Young key populations often have needs that are unique, and their meaningful participation is critical to a successful HIV response.