EVALUATION REPORT

EVALUATION OF THE UNICEF PMTCT / PAEDIATRIC HIV CARE AND TREATMENT PROGRAMME

EVALUATION OFFICE

May 2017

unicef | for every child

Evaluation of the UNICEF PMTCT/Paediatric HIV Care and Treatment Programme

Final report

United Nations Children's Fund
Three United Nations Plaza
New York, New York 10017

May 2017

To download the full report, visit:
https://www.unicef.org/evaldatabase/index_95015.html

For further information, please contact:

Evaluation Office
United Nations Children's Fund
Three United Nations Plaza
New York, New York 10017
evalhelp@unicef.org

Photo Credits

Cover: © UNICEF/UNI197921/Schermbrucker
Chapter 1: © UNICEF/UNI201831/Schermbrucker
Chapter 2: © UNICEF/UNI197957/Schermbrucker
Chapter 3: © UNICEF/UNI201852/Schermbrucker
Chapter 4: © UNICEF/UNI197947/Schermbrucker
Chapter 5: © UNICEF/UNI197954/Schermbrucker
Chapter 6: © UNICEF/UNI202904/Schermbrucker

PREFACE

Over the past 10 years, the impact of prevention of mother-to-child transmission of HIV (PMTCT) programmes has been impressive. PMTCT has even been described as one of the greatest public health achievements of recent times. This programme area has undergone a huge transformation, both conceptually and practically, from an initial focus on offering single-dose nevirapine to HIV-positive women during labour and to their newborns, to a complex set of interventions for pregnant women and their children. These changes mostly occurred after 2011, which saw the launch of the Joint United Nations Programme on HIV/AIDS (UNAIDS) *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive*.

The United Nations Children's Fund (UNICEF) Evaluation Office has commissioned this evaluation to assess the contribution of UNICEF engagement to galvanizing global commitment, action and resources to mount a comprehensive response to HIV among children. The evaluation also assesses the extent to which UNICEF engagement has helped low- and middle-income countries scale up effective and efficient programmes to eliminate new HIV infections among children and provide HIV treatment to children and their families living with HIV. The purpose of the evaluation is to support accountability and learning in relation to UNICEF's efforts to support the scale up of PMTCT and paediatric HIV care and treatment programmes.

The evaluation was carried out through exemplary collaboration between the Evaluation Office and the Programme Division/HIV section. This collaboration facilitated the substantive use of evaluation findings and recommendations to inform HIV events and programming processes, including the General Assembly 2016 High-Level Meeting on Ending AIDS and 'The Global Vision and Strategic Direction of UNICEF's HIV Response in the Next Strategic Plan 2018–2021'. The findings and recommendations will also be used to inform UNICEF's future work within the 2030 Agenda for Sustainable Development, as guided by the UNAIDS Strategy 2016–2021; and to inform UNICEF's thinking with respect to the positioning of HIV/AIDS in its new Strategic Plan 2018–2021 (focusing on the first decade of life) and the management of the UNICEF HIV portfolio going forward.

The Evaluation Office commissioned the consulting firm Itad to field a team to undertake the evaluation. On behalf of the Evaluation Office, I would like to express my appreciation to the team for its work, particularly Isabelle de Zoysa, who provided excellent leadership, with the support of Emma Newbatt, Mathew Cooper, Lynette Lowndes, Matthew Chersich, Giada Tu-Thanh and Sam McPherson. I am grateful to UNICEF staff at all levels of the organization for their interest and support throughout the evaluation process, particularly HIV regional advisers, staff from the country case studies (Cambodia, Cameroon, Haiti, India, South Africa, Ukraine and Zimbabwe). Special thanks to colleagues from the Programme Division/HIV section—Chewe Luo, Associate Director HIV/AIDS, and Ken Legins, former Senior Advisor and Team Lead for Knowledge, Policy and Innovation—for their coordination roles. I would also like to thank the Evaluation Office colleagues who managed this evaluation: Abdoulaye Seye, Evaluation Manager, Beth A. Plowman, Senior Evaluation Specialist, for her oversight and support, and Dalma Rivero, Senior Administrative Assistant, who provided strong administrative support throughout the process.

Colin Kirk
Director, Evaluation office
UNICEF New York Headquarters

CONTENTS

TABLES AND FIGURES

ACKNOWLEDGEMENTS

The Itad evaluation team would like to acknowledge the constructive engagement and responsiveness of all those who were consulted during the course of this evaluation. Their expert knowledge and reflective insights have made valuable contributions to the report.

ACRONYMS

AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral
ART	Antiretroviral treatment
CDC	Centers for Disease Control and Prevention
CSO	Civil society organization
CHAI	Clinton Health Access Initiative
CRC	Convention on the Rights of the Child
CPD	Country programme document
DHIS	District Health Information Software
eMTCT	Elimination of mother-to-child transmission of HIV
HQ	Headquarters
IATT	Inter-Agency Task Team
IPSAS	International Public Sector Accounting Standards
KEQ	Key evaluation questions
LMICs	Low- and middle-income countries
MDG	Millennium Development Goal
MNCH	Maternal, newborn and child health
MoRES	Monitoring Results for Equity System
NGO	Non-governmental organization
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission of HIV
SDG	Sustainable Development Goal
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UBRAF	Unified Budget, Results and Accountability Framework
UNFPA	United Nations Population Fund
UNSAS	United Nations System Accounting Standards
WHO	World Health Organization

EXECUTIVE SUMMARY

OVERVIEW OF THE EVALUATION

UNICEF commissioned a corporate evaluation of its PMTCT and paediatric HIV care and treatment programme to reflect on its contribution over the period 2005–2015. The evaluation addressed the following objectives:

1. To contribute to improving the organization's accountability for its performance by defining and documenting key achievements as well as missed opportunities in UNICEF's engagement with partners and countries between 2005 and 2015;
2. To generate evidence and learning to enhance understanding on how UNICEF's strategies and programmes have evolved, what has worked and what has not worked and why and to make recommendations for UNICEF's future engagement in PMTCT and paediatric HIV care and treatment.

The evaluation focused on four thematic areas: 1) leadership, advocacy, coordination and partnerships; 2) resource mobilization; 3) strategic information and knowledge generation and dissemination; and 4) key aspects of UNICEF's organization. It also considered three cross-cutting issues – gender, human rights and equity – and examined how the response to PMTCT and paediatric HIV has played out in humanitarian situations.

EVALUATION DESIGN

The evaluation is framed around a theory of change, which formed the basis for the development of key evaluation questions. The evaluation focused on UNICEF's contributions to programme responses and did not seek to address issues of outcomes and impact.

The evaluation approach was based on an *ex post* analysis of performance against the theory of change using data generated from primary sources (through key informant interviews, group discussions, an online survey and seven country case studies), supplemented by secondary data analysis (based on a review of key documents and data sources). Four of the case studies involved country visits (in-depth case studies in Cameroon, India, South Africa and Zimbabwe) and three were conducted remotely ('light touch' case studies in Cambodia, Haiti and Ukraine).[1]

This evaluation report presents detailed findings for each thematic area, as well as overarching conclusions and strategic recommendations.

KEY FINDINGS

Leadership, advocacy, coordination and partnerships

UNICEF has been a prominent advocate for the scale-up of HIV prevention and treatment services for children. It has forged strong strategic alliances with a range of partners and provided valued support for programme scale-up at the country level.

UNICEF and its partners took swift and decisive action to support the process of mobilizing national stakeholders around the targets of the *Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive* (hereafter referred to as 'the Global Plan') and translating national commitments into action.

In most case study countries, UNICEF served as a lead agency for issues related to HIV and children. The organization was particularly recognized for supporting decentralized planning, implementation and capacity building at all levels and developing programme innovations.

UNICEF has made a strong push to integrate HIV services within the maternal, newborn and child health (MNCH) platform, according to 'Double Dividend' principles. Vertical approaches to HIV programming at the country level have, however, tended to dampen UNICEF's efforts to reinforce linkages between health and HIV at the planning

[1] The 'light touch' case studies entailed a focused document review complemented by interviews conducted remotely (by Skype or telephone) with 8-10 stakeholders from governments, partners and UNICEF.

and management levels and more widely across programmes and sectors. More work is also required to strengthen community systems.

Resource mobilization

UNICEF has faced challenges related to fundraising for its HIV and AIDS work. Despite increases in global financing for HIV and AIDS and UNICEF total revenues, UNICEF's HIV and AIDS resources have declined since 2008. UNICEF's expenditure on HIV and AIDS also declined over time from a peak of US$188 million between 2008 and 2010 to US$107 million in 2014 and 2015, accounting for just 2 per cent of UNICEF's total programme expenditure in 2015 (down from 8 per cent in 2005). A high proportion of UNICEF's resource base is tightly earmarked, increasing transaction costs and restricting the ability to flexibly programme resources.

UNICEF has played a valuable role in supporting countries' access to external resources, particularly from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), but there is little evidence of UNICEF playing this resource mobilization role at the global level. There have been significant resource gaps in some countries for the achievement of high-level targets.

Strategic information, knowledge generation and dissemination

UNICEF has worked with partners to generate, analyse and disseminate strategic information on the HIV epidemic among children, both at country and global levels. Although UNICEF is recognized for its efforts to generate age- and sex-disaggregated data, otherwise, its work on strategic information has had limited visibility.

UNICEF has championed data-driven approaches to improving programme performance and piloted innovative data management approaches to improve service delivery. It has also provided valuable support to national authorities to manage rapid policy shifts, towards simpler and more effective regimens for PMTCT. Particularly noteworthy is UNICEF's strong push for the Option B+ policy, which has facilitated a surge in programme scale-up since 2011.

UNICEF's organization

UNICEF has deployed diverse approaches to address its corporate priority on HIV/AIDS at different levels of the organization. Some regional strategic priority documents and many country programme documents (CPDs) clearly single out HIV/AIDS as a major priority while others incorporate HIV within other overarching priorities. UNICEF offices have tailored their engagement in the children and HIV response accordingly. Stakeholders value this flexibility and responsiveness to country needs and priorities given the diversity of settings and the rapid pace at which the HIV and children response has developed in recent years.

UNICEF struggled to adapt to dwindling financial and human resources for its HIV and AIDS work. While some country offices now have few or no dedicated HIV staff, there are few examples of shared HIV accountabilities across programmes. In some cases, UNICEF's ability to meet demands for HIV/AIDS results has been stretched.

Cross-cutting issues

UNICEF is generally, though not universally, recognized as having integrated gender, equity and human rights dimensions into its work. Opportunities remain for UNICEF to strengthen its focus in these areas, however, and more vocally define and drive the agenda.

Regarding gender, UNICEF is valued for its focus on women and children but there is limited evidence that the organization has worked to integrate broader gender issues within its PMTCT/paediatric HIV care and treatment response.

Regarding equity, UNICEF's support for the use of bottleneck analyses has made a valuable contribution to programme scale-up towards universal access, though there is less evidence that these tools are being deployed specifically as a way of reaching vulnerable, marginalized and hard-to-reach populations.

UNICEF has a clear mandate on human rights, which guides its work on HIV and AIDS but is not always particularly visible externally.

UNICEF has advocated for and supported the inclusion of PMTCT/paediatric HIV care and treatment services into various emergency responses.

CONCLUSIONS

Since 2005, there has been good progress towards preventing HIV infection in children and improving the use of treatment among pregnant women and mothers. The scale-up of paediatric HIV treatment programmes continues to lag behind, however. Following the development and 2011 launch of the Global Plan, the last five years have been UNICEF's most productive in terms of expanding and improving programmes to prevent new HIV infections in children.

Working with partners, UNICEF has played a critical role in scaling up HIV prevention, care and treatment programmes among children through its targeted advocacy for children affected by HIV, its convening role at the global, regional and country levels, and its substantive financial and technical support to country level partners across a broad range of areas, including policy development, programme planning, support to implementation and knowledge-building activities.

HIV/AIDS has been a corporate priority throughout the evaluation period; however, it has been operationalized in diverse ways at different levels in recognition of the importance of tailoring approaches to context and that 'one size does not fit all'. This flexibility and responsiveness to country needs and priorities is highly valued by stakeholders.

The rapid and substantial decline in UNICEF's resources for HIV and AIDS since 2005 has put pressure on its PMTCT/paediatric HIV care and treatment work. Although UNICEF has sought to adapt over time to dwindling resources and staff, its ability to deliver on these results has been severely curtailed in many settings, and the visibility of its HIV and AIDS work has been limited.

UNICEF is widely perceived as the organization that can 'connect the dots' and provide support for programme integration at all levels. This integration effort is not, however, fully realized everywhere, and there is even less evidence of broader inter-sectoral linkages, with some notable exceptions. Challenges have included vertical structures for HIV/AIDS programming in countries, as well as UNICEF's own internal structures and operations, which tend to compartmentalize HIV work.

The progress made in regards to preventing new HIV infections among children has been unequal between and within countries and remains fundamentally challenged by issues related to gender, human rights and inequality across the wider social determinants of health. Although UNICEF has the potential to inform and drive the agenda around these issues, it is not currently making the most of its position.

Though much has been achieved, the job is not yet done. Many countries still face enormous challenges as they strive to achieve targets, and the demands on UNICEF remain high. In addition, UNICEF has achieved limited progress in its work on the 'second decade' of life, with continued high risk of HIV infection among adolescent girls and young women aged 15–24, and the organization has not been very active in promoting 'prong 2' of the PMTCT framework in terms of sexual and reproductive health services for young women living with HIV. The result is that exposure of children to HIV continues at very high levels, and the risk of a rebound of the epidemic among children is real.

RECOMMENDATIONS

The following eight evaluation recommendations are intended to feed into the development of the UNICEF Strategic Plan 2018–2021. The recommendations should also inform efforts that are required immediately to guide UNICEF's work on HIV and AIDS in a rapidly changing environment.

1. Expand UNICEF's advocacy efforts to keep HIV prevention, care and treatment among children high on the global agenda.
2. Clearly define UNICEF's unique role and contribution to the HIV response in the post-2015 era, building on its comparative advantages.
3. Tailor HIV programming carefully to country needs, capitalizing on UNICEF's decentralized mode of operations and its focus on making a difference at country level.
4. Take the lead on the mainstreaming agenda, demonstrating how HIV can be effectively linked with work in other key programmes and sectors.
5. Develop strategic approaches to keep HIV visible as a key corporate priority within UNICEF, across diverse organizational structures.
6. Consider making equity the focus of continued programme scale-up, while strengthening UNICEF's programming approaches to more explicitly address gender and human rights.
7. Position UNICEF's work clearly within existing partnership frameworks, which may need to be renegotiated or strengthened, as required.
8. Invest in efforts aimed at ensuring that the necessary funds for UNICEF's HIV response are mobilized.

RÉSUMÉ ANALYTIQUE

APERÇU DE L'ÉVALUATION

UNICEF a commandé une évaluation interne de son programme relatif à la PTME, à la prise en charge et au traitement pédiatriques du VIH afin de mesurer sa contribution au cours de la période 2005-2015. Cette évaluation avait pour objectif de :

1. contribuer à améliorer la responsabilité de l'organisation à l'égard de ses performances en recensant et en documentant les grandes réalisations ainsi que les opportunités manquées de l'UNICEF dans le cadre de son engagement avec les partenaires et les pays entre 2005 et 2015 ;

2. produire des données factuelles et tirer des enseignements permettant d'améliorer la compréhension de l'évolution des stratégies et programmes de l'UNICEF, mais aussi les réussites et les échecs de l'organisation, et élaborer des recommandations pour l'engagement futur de l'UNICEF dans la PTME, la prise en charge et le traitement pédiatriques du VIH.

Pour ce faire, l'évaluation s'est concentrée sur quatre domaines thématiques : 1) le leadership, les actions de plaidoyer, la coordination et les partenariats ; 2) la mobilisation des ressources ; 3) la production et la diffusion d'informations et de connaissances stratégiques et 4) les aspects clés de l'organisation. Elle s'est également intéressée à trois problématiques transversales – l'égalité des sexes, les droits de l'homme et l'équité – et a analysé la manière dont l'UNICEF a mis en œuvre ses actions à l'appui de la PTME et de la lutte contre le VIH pédiatrique dans les situations humanitaires.

CONCEPTION DE L'ÉVALUATION

L'évaluation s'articule autour d'une théorie du changement qui a servi de base pour l'élaboration des questions clés. Elle s'est principalement intéressée aux contributions de l'UNICEF pour ce qui est des réponses programmatiques sans chercher à traiter la question des effets et de l'impact.

Cette évaluation s'est par ailleurs fondée sur une analyse ex post des performances de l'organisation intégrant la théorie du changement. Les données utilisées sont issues de sources primaires (entretiens avec des informateurs clés, discussions de groupes, enquête en ligne et sept études de cas effectuées dans différents pays), et ont été complétées par une analyse de données secondaires (s'appuyant sur l'examen de documents clés et de sources de données). Quatre des sept études de cas ont inclus des visites de pays (études de cas approfondies au Cameroun, en Inde, en Afrique du Sud et au Zimbabwe) tandis que les trois autres ont été menées à distance (études restreintes au Cambodge, en Haïti et en Ukraine).[1]

Le présent rapport d'évaluation présente les résultats détaillés pour chaque domaine thématique ainsi que ses conclusions générales et recommandations stratégiques.

PRINCIPALES CONCLUSIONS

Leadership, plaidoyer, coordination et partenariats

L'UNICEF a plaidé activement en faveur de l'expansion des services de prévention et de traitement du VIH chez les enfants. Le Fonds a noué des alliances stratégiques avec de nombreux partenaires et apporté un soutien précieux à l'élargissement des programmes au niveau des pays.

L'UNICEF et ses partenaires ont mené des actions rapides et décisives pour appuyer, d'une part, la mobilisation des parties prenantes nationales en faveur des objectifs du *Plan mondial pour éliminer les nouvelles infections à VIH chez les enfants à l'horizon 2015 et pour maintenir leurs mères en vie* (le « Plan mondial ») et, d'autre part, la traduction des engagements nationaux en mesures concrètes.

[1] Les études de cas dites « restreintes » incluaient une étude documentaire précise complétée d'entretiens conduits à distance (par Skype ou par téléphone) avec 8 à 10 parties prenantes (membres de gouvernements, partenaires et personnel de l'UNICEF).

Dans la plupart des pays ayant fait l'objet d'une étude de cas, l'UNICEF a joué un rôle de chef de file pour les questions liées aux enfants et au VIH. L'organisation a notamment été saluée pour son appui aux processus de décentralisation de la planification, de la mise en œuvre et du renforcement des capacités à tous les niveaux et pour avoir engendré des innovations au sein des programmes.

L'UNICEF a fortement contribué à l'intégration des services de prise en charge du VIH au sein des établissements de santé maternelle, néonatale et infantile en vertu du principe de double dividende. Toutefois, les approches verticales des programmes de lutte contre le VIH déployées au niveau des pays ont eu tendance à nuire aux efforts de l'UNICEF visant à resserrer les liens entre santé et VIH aux niveaux de la planification et de la gestion et, plus largement, au sein des programmes et des différents secteurs. Davantage de travail est requis pour renforcer les dispositifs gérés par les communautés locales.

Mobilisation des ressources

L'UNICEF a rencontré des difficultés pour lever des fonds en faveur de son action contre le VIH/sida. Malgré la hausse du financement mondial de la lutte contre le VIH et des recettes globales de l'UNICEF, les ressources de l'organisation affectées au VIH et au sida déclinent depuis 2008. Les dépenses de l'UNICEF relatives à cette thématique ont également baissé au fil du temps, pour passer de 188 millions de dollars en 2008 à 107 millions de dollars en 2014 et 2015, soit 2 % seulement du montant total de ses dépenses programmatiques en 2015 (contre 8 % en 2005). Une importante part des ressources de l'UNICEF est constituée de fonds à affectation stricte, ce qui augmente les coûts de transaction et restreint la possibilité de planifier avec souplesse l'allocation des ressources programmatiques.

L'UNICEF a joué un rôle important en soutenant l'accès des pays aux ressources externes, et notamment au Fonds mondial de lutte contre le sida, la tuberculose et le paludisme (le « Fonds mondial ») mais le rôle de mobilisateur de fonds qu'a pu jouer l'organisation au niveau mondial reste encore à démontrer. En effet, à l'heure actuelle, certains pays accusent encore un important déficit en ressources qui met à mal la réalisation de leurs objectifs de haut niveau.

Production et diffusion d'informations et de connaissances stratégiques

L'UNICEF a travaillé en collaboration avec un certain nombre de partenaires pour produire, analyser et diffuser tant au niveau national que mondial des informations stratégiques sur l'épidémie de VIH chez les enfants. Si l'organisation est reconnue pour ses efforts en matière de production de données ventilées par âge et par sexe, la visibilité de son action relative aux informations stratégiques demeure néanmoins limitée.

L'UNICEF a défendu l'idée d'approches guidées par les données pour améliorer les performances de ses programmes, et a été l'instigateur de démarches novatrices en matière de gestion des données en vue d'améliorer les prestations de service. Le Fonds a en outre apporté un soutien précieux à certains pays pour gérer les transitions politiques rapides visant à la mise en place de systèmes de PTME plus simples et plus efficaces. Il convient notamment de souligner son action décisive en faveur de l'Option B+, qui a contribué à accélérer la généralisation de cette approche depuis 2011.

Organisation de l'UNICEF

L'UNICEF a déployé diverses approches pour que la problématique du VIH/sida soit hissée au rang de priorité à différents niveaux de l'organisation. Certains documents stratégiques régionaux prioritaires et de nombreux descriptifs de programme de pays (DPP) citent clairement le VIH/sida comme une priorité absolue tandis que d'autres intègrent la thématique au sein de domaines prioritaires plus généraux. Les bureaux de l'UNICEF ont donc adapté leurs actions de lutte contre le VIH pédiatrique en conséquence. Les parties prenantes apprécient tout particulièrement cette flexibilité et cette réactivité du Fonds face aux besoins et priorités de chaque pays compte tenu de la diversité des situations et du rythme accéléré auquel la riposte au VIH pédiatrique s'est développée ces dernières années.

L'UNICEF s'est efforcé de s'adapter à la diminution des ressources financières et humaines disponibles pour ses actions de lutte contre le VIH/sida. Or, si certains bureaux de pays font désormais face à une carence voire à une absence complète de personnel dédié à la problématique du VIH, les cas de gestion partagée de cette thématique au sein des programmes sont très peu nombreux. De ce fait, dans certains cas, la capacité de l'UNICEF à satisfaire aux exigences de résultats dans ce domaine a atteint ses limites.

Questions transversales

Même si ce constat n'est pas universellement reconnu, il est généralement admis que l'UNICEF a intégré les dimensions de genre, d'équité et de droits de l'homme dans son travail. Néanmoins, des marges d'amélioration subsistent pour l'organisation, qui pourrait se concentrer davantage sur ces thématiques, et participer plus activement à la définition et à la concrétisation des priorités.

Concernant la problématique hommes-femmes, bien que l'UNICEF soit reconnu pour son soutien en faveur des femmes et des enfants, peu de données indiquent que l'organisation a œuvré pour intégrer les questions plus larges de l'égalité des sexes au sein de ses programmes de PTME, de prise en charge et de traitement pédiatriques du VIH.

Pour ce qui est de la question de l'équité, l'action de l'UNICEF en faveur des analyses des goulots d'étranglement a largement contribué à l'élargissement des programmes visant un accès universel au traitement par antirétroviraux, bien qu'un nombre moins important d'éléments indique que ces analyses sont spécifiquement déployées pour atteindre les populations vulnérables, marginalisées et difficiles d'accès.

Même s'il n'est pas toujours très visible de l'extérieur, le mandat de l'UNICEF en matière de droits de l'homme est très clair et il guide son action de lutte contre le VIH/sida.

L'UNICEF a plaidé en faveur de l'intégration de services de PTME, de prise en charge et de traitement pédiatriques du VIH dans diverses interventions d'urgence et l'a favorisée.

CONCLUSIONS

Depuis 2005, des progrès notables ont été accomplis dans le domaine de la prévention du VIH chez l'enfant et de l'amélioration du recours au traitement chez les femmes enceintes et les mères. En revanche, la généralisation des programmes de traitement pédiatrique du VIH continue d'accuser un certain retard. En effet, depuis l'élaboration et le lancement du Plan mondial en 2011, l'UNICEF s'est en grande partie consacré à la diffusion et à l'amélioration de ses programmes de prévention des nouveaux cas d'infection chez les enfants.

Dans le cadre de ses partenariats, l'UNICEF a joué un rôle essentiel dans l'intensification des programmes de prévention, de prise en charge et de traitement du VIH chez les enfants par le biais de ses plaidoyers ciblés en faveur des enfants touchés par le virus, de son rôle fédérateur aux niveaux mondial, régional et national et de son appui financier et technique substantiel aux partenaires à l'échelon des pays dans un grand nombre de domaines tels que la conception de politiques, la planification et la mise en œuvre de programmes et les activités de développement des connaissances.

Si le VIH/sida a fait partie des domaines prioritaires de l'organisation pendant toute la période de l'évaluation, les activités liées à cette problématique se sont toutefois concrétisées de diverses manières selon les niveaux concernés afin de proposer une solution adaptée aux différents contextes, et non une solution unique ne sachant convenir à la diversité des situations. Cette flexibilité et cette réactivité à l'égard des besoins et des priorités de chaque pays est fortement appréciée des parties prenantes.

Le déclin rapide et important des ressources de l'UNICEF affectées au VIH et au sida depuis 2005 a exercé une pression sur ses actions de PTME, de prise en charge et de traitement pédiatriques du VIH. Bien que l'organisation ait cherché à s'adapter au fil du temps à la réduction de ses ressources humaines et financières, sa capacité à atteindre des résultats dans ce domaine a été fortement restreinte dans de nombreuses situations et son travail a fait l'objet d'une visibilité limitée.

L'UNICEF est largement perçu comme une organisation capable de jeter des ponts là où ils sont nécessaires et de soutenir l'intégration des programmes à tous les niveaux. Cependant, cet effort d'intégration ne s'est pas nécessairement concrétisé partout et les données attestant de liens intersectoriels plus larges sont encore moins nombreuses, à l'exception de quelques cas notables. Parmi les difficultés rencontrées, citons notamment les approches verticales déployées pour la programmation du VIH/sida au niveau des pays, ainsi que les structures et opérations internes à l'UNICEF qui ont tendance à segmenter les activités liées au VIH.

Les avancées réalisées dans le domaine de la prévention des nouveaux cas d'infection des enfants par le VIH sont inégales entre et au sein des pays et sont profondément remises en cause par des problèmes liés à l'égalité entre les sexes, aux droits de l'homme et aux inégalités face aux déterminants sociaux de la santé. Bien que l'UNICEF ait le potentiel pour davantage cibler et faire avancer ces questions dans ses programmes, l'organisation ne tire pas pleinement profit de cette position de force.

Bien que d'importants progrès aient été accomplis, le but n'est pas encore pleinement atteint. De nombreux pays font toujours face à d'immenses difficultés alors qu'ils cherchent à atteindre les objectifs établis, et les exigences vis-à-vis de l'UNICEF restent élevées. En outre, l'UNICEF n'a que peu progressé sur la question de la « deuxième décennie de l'enfance » et le risque d'infection par le VIH demeure élevé chez les jeunes filles et les jeunes femmes âgées de 15 à 24 ans. Par ailleurs, l'organisation ne s'est pas révélée très active dans le cadre de la promotion du 2e volet de son programme de PTME et notamment de services de santé sexuelle et procréative en faveur des jeunes femmes vivant avec le VIH. De fait, les taux d'exposition des enfants au VIH demeurent extrêmement élevés et le risque de reprise épidémique chez les enfants reste présent.

RECOMMANDATIONS

Les huit recommandations suivantes formulées à l'issue de l'évaluation ont pour objectif de contribuer à l'élaboration du plan stratégique 2018-2021 de l'UNICEF. Elles ont également pour vocation de préciser les efforts à déployer immédiatement pour guider le travail de l'organisation sur le VIH/sida dans un environnement en mutation rapide. Ainsi, il convient que l'UNICEF :

1. intensifie ses activités de plaidoyer afin que la prévention, la prise en charge et le traitement du VIH chez les enfants reste au cœur des grandes priorités mondiales ;
2. définisse clairement son rôle et sa contribution dans la riposte au VIH pour l'après-2015 en se fondant sur ses avantages comparatifs ;
3. veille à adapter soigneusement son programme relatif au VIH aux besoins de chaque pays en s'appuyant sur son mode de fonctionnement décentralisé et sur sa volonté de jouer un rôle décisif au niveau de chaque pays ;
4. joue le rôle de chef de file pour l'intégration de la problématique du VIH en démontrant la manière dont cette dernière peut être effectivement reliée aux actions menées dans le cadre d'autres programmes et secteurs clés ;
5. développe des approches stratégiques afin que la question du VIH demeure un domaine prioritaire visible au sein de l'organisation au travers de différentes structures organisationnelles ;
6. envisage de placer la dimension de l'équité au cœur de son processus d'expansion des programmes tout en renforçant ses approches programmatiques de sorte à mieux prendre en compte les dimensions d'égalité des sexes et des droits de l'homme ;
7. positionne clairement son travail au sein de ses partenariats existants qu'il pourrait convenir de renégocier ou de renforcer le cas échéant ;
8. s'emploie à garantir que les fonds nécessaires à ses actions de lutte contre le VIH sont mobilisés.

RESUMEN

PANORAMA GENERAL DE LA EVALUACIÓN

UNICEF encargó una evaluación institucional de su programa de prevención de la transmisión del VIH de la madre al niño y la atención pediátrica del VIH, con el objeto de conocer su contribución durante el período 2005-2015. La evaluación se centró en los siguientes objetivos:

1. Ayudar a mejorar la rendición de cuentas de la organización por su desempeño, definiendo y documentando logros clave, así como oportunidades perdidas respecto de la colaboración de UNICEF con los asociados y los países entre 2005 y 2015.

2. Generar aprendizaje y una base empírica para comprender mejor cómo han evolucionado las estrategias y los programas de UNICEF; saber qué medidas han sido eficaces, cuáles no lo han sido y por qué; y formular recomendaciones para las futuras actividades de UNICEF en materia de prevención de la transmisión del VIH de la madre al niño y la atención pediátrica del VIH.

La evaluación se centró en cuatro esferas temáticas: 1) liderazgo, promoción, coordinación y asociaciones; 2) movilización de recursos; 3) información estratégica, generación y difusión de conocimientos; y 4) aspectos esenciales de la organización de UNICEF. Así mismo, tuvo en cuenta tres cuestiones intersectoriales –igualdad de género, derechos humanos y equidad– y examinó cómo han influido en las situaciones de carácter humanitario las actividades de prevención de la transmisión del VIH de las madres a sus hijos y la atención pediátrica del VIH.

DISEÑO DE LA EVALUACIÓN

La evaluación se enmarca en una teoría del cambio que constituyó la base para la formulación de las principales preguntas de evaluación. Esta se centró en la contribución de UNICEF a las respuestas de los programas y no buscó abordar cuestiones referentes a los resultados o los impactos.

El enfoque de la evaluación se basó en un análisis ex post de la actuación profesional en función de la teoría del cambio, utilizando datos de fuentes primarias (mediante entrevistas a informantes clave, debates en grupo, una encuesta en línea y estudios monográficos de siete países) y el complemento de un análisis de datos secundarios (basado en una revisión de documentos importantes y fuentes de datos). Cuatro de los estudios monográficos incluyeron visitas a los países (se realizaron estudios monográficos en profundidad en Camerún, la India, Sudáfrica y Zimbabwe) y tres se efectuaron a distancia (estudios monográficos sencillos en Camboya, Haití y Ucrania).[1]

En este informe de evaluación se presentan observaciones detalladas por cada esfera temática, al igual que conclusiones generales y recomendaciones estratégicas.

OBSERVACIONES FUNDAMENTALES

Liderazgo, promoción, coordinación y asociaciones

UNICEF ha abogado firmemente por la ampliación de los servicios de prevención y tratamiento pediátrico del VIH. Este organismo ha forjado sólidas alianzas estratégicas con diversos asociados y ha proporcionado un valioso apoyo a la expansión de los programas en los países.

UNICEF y sus asociados tomaron medidas rápidas y decisivas tanto para lograr la movilización de las partes interesadas de los países en torno a las metas del *Plan Mundial para Eliminar las Nuevas Infecciones por VIH en Niños para 2015 y para Mantener con Vida a sus Madres* (en adelante denominado “Plan Mundial”), como para transformar los compromisos nacionales en acciones.

En la mayoría de los países que realizaron estudios monográficos, UNICEF actuó como organismo coordinador de los asuntos referentes al VIH y la

[1] Los estudios monográficos sencillos implicaron análisis de documentos específicos, complementados con entrevistas efectuadas a distancia (por Skype o por teléfono) con 8-10 interesados de los gobiernos, asociados y UNICEF.

infancia. UNICEF mereció especial reconocimiento por su respaldo a la planificación descentralizada, la aplicación y el fomento de la capacidad a todos los niveles, y sus innovaciones programáticas.

UNICEF se ha esforzado para integrar los servicios relativos al VIH en la plataforma de salud de la madre, el recién nacido y el niño, de conformidad con los principios del "doble dividendo". Sin embargo, los enfoques verticales hacia los programas nacionales sobre el VIH han tendido a desalentar el trabajo de UNICEF dirigido a reforzar los vínculos entre la salud y el VIH a nivel de planificación, gestión, programas y sectores. También es preciso trabajar con más ahínco para fortalecer los sistemas comunitarios.

Movilización de recursos

UNICEF ha tenido que hacer frente a dificultades para recaudar fondos destinados a sus actividades sobre el VIH/SIDA. A pesar de los incrementos en la financiación mundial para combatir el VIH/SIDA y en los ingresos totales de UNICEF, sus recursos para abordar este flagelo han disminuido desde 2008. El gasto de UNICEF en programas sobre el VIH/SIDA también se ha reducido a través del tiempo. En efecto, de un máximo de 188 millones de dólares entre 2008 y 2010 se pasó a 107 millones de dólares en 2014 y 2015, es decir, apenas un 2% del total de gastos de los programas de UNICEF en 2015 (en comparación con un 8% en 2005). Una alta proporción de los recursos disponibles de UNICEF se destinan estrictamente a fines concretos, lo que eleva los costos de las transacciones y limita la capacidad para programar los recursos de manera flexible.

UNICEF ha desempeñado una valiosa función al apoyar el acceso de los países a recursos externos, especialmente del Fondo Mundial de Lucha contra el SIDA, la Tuberculosis y el Paludismo (el Fondo Mundial), pero hay pocas pruebas de que esté movilizando recursos a nivel mundial. En algunos países ha habido carencias significativas de recursos para poder cumplir metas de alto nivel.

Información estratégica, generación y difusión de conocimientos

UNICEF ha colaborado con sus asociados en la generación, el análisis y la difusión de información estratégica sobre la epidemia del VIH entre los niños, tanto en el plano nacional como mundial. Aun cuando UNICEF es reconocido por sus esfuerzos para generar datos desglosados por edad y género, su trabajo sobre información estratégica no ha tenido mucha resonancia.

UNICEF ha abogado por los enfoques basados en datos para mejorar los resultados de los programas, y ha aplicado, de forma experimental, enfoques innovadores de gestión de datos para una prestación más efectiva de los servicios. Así mismo, ha sido de gran ayuda para lograr que las autoridades nacionales gestionen sin demora cambios normativos que se traduzcan en regímenes más sencillos y efectivos para la prevención de la transmisión del VIH de madres a hijos. Es de destacar el impulso de UNICEF a la Opción B+, que ha facilitado la ampliación de los programas desde 2011.

Aspectos esenciales de la organización de UNICEF

UNICEF ha aplicado diversos enfoques para abordar su prioridad institucional en materia de VIH/SIDA a distintos niveles de la organización. Algunos documentos que revisten prioridad estratégica regional y muchos documentos de los programas para los países identifican el VIH/SIDA como la principal prioridad, mientras que otros lo incorporan en prioridades diferentes. Esto se refleja en la forma en que las oficinas de UNICEF han adaptado su respuesta. Las partes interesadas valoran esta flexibilidad y receptividad a las necesidades y prioridades de los países, dada la diversidad de los entornos y la rapidez con que ha avanzado la respuesta al VIH pediátrico en los últimos años.

UNICEF luchó para adaptarse a la disminución gradual de los recursos financieros y humanos para llevar a cabo su labor sobre el VIH/SIDA. Aunque algunas oficinas en los países tienen actualmente poco o ningún personal dedicado al VIH, existen pocos ejemplos de responsabilidad compartida entre programas sobre el VIH. En algunos casos, la capacidad de UNICEF para satisfacer las exigencias de resultados sobre el VIH/SIDA se ha visto sobrecargada.

Cuestiones intersectoriales

A UNICEF se le reconoce de manera general –aunque no de forma universal– el hecho de haber integrado en sus actividades las dimensiones de género, equidad y derechos humanos. No obstante, es necesario que continúe centrándose en estas esferas, y que siga impulsando y dando a conocer sus programas.

En cuanto a la dimensión de género, la atención especial que UNICEF presta a la mujer y a la infancia es altamente apreciada, pero son escasas las pruebas de que haya trabajado para integrar cuestiones más generales en materia de género en sus iniciativas de prevención de la transmisión maternoinfantil del VIH y en la atención y tratamiento de los casos pediátricos de VIH.

Con respecto a la equidad, el apoyo de UNICEF a los análisis de los obstáculos ha representado una gran contribución para ampliar el alcance de los programas con miras al acceso universal, a pesar de que existen menos evidencias de que estos instrumentos se estén utilizando específicamente para llegar a las poblaciones vulnerables, marginadas y con las que es difícil entrar en contacto.

El claro mandato que tiene UNICEF frente a los derechos humanos orienta su labor sobre el VIH y el SIDA, pero no siempre se aprecia desde el exterior.

UNICEF ha promovido y apoyado la inclusión, en diversas situaciones de emergencia, de servicios de prevención de la transmisión maternoinfantil del VIH y de atención de los casos de VIH pediátrico.

CONCLUSIONES

Desde 2005 se han registrado notables progresos en la prevención de la infección por el VIH entre los niños y en el número de madres y mujeres gestantes que reciben tratamiento. Sin embargo, la ampliación de los programas de tratamiento pediátrico del VIH sigue atrasada. Tras la puesta en marcha del Plan Mundial en 2011, los últimos cinco años han sido los más productivos de UNICEF desde el punto de vista de la expansión y el mejoramiento de los programas para prevenir nuevos casos de infección pediátrica por el VIH.

En colaboración con sus asociados, UNICEF ha desempeñado un papel crucial en la expansión de los programas de prevención, atención y tratamiento pediátrico del VIH, por medio de su defensa de los niños afectados; su capacidad de convocatoria a nivel mundial, regional y nacional; y su decisivo apoyo financiero y técnico a los asociados en los países en una gran diversidad de ámbitos –por ejemplo, formulación de políticas, planificación de programas y respaldo a actividades generadoras de conocimiento.

El VIH/SIDA ha sido una prioridad institucional a lo largo del proceso de evaluación. No obstante, las intervenciones se han puesto en práctica de distintas maneras y a diferentes niveles, teniendo en cuenta la importancia de adaptar los métodos a cada contexto particular. Los interesados valoran altamente esta flexibilidad y capacidad de respuesta a las necesidades y prioridades de los países.

Desde 2005, la rápida y considerable disminución de los recursos de UNICEF para el VIH/SIDA ha ejercido presión sobre su labor de prevención de la transmisión de madre a hijo y la atención pediátrica del VIH. Si bien UNICEF ha procurado adaptarse a la disminución gradual de recursos y de personal, su capacidad para obtener resultados se ha visto seriamente afectada en numerosos contextos, y la proyección pública de su labor sobre el VIH y el SIDA ha sido limitada.

UNICEF es considerado ampliamente como el organismo que puede "hacer conexiones" y facilitar la integración de los programas a todos los niveles. Pero esta integración no se ha logrado plenamente en todas partes, e incluso hay menos evidencias de vínculos intersectoriales, con algunas notables excepciones. Entre los desafíos figuran las estructuras verticales de los programas sobre el VIH/SIDA en los países, así como también las propias estructuras y operaciones internas de UNICEF, que tienden a compartimentar el trabajo en torno al VIH.

Los avances para prevenir nuevos casos de infección por el VIH entre los niños han sido desiguales entre los países y dentro de ellos, y se siguen viendo afectados por cuestiones de género, derechos humanos y desigualdad en los determinantes sociales más generales de la salud. Aun cuando UNICEF tiene la capacidad para comunicar e impulsar la agenda en torno a estos temas, actualmente no está sacando el mejor partido de su posición.

Pese a que se han realizado grandes progresos, la labor no está completa. Numerosos países todavía encaran enormes retos para cumplir las metas, y las exigencias sobre UNICEF siguen siendo altas. Además, el trabajo de este organismo en lo que respecta a la segunda década de la vida apenas ha mostrado avances, y el riesgo de infección por el VIH entre las niñas adolescentes y las mujeres jóvenes de 15 a 24 años sigue siendo elevado. Además, en el marco de la prevención de la transmisión del VIH de la madre al niño, UNICEF no ha promovido activamente el aspecto de los servicios de salud sexual y reproductiva para las mujeres que viven con el VIH. El resultado es que la exposición de los niños y las niñas al VIH sigue siendo sumamente alto, con un verdadero riesgo de que la epidemia resurja entre ellos.

RECOMENDACIONES

Las ocho recomendaciones de la evaluación tienen por objeto contribuir a la formulación del Plan Estratégico de UNICEF 2018-2021. También deberán servir de base a los esfuerzos que se requieren de inmediato para orientar el trabajo de UNICEF sobre el VIH y el SIDA en un entorno rápidamente cambiante.

1. Ampliar la labor de promoción de UNICEF a fin de que la prevención, atención y tratamiento del VIH pediátrico ocupen un lugar destacado en la agenda mundial.

2. Definir claramente la función de UNICEF y su contribución a la respuesta al VIH después de 2015, aprovechando sus ventajas comparativas.

3. Adaptar cuidadosamente los programas contra el VIH a las necesidades de los países, aprovechando la descentralización de las operaciones de UNICEF y su interés en marcar una diferencia a nivel nacional.

4. Asumir un papel directivo en el programa de integración, demostrando cómo puede vincularse efectivamente el VIH con otros programas y sectores clave.

5. Formular enfoques estratégicos para dar visibilidad al VIH como prioridad institucional fundamental de UNICEF, en diversas estructuras orgánicas.

6. Examinar la posibilidad de convertir la equidad en el centro de la expansión continua de los programas, reforzando al mismo tiempo los enfoques programáticos de UNICEF, a fin de abordar más explícitamente las dimensiones de género y de derechos humanos.

7. Ubicar la labor de UNICEF en los marcos de asociación existentes, que pueden renegociarse o fortalecerse, según se requiera.

8. Invertir en iniciativas tendientes a garantizar la movilización de los recursos necesarios para la respuesta de UNICEF al VIH.

1 INTRODUCTION

Since 2005, UNICEF has taken a leading role in helping low- and middle-income countries (LMICs) scale up programmes to prevent new HIV infections among children, provide HIV care and treatment to children and their families living with HIV, prevent and treat new infections among adolescents, provide protection, care and support to families affected by HIV and extend HIV services to affected children and their families during emergencies.

Eliminating HIV transmission from mother to child and providing care and treatment to those already infected remain global priorities on the post-2015 agenda and are central to the commitment to end AIDS by 2030. This objective will be reached through Sustainable Development Goal (SDG) 3, Target 3.3, which focuses on ensuring healthy lives and promoting well-being for all at all ages. Towards this end, UNICEF and its partners will contribute to the UNAIDS Strategy (2016–2021) to Fast-Track the AIDS response to end AIDS by 2030, which was endorsed by Member States at the June 2016 High-Level Meeting on HIV/AIDS,[2] as well as A Promise Renewed, the child survival call to action to end preventable child and maternal deaths.

UNICEF has commissioned a corporate evaluation of its PMTCT/paediatric HIV care and treatment programme to reflect on its contribution over the period 2005–2015 and inform its positioning going forward. This report presents the findings of that evaluation. The evaluation is presented in seven parts. Following this Introduction, Section 2 provides the evaluation objectives and scope; Section 3 articulates the evaluation methodology; Section 4 provides a brief overview of the strategic context of PMTCT and paediatric HIV care and treatment during the study period; Section 5 presents the evaluation key findings; and Sections 6 and 7 detail overall conclusions and recommendations for UNICEF.

[2] Resolution adopted by the United Nations General Assembly, 'Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030', A/RES/70/266, 8 June 2016.

OBJECTIVES AND SCOPE OF THE EVALUATION

2.1 PURPOSE OF THE EVALUATION

The purpose of the evaluation is to support accountability and learning in relation to UNICEF's efforts to support the scale up of PMTCT and paediatric HIV care and treatment programmes. As indicated in the terms of reference, the findings and recommendations will be used to guide UNICEF's implementation strategies (sectoral and cross-cutting) to achieve the HIV outcomes specified in the Strategic Plan 2014–2017; to inform UNICEF's future work within the 2030 Agenda for Sustainable Development, as guided by the UNAIDS Strategy 2016–2021; and to inform UNICEF's thinking with respect to the positioning of HIV/AIDS in its new Strategic Plan 2018–2021 (focusing on the first decade of life) and the management of the UNICEF HIV portfolio going forward.

2.2 OBJECTIVES

This evaluation has two key objectives:

1. **To contribute to improving the organization's accountability** for its performance by defining and documenting key achievements as well as missed opportunities in UNICEF's engagement with partners and countries in support of improved PMTCT and paediatric HIV care and treatment outcomes between 2005 and 2015;
2. **To generate evidence and learning** to enhance the understanding of the organization and other stakeholders on how UNICEF's strategies and programmes related to PMTCT and paediatric HIV care and treatment have evolved, what has worked, what has not worked and why and to make recommendations for UNICEF's future engagement in PMTCT and paediatric HIV care and treatment.

2.3 SCOPE

The evaluation was tasked with examining four aspects of UNICEF's PMTCT and paediatric HIV care and treatment programming efforts over the period 2005–2015:

1. **Leadership, advocacy, coordination and partnerships:** the ability to foster or to be effective within partnerships by leveraging corporate knowledge and assets to become a trusted advisor for donors, national governments and other global and national stakeholders; and the ability to influence global, regional and national PMTCT and paediatric HIV care and treatment agendas over time.
2. **Resource mobilization:** the ability to generate the required funds for PMTCT programmes and projects that UNICEF supports across levels; the ability to leverage major funders' resources to achieve UNICEF's strategic priorities; the ability to function as an effective support to governments attempting to access funds for PMTCT and paediatric HIV care and treatment; and the ability to foster an adequate global resource base for these programme areas.
3. **Strategic information, knowledge generation and dissemination:** the contribution to global and national policies and strategies through evidence generated by UNICEF- and partner-supported research and programming, as well as through UNICEF's global data, estimation and progress reporting; and the translation of global policies and evidence into national plans, operational guidance and tools.
4. **Key aspects of UNICEF's organization:** the ability to establish an effective presence at the global, regional and country levels; the proper employment of UNICEF's comparative advantages; the ability of the organization to adapt based on new scientific and operational information; and the extent to which UNICEF's structures in relation to HIV have been fit for purpose over time.

The evaluation was also directed to address three **cross-cutting issues** – gender, human/child rights and equity – and to examine how the response to PMTCT and paediatric HIV has played out in humanitarian situations.

EVALUATION APPROACH AND METHODOLOGY

3.1 EVALUATION APPROACH AND QUESTIONS

This evaluation is theory-based, which means it is centred on the use of a theory of change to explain and document assumptions made along the way and the processes and causal pathways by which the programme is expected to have led to its intended results. The theory of change for this evaluation (presented in Figure 1) formed the basis for the development of key evaluation questions (KEQs), which built on those presented in the terms of reference (*see Table 1*). Figure 1 depicts the theory of change.

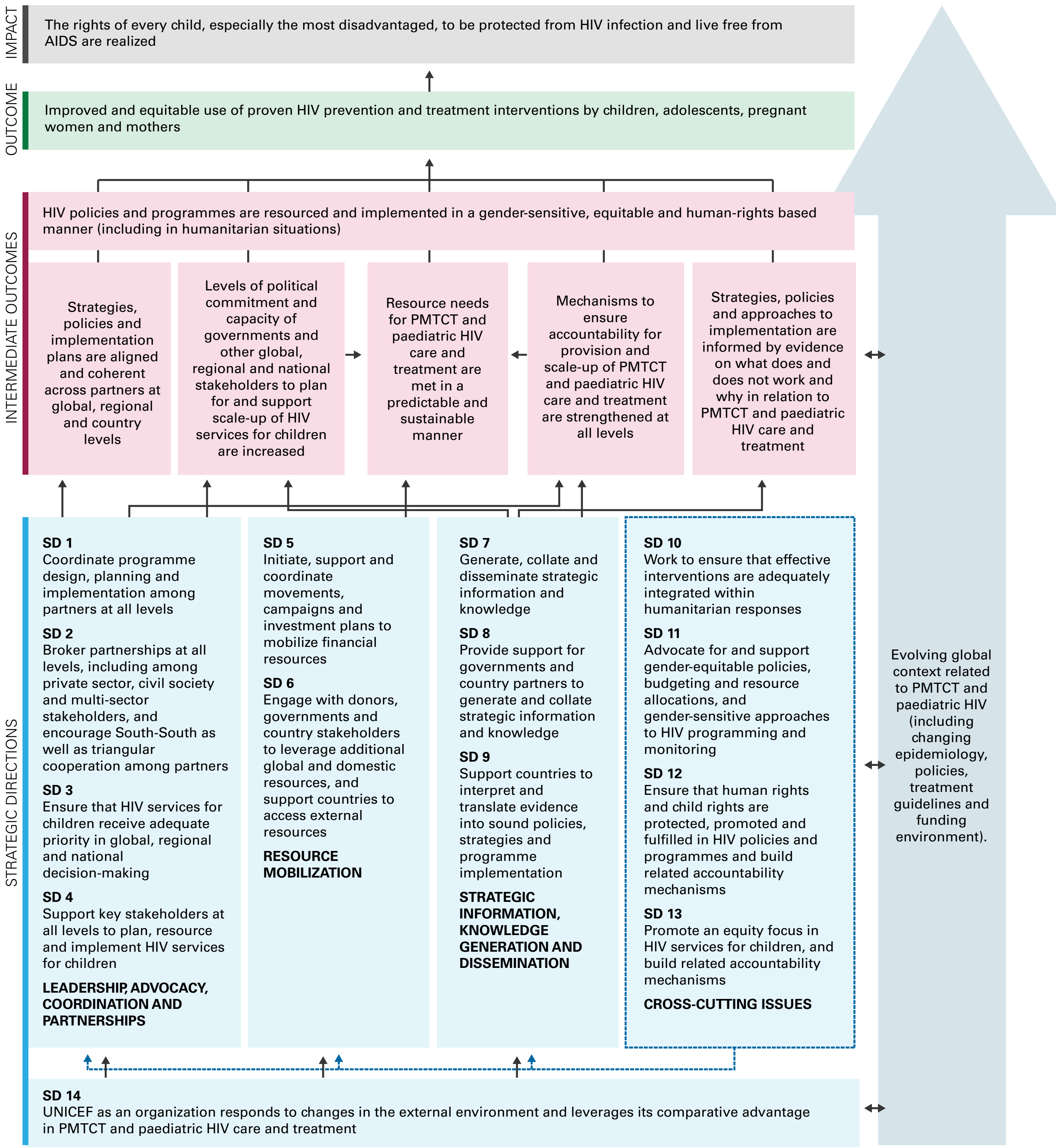
The evaluation team then defined an evaluation framework that has acted as the guiding framework for the evaluation, detailing the various data collection and analytical approaches to be deployed. The full evaluation framework is included in Annex B to this report and includes signposting to the section of the report in which the evaluation question is primarily addressed.

TABLE 1: KEY EVALUATION QUESTIONS

Coordination, partnerships, leadership and advocacy	
KEQ1	How have UNICEF's leadership, convening and coordination roles evolved since 2005 vis-à-vis that of other partners?
KEQ2	To what extent did UNICEF's leadership, convening and coordination efforts lead to improved alignment and coherence of strategies, policies and implementation plans for addressing HIV in children?
KEQ3	To what extent did UNICEF's efforts to broker partnerships contribute to building a strong base for programme scale-up towards targets?
KEQ4	To what extent were UNICEF's efforts to promote South–South and triangular cooperation among partners helpful for ensuring alignment and coherence and securing commitments?
KEQ5	What trade-offs were made to ensure that partnership arrangements worked as intended, and what risks were involved?
KEQ6	To what extent did UNICEF's advocacy efforts lead to increased prioritization of and commitments to HIV services for children?
KEQ7	How has the focus on achieving HIV goals been balanced with the drawbacks of vertical programming?
KEQ8	To what extent has UNICEF contributed to the building of national health and community systems that serve women and children?
KEQ9	To what extent was UNICEF successful in enabling key stakeholders, including civil society stakeholders and people living with HIV, to build coalitions in support of HIV services for children, strengthen programme planning and implementation and reinforce accountability mechanisms at all levels?
Resource mobilization	
KEQ10	To what extent has UNICEF been effective in securing sufficient financial resources for planned activities in support of HIV in children (internally)?
KEQ11	To what extent has UNICEF been able to mobilize resources in a timely and efficient manner?

KEQ12	What has been UNICEF's role and contribution to: 1) mobilizing financial resources globally; 2) increasing domestic spending on PMTCT and paediatric HIV care and treatment; and 3) supporting countries to access external resources?
KEQ13	To what extent has UNICEF supported countries to establish a sustainable PMTCT and paediatric HIV/AIDS programme?
Strategic information, knowledge generation and dissemination	
KEQ14	To what extent has UNICEF – directly and through partners – contributed to the generation, collation and dissemination of strategic information and other forms of knowledge on HIV and children at national and global levels?
KEQ15	To what extent has UNICEF strengthened country level ability to generate and collate data for accountability and learning around HIV and children?
KEQ16	To what extent has UNICEF strengthened global and country level ability to use strategic information and research findings to inform policies and strategies for scaling up proven effective approaches to address HIV among children?
Cross-cutting issues	
KEQ17	To what extent has UNICEF been able to promote the inclusion of HIV services for women and children in humanitarian settings?
KEQ18	How has the focus on HIV services been balanced with other priorities in humanitarian settings?
KEQ19	To what extent has UNICEF been able to support gender-sensitive HIV programming?
KEQ20	To what extent has UNICEF promoted human rights-based programming and accountability setting in relation to children and HIV?
KEQ21	To what extent has UNICEF's increasing focus on equity shaped its response to children and HIV?
KEQ22	To what degree has this equity focus contributed to programme scale-up?
UNICEF's organizational structure	
KEQ23	To what extent has UNICEF leveraged its comparative advantage based on mandate, structure and resources to achieve sustainable country-led PMTCT and paediatric HIV care and treatment programmes?
KEQ24	To what extent are there synergies, gaps, overlaps and/or missed opportunities in programming that arise from UNICEF's organizational structure?
KEQ25	To what extent has UNICEF been able to adapt internally (at country, regional and global levels) to respond to key shifts in PMTCT/paediatric AIDS?
KEQ26	To what extent has UNICEF developed its capacity to deliver on its leadership, strategic information and resource mobilization roles?

Figure 1: Theory of change



3.2 PHASES OF THE EVALUATION

The evaluation was conducted in three phases:

1. **Inception phase (January–February 2016):** The team conducted a scoping review of available documentation, developed a draft theory of change for UNICEF's work during 2005–2015 and undertook a visit to UNICEF Headquarters (HQ) to carry out interviews with key stakeholders, refine, and validate the theory of change in consultation with UNICEF staff in a workshop.

2. **Data collection and analysis phase (March–June 2016):** This phase involved an examination of UNICEF's work at the national level through four in-depth country studies and three remote light touch country studies; interviews with stakeholders at the global and regional levels; an online survey; an extensive document review; and a team workshop to review the evidence and discuss preliminary findings.

3. **Final report preparation and validation (July–October 2016):** This phase focused on the synthesis of findings, drawing together evidence from multiple data sources into a draft report for UNICEF review and feedback. This report represents the final version of the evaluation report, following revisions in response to feedback from UNICEF.

3.3 EVALUATION METHODS

3.3.1 Data collection methods

STRUCTURED DOCUMENT REVIEW

An extensive document review drawing on a range of documents from UNICEF and other sources was undertaken as part of this evaluation. Sources included global- and regional-level documentation such as UNICEF's strategic planning documents and progress reports; the results of an internal survey conducted among UNICEF HIV staff at the country office level; policy, guidance and advocacy documents; financial data; strategic information and knowledge products; and UNICEF staffing and reporting information. In the case study countries, the evaluation team also collected and reviewed national strategies, plans and reports; financial data regarding programme budgets and expenditures and funding allocations from domestic and international sources; national programme reviews and evaluations; strategic information and knowledge products; and other relevant publicly available documentation.

KEY INFORMANT INTERVIEWS/GROUP DISCUSSIONS

The evaluation team conducted interviews and group discussions with a total of 243 people at global, regional and national levels (*see Annex G*). Interviewees included staff from UNICEF HQ; regional offices and country offices; the World Health Organization (WHO); the United Nations Population Fund (UNFPA); UNAIDS; and other international and national non-governmental organizations (NGOs). Interviewees were identified through a process of consultation with UNICEF and supplemented with the team's collective knowledge of the HIV/AIDS sector. The aim was to achieve a balance of perspectives between UNICEF, partners and governments.

IN-DEPTH COUNTRY CASE STUDIES

Field visits were conducted in four countries (Cameroon, India, South Africa and Zimbabwe) to develop case studies for the evaluation. The purpose of these case studies was to record how UNICEF has delivered its programme on HIV in children at the country level to contextualize the analysis of the theory of change. The four countries were selected from the 22 high-burden countries prioritized in the Global Plan.[3] Selection criteria are presented in Annex C.

LIGHT TOUCH COUNTRY CASE STUDIES

The evaluation team also conducted three remote light touch case studies in Cambodia, Haiti and Ukraine. The purpose of the light touch studies was to develop a better understanding of how UNICEF's response to HIV in children has been operationalized at the country level in lower prevalence countries that were not identified for priority action within the Global Plan but are still important to UNICEF's

[3] Joint United Nations Programme on HIV/AIDS, *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive: 2011-2015*, UNAIDS, Geneva, 2011.

global mandate (*see Annex C*). The light touch case studies entailed a focused document review complemented by interviews conducted remotely (by Skype or telephone) with 8 to 10 stakeholders from governments, civil society partners and UNICEF staff.

ONLINE SURVEY

An online survey (*see Annex I*) was conducted to incorporate the views of a wide range of respondents at the country level. It consisted of both closed and open-ended questions and was tailored to whether the respondent was UNICEF staff or external to UNICEF. The survey was disseminated to governments, development partners and other organizations working in PMTCT/paediatric HIV care and treatment at the country level via the UNICEF country office focal points. This approach was proposed by the UNICEF Evaluation Office as a pragmatic way of accessing stakeholders in the absence of consolidated contact lists.

TABLE 2: OVERVIEW OF KEY INFORMANT INTERVIEWS

	Number of interviewees
Global level	
UNICEF	24
Partner	23
Regional level	
UNICEF	20
Partner	5
Country level	
UNICEF	62
Partner	61
Government	48
Total	**243**

3.3.2 Data analysis methods

ANALYSIS OF DOCUMENTS

An extensive review was conducted of the available documentation to inform the various components of the analysis. Evidence was extracted per thematic area and fed into the analysis at both the country level (as part of the case studies) and the global level (during the generation of overall findings).

ANALYSES OF INTERVIEW AND GROUP DISCUSSIONS

The interviews undertaken for this evaluation were coded thematically, based on a coding structure linked to the evaluation questions. This ensured that findings from interviews could be directly linked to relevant KEQs and that themes could be drawn out to generate a robust synthesis of views.

ANALYSIS OF SURVEY DATA

The analysis of the qualitative data collected through the online survey was undertaken through a process of examining themes within the data, similar to the coding process described above. Quantitative data was analysed through the creation of summary statistics, with data disaggregated by respondent type (for example, UNICEF, government, partner) and by region.

RECORDING AND ANALYSIS OF TIMELINES

Timelines were constructed as a way of describing the evolution of the programme since 2005 and exploring ways in which UNICEF has responded to and influenced the evolving context in terms of changes in priorities, strategies, resources, policies and organizational structures. Detailed timelines were constructed to capture significant events and decision points in the case study countries (included in the case study reports) and globally, and were used as a lens through which to analyse data to identify the ways in which UNICEF has contributed to, or responded to, the main changes.

TREND ANALYSIS

A trend analysis was undertaken of quantitative data such as financial resources both for UNICEF and for the relevant programme areas. The methodology for this analysis is detailed in Annex F and included analysis of the global HIV financing landscape, HIV financing in the four case study countries, UNICEF income for HIV/AIDS and expenditure on HIV/AIDS and PMTCT and paediatric care and treatment over the evaluation time period.

CROSS-CASE STUDY ANALYSIS

The country case study reports were structured to allow for robust analysis and synthesis across the seven countries. For each thematic area of the evaluation, including the cross-cutting issues, a cross-case study analysis was undertaken to highlight common themes and issues and identify contrasts and similarities to explore the relationships of UNICEF's response with key contextual factors.[4]

3.3.3 Synthesis and reporting

The last phase of the evaluation focused on synthesizing the evidence from across the data sources and components of analysis and developing key findings and conclusions that respond to the KEQs. The team conducted a two-day workshop at the Itad offices to discuss the emerging findings and refine the conclusions, examining the evidence to assess whether the theory operated as assumed and contributed to the desired intermediate outcomes.

3.4 EVALUATION GOVERNANCE

The UNICEF Evaluation Office, working closely with the UNICEF Programme Division-HIV/AIDS Section, was responsible for the management of the evaluation, monitoring the quality and independence of the evaluation, ensuring the findings and conclusions were relevant and recommendations were implementable and supported dissemination. The evaluation was also overseen by an Evaluation Reference Group within UNICEF,[5] with the following roles:

- Contributing to the conceptualization, preparation and design of the evaluation, informing the selection of case study countries and reviewing the theory of change;
- Assisting in the identification of UNICEF staff and external stakeholders to be consulted during the evaluation process;
- Reviewing and commenting on the draft inception and evaluation reports (including feedback on bolstering the recommendations).

Input was also sought from other UNICEF staff members at various points during the evaluation process, including on the theory of change, country case study reports and the draft evaluation report.

3.5 EVALUATION LIMITATIONS

The evaluation methodology was subject to some limitations (described in bullets below), most of which were identified during the inception phase and addressed through mitigating measures. As such, the evaluators are confident that they have not significantly undermined the evaluation's findings.

- Much of the evidence to support the evaluation findings is qualitative, generated through stakeholder interviews. Given that the evaluation is looking back over a 10-year period, there is a risk of recall bias. The team took several steps to mitigate this, most notably ensuring that the sample of interviewees covered different stakeholder groups and included people who were active at different points during 2005–2015.
- As per the terms of reference, the four in-depth case studies were undertaken in countries prioritized by the Global Plan. At an early stage, it was recognized that not including a sample of non-Global Plan priority countries in the evaluation would present a serious limitation. The decision was therefore taken to do three further light touch studies. Although this mitigated the evidence gap to a certain extent, it was not possible to examine these countries in as much depth given that the evaluation team did not visit the country and undertook less intensive data collection.

---

[4] Of note is that the country case studies used the INK management model as a way of framing findings around the organizational structure the KEQs. However, the model has not been deployed in this way during the final analysis phase. In analysing the evidence and drawing out findings, the evaluation team found that they did not fit 'naturally' within the model, and therefore took the decision to deploy a 'bottom up' approach to generating findings, driven by the themes from the data.

[5] This included representatives of the UNICEF Programme Division-HIV/AIDS Section, the UNICEF Division of Data, Research and Policy-Data and Analytics Section, UNICEF regional offices, and the UNICEF Evaluation Office.

- Given that, at the country level, the online survey was disseminated by the HIV focal points to partners known to them, and that respondents are self-selected, there was a risk of selection bias.[6] The evaluation team and the UNICEF Evaluation Office recognized this and in response, survey data was used for triangulation of evidence only.
- In relation to the resource mobilization component, the evaluation team identified limitations regarding the financial data that was available to inform the analysis of UNICEF's income and expenditure on PMTCT and paediatric HIV care and treatment – most notably the change in accounting policy from United Nations System Accounting Standards (UNSAS) to the International Public Sector Accounting Standards (IPSAS). This is discussed in more detail in Annex F.
- Given the geographic focus and the background of many of the respondents interviewed, the evaluation found limited evidence on UNICEF's response to PMTCT and paediatric HIV in humanitarian situations compared with the other themes being explored.
- As requested in the terms of reference, the evaluation focused on assessing UNICEF's contributions to programme responses. It did not seek to assess how these responses led to outcomes and impact in relation to coverage levels and new HIV infections and survival rates in children. The evaluation was not tasked with evaluating other relevant areas of UNICEF's work (such as procurement and supply activities). Therefore, this evaluation should not be considered a fully comprehensive evaluation of UNICEF's contribution to the field of PMTCT and paediatric HIV care and treatment.

[6] Country office HIV focal points were encouraged to share the survey with 5-10 individuals responsible for or engaged in PMTCT and paediatric AIDS programming who are *most familiar* with UNICEF's support in the area. Suggested respondents included: United Nations agencies, development partners and donors who are engaged/knowledgeable of PMTCT and paediatric AIDS programmes in the country (e.g. WHO, UNAIDS, NGOs, donors, academics) as well as organizations that are recipients of UNICEF programme cooperation agreements.

OVERVIEW OF THE STRATEGIC CONTEXT DURING 2005–2015

In 2005, programmes for HIV prevention, care and treatment among children were only starting up in most LMICs. Coverage levels were still very low: In 2005, only 9 per cent of pregnant women living with HIV received antiretroviral (ARV) medications for PMTCT,[7] resulting in more than 600,000 new infections among children. Access to ARV treatment (ART) for people living with HIV remained low, with only 1.3 million people receiving ART and few of them children.[8]

Commitments to address these gaps mounted in the period 2005–2011 (*see Figure 2*). In 2006, the United Nations General Assembly High-Level Meeting on AIDS resulted in commitments to mobilize more resources and expand and accelerate the HIV/AIDS response towards the 2015 targets.[9] The Global Plan issued in 2011 provided global targets for the elimination of mother-to-child transmission of HIV (eMTCT) by 2015 and called for a concerted country-driven effort to guide action towards these targets. The Global Plan covered all LMICs but called for exceptional efforts in the 22 countries with the highest estimated numbers of pregnant women living with HIV.

The subsequent scale-up of ARV-based prevention and treatment programmes among children in LMICs has been impressive. In the 21 Global Plan priority countries in sub-Saharan Africa, coverage of ARV medications among pregnant women living with HIV increased from 36 per cent in 2009 (the baseline year for the Global Plan) to 80 per cent in 2015, and new HIV infections in children fell from 270,000 in 2009 to 110,000 in 2015 – a 60 per cent reduction (compared with a 24 per cent reduction between 2000 and 2008).[10] By 2016, four countries (Armenia, Belarus, Cuba and Thailand) were certified as having reached eMTCT.[11] Global coverage of ART among people of all ages reached 46 per cent (17 million people) at the end of 2015,[12] with Eastern and Southern Africa experiencing the largest gains.[13]

The prevention of HIV in children is a success story of our time, with unprecedented increases in access to services among pregnant women and their exposed children in many countries. The scale-up and improvement of PMTCT services has reduced the annual number of new infections among children globally by 56 per cent from 2010 to 2015 and by 70 per cent from 2000 to 2015.[14] Since 1995, an estimated 1.6 million new HIV infections among children have been averted thanks to the provision of ARV medicines to women living with HIV during pregnancy or breastfeeding (*see Figure 3*).[15] As a combined result of increases in both prevention and treatment interventions, AIDS-related deaths among children under 5 fell by 62 per cent from 2000 to 2015.[16]

[7] Joint United Nations Programme on HIV/AIDS, *Report on the Global AIDS Epidemic*, UNAIDS, 2006.

[8] Ibid.

[9] Resolution adopted by the United Nations General Assembly, 'Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030', A/RES/70/266, 8 June 2016.

[10] Joint United Nations Programme on HIV/AIDS, *On the fast-track to an AIDS-free generation: The incredible journey of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive*, UNAIDS, 2016.

[11] Joint United Nations Programme on HIV/AIDS, *HIV Prevention Update*, UNAIDS, 2016.

[12] Joint United Nations Programme on HIV/AIDS, *Global AIDS Update,* UNAIDS, 2016.

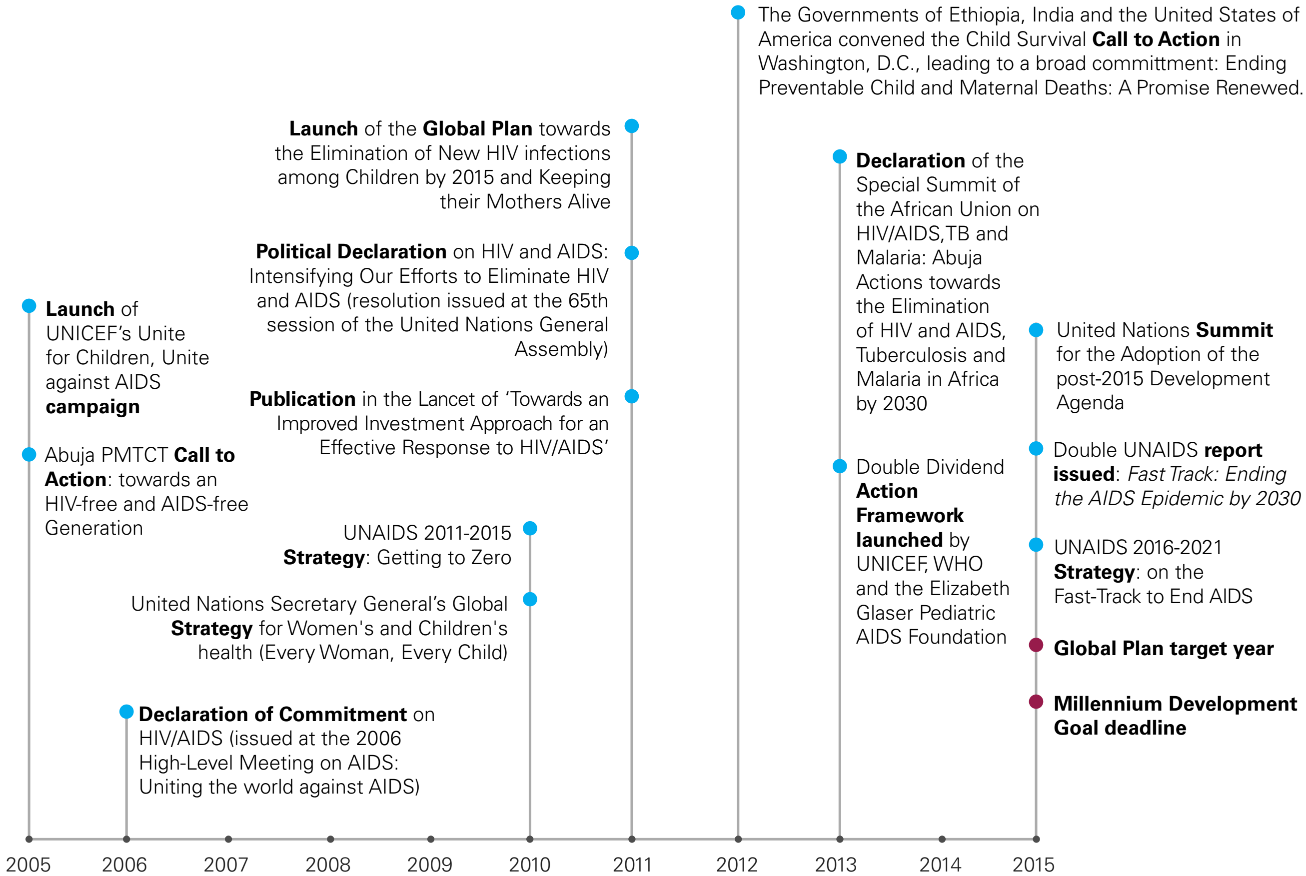
[13] Ibid.

[14] Joint United Nations Programme on HIV/AIDS, *Prevention Gap Report*, UNAIDS, 2016.

[15] Ibid.

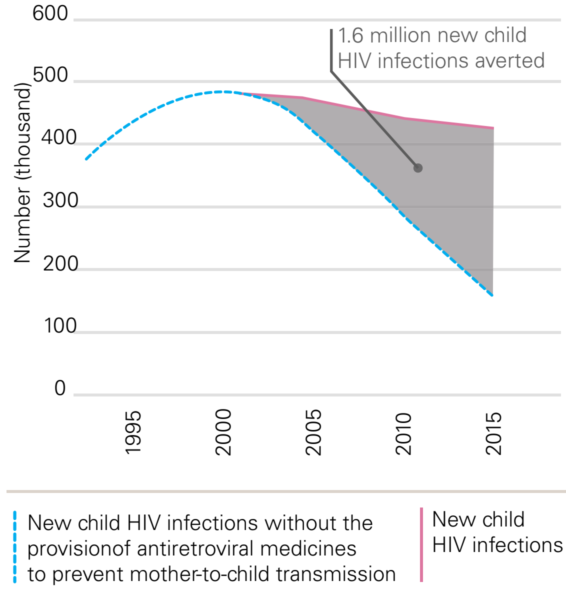
[16] Joint United Nations Programme on HIV/AIDS, *On the fast-track to an AIDS-free generation: The incredible journey of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive*, UNAIDS, 2016.

Figure 2: Timeline of key events 2005–2015



However, progress towards global targets has been uneven and significant challenges remain. Coverage of PMTCT interventions has not increased as planned in all countries, access to treatment for children remains low and the risk of HIV remains unacceptably high among young women of reproductive age. Despite the progress, 110,000 children were still newly infected with HIV in 2015 in the 21 Global Plan priority countries in sub-Saharan Africa (41,000 in Nigeria alone). The treatment gap among children remains large, with only 51 per cent of the 1.4 million children under 15 years living with HIV in the 21 countries accessing ART in 2015.[17] The global burden of infection has, moreover, stayed high, with 36.7 million people of all ages living with HIV.[18] In 2015, the estimated annual number of new HIV infections among adults remained stable at approximately 1.9 million. Between 2010 and 2015, there were 5.2 million new HIV infections among women of reproductive age – a decline of only 2 per cent during that period.[19] Furthermore, many women, including women living with HIV, do not have access to the family planning services they need. Thus, HIV exposure of infants remains high, as does the need for services for HIV prevention and treatment among children.

Figure 3: New HIV infections among children (aged 0–14 years) with and without the provision of ARV medicines for PMTCT, global, 1995–2015[20]



[17] Ibid.

[18] Joint United Nations Programme on HIV/AIDS, *Global AIDS Update*, UNAIDS, 2016.

[19] Joint United Nations Programme on HIV/AIDS, *Prevention Gap Report*, UNAIDS, 2016.

[20] Joint United Nations Programme on HIV/AIDS, *Prevention Gap Report*, UNAIDS, 2016.

5

FINDINGS

5.1 THEMATIC LEADERSHIP, ADVOCACY, COORDINATION AND PARTNERSHIPS

This section responds to KEQs 1–9. It considers how UNICEF has contributed to improved alignment and coherence across partners at all levels and increased levels of political commitment and capacity of governments and other stakeholders to plan for and support scale up of HIV services for children.

KEY MESSAGES:

UNICEF has been a prominent advocate for the scale-up of HIV prevention and treatment services for children, though this has been largely in the programmatic arena and to a lesser extent at the political level. The organization has forged strong strategic alliances with a range of partners and provided valued support for programme scale-up at the country level. The 2011 Global Plan is widely viewed as a game changer, attracting and consolidating financial and technical resources around a set of ambitious targets for reducing new HIV infections in children in priority countries. In most case study countries, UNICEF served as a lead agency for issues related to HIV in children, thereby helping to align strategies, policies and implementation plans across partners and ensure their coherence with national priorities.

5.1.1 UNICEF's role in ensuring that HIV services for children receive adequate priority

UNICEF has been a prominent advocate for the scale-up of HIV services for children. There is evidence that UNICEF served as a persistent, credible and persuasive voice for children affected by HIV throughout the period of interest, especially at the country level. The case studies have, in most instances,[21] documented how UNICEF's influence at the country level built on its engagement across a wide range of programmes serving children and leveraging its presence in various partnership forums, health financing mechanisms and working groups charged with shaping the national response to the epidemic. A large majority of e-survey respondents strongly agreed (46 per cent) or agreed (43 per cent) that UNICEF had contributed to national shifts in priorities and increasing commitments in relation to PMTCT and paediatric HIV care and support.[22]

The Unite for Children, Unite against AIDS campaign served to raise the alert that children were missing from the global AIDS agenda and to specify strategies to make a difference. An evaluation of the first five years of the campaign suggests that it faced a number of early challenges, including constrained resources and the uneven engagement of national committees and external partners.[23] The external visibility of the campaign remained limited,[24] and none of the external interview or e-survey respondents spontaneously made reference to it. When prompted, one previous UNICEF staff member commented that "It [the campaign] was much more about internal mobilization than about mobilizing others." It does seem, however, to have helped to facilitate, focus and organize action around HIV in children, especially within UNICEF. One UNICEF regional office staff member said, "That campaign had really enabled us, had given us a ready platform to raise money and to organize our response around the four Ps with PMTCT and paediatric treatment being two of the four Ps."

The Global Plan is widely viewed as a game changer.[25] The Global Plan was developed through a consultative process by a high-level Global Task Team established by UNAIDS and co-chaired by the

---

[21] Especially in Cameroon, India, South Africa and Zimbabwe.

[22] See Annex I, Table I.17.

[23] United Nations Children's Fund, *Unite For Children, Unite Against AIDS Campaign Evaluation*, UNICEF, New York, 29 July 2010.

[24] Ibid.

[25] Joint United Nations Programme on HIV/AIDS, *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive: 2011-2015*, UNAIDS, 2011.

UNAIDS Executive Director and United States Global AIDS Coordinator, with strong technical but limited political UNICEF involvement. In all of the in-depth case study countries, the Global Plan was reported to have improved partner convergence and led to sharply accelerated action to meet ambitious targets for eMTCT. For example, national stakeholders in Zimbabwe indicated that the country's inclusion in the list of countries prioritized by the Global Plan attracted critical financial and technical support to the country, providing an impetus for programme scale-up.

UNICEF provided critical support for promoting the Global Plan at the country level. Many UNICEF staff and partners indicated that UNAIDS and the United States President's Emergency Plan for AIDS Relief (PEPFAR) have made key decisions at the global level about strategic approaches and targets related to HIV in children, exemplified by the Global Plan, with insufficient UNICEF involvement in the planning stages and limited UNICEF visibility at the political level. UNICEF's main focus has been on programmatic and technical issues and it has been less effective in relation to high-level political advocacy (and associated resource mobilization, as noted in Section 5.2), which would have required the more active engagement of UNICEF's senior management. Nonetheless, country case studies illustrate that UNICEF and its partners moved quickly to support the process of mobilizing national stakeholders around the 2015 eMTCT targets and translating national commitments into action. There is evidence that the Global Plan's influence went beyond the 22 countries identified for priority action, and many UNICEF regional and country offices actively and enthusiastically promoted the Global Plan and its eMTCT targets, even in low-burden settings.[26] One UNICEF HQ staff member remarked, "The Global Plan was taken up by UNAIDS, momentarily sidelining other partners, including UNICEF. It raised attention to the issue but generated little momentum for action on the ground. UNICEF was needed to take up the challenge as an operational partner. The Global Plan elements needed to be translated and cascaded down into programmatic action."

Global and country level respondents recognized UNICEF for drawing attention to evidence on children being left behind in treatment scale-up. As stated by a global development partner, "UNICEF has raised the flag about paediatric ART and the discrepancies that exist between adult and paediatric coverage." However, the increased prioritization of HIV services for children has tended to privilege eMTCT and is less pronounced for HIV care and treatment among children. Multiple reasons are put forward for this, including the emphasis of the Global Plan on preventing new HIV infections in children and treating their mothers, together with the technical and programmatic challenges related to the follow-up and diagnosis of HIV-exposed children and to the treatment of HIV infection in young children. As noted by a senior UNICEF staff member, "The momentum on PMTCT has been more than that on paediatric HIV."

There is widespread concern that advocacy efforts need to be intensified post-2015 to maintain HIV and children's issues firmly on the development agenda. Some country level government stakeholders were confused about whether or not the Global Plan had ended in 2015, and many felt the need for another global campaign or initiative for children and HIV. They reflected that the visibility of issues related to HIV in children and the sense of urgency might be hard to maintain in countries that have achieved high PMTCT and ART coverage rates, given the reduced need to initiate ART among women during pregnancy and declining numbers of new HIV infections in children. For instance, South Africa's recent investment case[27] describes scenarios for the gradual scaling down of current PMTCT approaches, given the expectation that most women living with HIV will be identified and started on treatment before pregnancy. It does not describe specific efforts to reach children within ART scale-up planning. A global development partner stated, "We're victims of our own success. Things have been going well, and we've been reducing the rate of transmission, so people figure, 'Oh, we've taken care of that. On to something else.' I think we have to keep the focus on the fact that we're still having 110,000 HIV transmissions in Global Plan countries and additional numbers elsewhere. The battle isn't won yet."

[26] In fact, the first four countries certified to have reached the elimination targets are not among the 22 priority countries.

[27] Department of Health, South Africa and South African National AIDS Council, 'South African HIV and TB Investment Case – Summary Report Phase 1', March 2016.

5.1.2 UNICEF's efforts to broker partnerships and coordinate programme design, planning and implementation

UNICEF has forged strong strategic alliances with a range of partners that have shaped models of engagement. Within the UNAIDS division of labour, UNICEF serves as the co-lead (with WHO) for accountabilities related to PMTCT and paediatric HIV treatment, care and support. UNICEF has built partnerships with a broad array of interested parties within the Inter-Agency Task Team (IATT) and through other mechanisms, informal and formal, to address key issues in programme scale-up. For example, UNICEF has entered into bilateral agreements with key organizations, such as the Centers for Disease Control and Prevention (CDC), the Global Fund and the Clinton Health Access Initiative (CHAI). UNICEF has also developed joint activities with a range of private sector and civil society organizations (CSOs). Partners and the large majority of e-survey respondents express strong satisfaction with these arrangements, while acknowledging some tensions along the way.[28]

It should be noted, however, that UNICEF has not forged any formal partnerships at the strategic level with PEPFAR, the major funder of programmes for children and HIV in high-burden countries. Although good working relationships among technical staff were documented between UNICEF and PEPFAR and its implementing partners, there are indications that UNICEF has had limited influence on PEPFAR's strategic priorities and funding choices at the country level. In this regard, a number of UNICEF staff members, as well as respondents from partner agencies, pointed to the need for UNICEF to develop a stronger relationship with PEPFAR at the global level, as well as at the country level, given PEPFAR's far-reaching influence.

In case study countries, UNICEF is widely recognized as a lead player for issues related to HIV in children, thereby helping to align strategies, policies and implementation plans across partners and ensure their coherence with national priorities. In all case study countries, UNICEF is actively engaged in a range of United Nations and non-United Nations partner coordination arrangements that support alignment on established roles and responsibilities and overall complementarity and provide a strong base for programme scale-up. UNICEF is an active and appreciated member of national coordination structures and plays a leadership role (with WHO) on issues related to HIV in children within the Joint United Nations Team on AIDS. It has forged collaborative arrangements with numerous international and national level partner agencies who work at country level on issues related to HIV and children. In most settings, UNICEF has also developed strong ties with a range of research and academic institutions, implementing partners and, to some extent, civil society. The majority of e-survey respondents strongly agreed (40 per cent) or agreed (45 per cent) that UNICEF has played an important role in coordinating programme design, planning and implementation among partners in their country.[29] Finally, UNICEF has promoted South–South exchanges, which national stakeholders in Cambodia, Cameroon and Zimbabwe indicated have been very useful, particularly for learning about innovative approaches to programming and service delivery.

UNICEF has played a key role in supporting and expanding the IATT.[30] The IATT has served as a useful platform for common action among partners, organized high-level advocacy events[31] and helped to inform policy and programme decisions for scale-up at the country level.[32] It is much appreciated by member organizations as a forum for sharing and developing technical and programmatic guidance (*see Section 5.3*), supporting concerted action in a fast-moving and crowded environment and tracking progress. Some respondents pointed out some lack of clarity, however, about UNICEF's role as convener and host of the IATT. One UNICEF HQ staff member said, "UNICEF has had difficulty distinguishing its role from the IATT. I don't think there's ever been clarity as to whether the IATT functions basically as UNICEF, or if it's more of an autonomous secretariat that UNICEF hosts and funds on behalf of a wider partnership. I'm sure that the perception of outside partners is also mixed in that regard, because those lines are not necessarily clear."

---

[28] See Annex I, Table I.18.

[29] See Annex I, Table I.19.

[30] The IATT was established in 1998 as a mechanism to ensure coordination among United Nations agencies and grew rapidly to include other interested parties.

[31] Such as the High-Level Global Partner's Forum in Abuja, Nigeria, in 2005, and in Johannesburg, South Africa, in 2007.

[32] Jashi M., et al., 'Informing Policy and Programme Decisions for Scaling Up the PMTCT and Paediatric HIV Response Through Joint Technical Missions', *Health Policy and Planning*, vol. 28, 2013, pp. 367-374.

Many partners interviewed in the global key informant interviews reflected on the need for UNICEF to be very selective and strategic in its partnership-building efforts, given its dwindling resource base and the increasingly crowded environment. UNICEF's investments into the IATT, for example, have been dependent on specified funding from external sources, which may not be available at the same level in the years to come. In addition, UNICEF's engagement as co-lead in the United Nations system with WHO requires time and effort to ensure coordinated yet timely responses among United Nations partners. Challenges are particularly significant at the country level. Partners accordingly felt that UNICEF should now focus less on engaging with implementing partners in smaller-scale initiatives and projects that address narrowly defined programmatic issues, in favour of higher-level partnerships that afford a greater emphasis on 'upstream' support to secure finances and shape policies and strategies for continued programme scale-up or consolidation as required.

5.1.3 UNICEF's role in strengthening systems to enable the scale-up of HIV services for children

UNICEF has attentively nurtured national ownership and stewardship of the response, and built capacity for high-level strategic planning and coordination where necessary. The country case studies document how UNICEF has worked very closely with key institutions at the country level responsible for the HIV/AIDS response, contributed to national policy development and strategic planning processes and aligned its response accordingly. In some cases, where national capacity was initially weak, UNICEF has provided inputs, as required. For example, the 2008 economic crisis in Zimbabwe placed national institutions under enormous pressure and UNICEF and partners provided technical and financial support to bolster its capacity across health and HIV. On the other hand, UNICEF's leadership role, as described in the evaluation terms of reference, has played out in a more subdued way in countries that have strong institutions and systems for the coordination of the national response and where many partners have contributed to progress, as was the case at the national level and in some provinces or states in India, South Africa and (post-crisis) Zimbabwe.

UNICEF has made substantial efforts to provide guidance and build capacity for programme planning and implementation at the national and sub-national levels. For example, government representatives and partners in South Africa indicated that UNICEF has played a "pivotal" role in rolling out the eMTCT programme throughout the country since 2010, through its contributions to a range of operational planning, policy development and capacity-building activities at all levels. UNICEF was especially commended for its role in developing and deploying data-informed and target-driven frameworks and related implementation plans for eMTCT in all of South Africa's provinces and districts in 2011 and systems for the continuous tracking of progress towards targets at the local level (*see Section 5.3*). UNICEF's leadership in guiding and supporting decentralized planning and implementation approaches was also noted in Cameroon and Zimbabwe and was recognized by e-survey respondents.[33] Some country level respondents, however, felt that UNICEF had at times tried to be present on too many fronts and that its "scattered" efforts had not been as effective as they could have been.

In some countries, UNICEF has played an important role in the procurement of HIV commodities, including paediatric ARVs and diagnostics, including in Cameroon, Ukraine and Zimbabwe. This is not the case in all countries, however – for example in India and South Africa, which have well-developed production, procurement and supply systems for many essential drugs and commodities. This might explain why 41 per cent of e-survey respondents felt that this had not been an area of focus (or a minimal one) for UNICEF in the period 2005–2015.[34]

UNICEF is recognized for its efforts to involve CSOs in PMTCT programming, though there is scope for UNICEF to promote greater engagement of civil society as well as private sector stakeholders in the response. For example, through the Optimizing HIV Treatment Access initiative, UNICEF has developed various strategies to strengthen community-facility linkages in support of lifelong treatment initiated among pregnant women and breastfeeding mothers in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi and Uganda.[35] The country case studies suggest, however, that UNICEF primarily

[33] See Annex I, Tables I.8 and I.21.

[34] See Annex I, Table I.13.

[35] United Nations Children's Fund, *2014 Annual Results Report: HIV and AIDS*, UNICEF, New York, 2015.

explored this role during earlier years, when it had access to more resources and the scale-up of HIV prevention and treatment programmes for children was just starting up. Contextual factors are also coming into play as in the case of Haiti, South Africa, Ukraine and Zimbabwe, where civil society representatives indicated that they have faced increasing financial and political barriers to their contribution to the HIV response.[36] Furthermore, with the exception of India, the country case studies found scant evidence of UNICEF reaching out to the private sector, including private health institutions and practitioners, which are poised to play a significant role in the delivery of HIV services.

5.1.4 UNICEF support to programme experimentation and innovations

UNICEF and its partners have pioneered innovative programme approaches to improve the reach and quality of HIV services for women and children, with some problems along the way. UNICEF has supported the introduction of several innovations in the case study countries that were on the cutting edge of reflection and experimentation when they were introduced by UNICEF, and which were subsequently adopted or adapted by national or state authorities within their programme. Examples include the use of point-of-care diagnostics for early infant diagnosis in South Africa and Zimbabwe, a paediatric telemedicine initiative in India, and the MomConnect initiative using mobile technology to send tailored reminders and messages to pregnant women, mothers and children in South Africa. However, UNICEF's investment in and promotion of the Mother-Baby Pack, which was launched in 2010, was generally considered an innovation with a failed outcome, according to UNICEF staff and country counterparts. NGO partners at the global level raised many practical and ethical concerns about the use of these packs and there was a management decision not to distribute the packs in the targeted countries other than Lesotho, where the government decided to continue. The experience generated some important lessons learned for UNICEF, with regards to managing the risks associated with rolling out innovations.

5.1.5 UNICEF's role in strengthening programme linkages

Although UNICEF has made a strong push to integrate HIV services within the MNCH platform according to 'Double Dividend' principles,[37] gaps remain. Full integration of HIV services and antenatal care and maternity services has been achieved at the service delivery level in nearly all case study countries. Programmes still face many challenges, however, especially in taking opportunities in child health services to keep track of HIV-exposed children and identify HIV-infected children who have fallen through the cracks.[38,39] Progress towards integrating the wider range of services for mothers and children has been delayed in some settings where vertical institutional structures and management processes have been established around the national response to children and HIV. A common scenario is that in which responsibilities for PMTCT and paediatric HIV care and treatment are fragmented across different structures dealing with either HIV or MNCH, making it difficult at times for UNICEF to negotiate a shared strategy, plan or protocol for following up on HIV-exposed children.

UNICEF has made investments in MNCH and supported broader health system strengthening that has supported integration efforts. UNICEF's broad mandate on child health and development means that it is well placed to contribute to the building of national health and community systems that serve women and children. For example, in Zimbabwe, UNICEF has enabled PMTCT scale-up in a national economic crisis situation through its broad-based health system strengthening work and by supporting financial mechanisms to lift user fees and protect access to MNCH services. This work was not focused on HIV alone but addressed a range of health outcomes. As mentioned above, however, the focus has tended to be on the formal health services, with fewer investments into strengthening community systems at scale to increase demand and extend service delivery.

There is some evidence that UNICEF is seeking to build linkages between HIV and programmes in

---

[36] See also Section 5.5.3.

[37] The Double Dividend Action Framework was launched by UNICEF, WHO and the Elizabeth Glaser Pediatric AIDS Foundation at the AIDS Conference in Harare in 2013 as part of an effort to strengthen linkages and integration across the health system towards the dual goals of ending paediatric HIV and AIDS and improving child survival. See: <www.unicef.org/aids/files/Action_Framework_Final(1).pdf>.

[38] Chamla D., et al. 'Evidence From the Field: Missed opportunities for identifying and linking HIV-infected children for early initiation of ART', *AIDS*, vol. 27, 2013, pp. S139–S146.

[39] Chamla D., et al., 'Integration of HIV in Child Survival Platforms: A novel programmatic pathway towards the 90-90-90 targets', *J Internation AIDS Soc*, vol. 18, 2015.

other sectors. Initiatives to introduce HIV testing for children in nutrition services were mentioned in some settings. UNICEF has also pioneered some cross-sectoral linkages with child protection/social protection programmes (*see Section 5.5*). For example, UNICEF has worked to develop functional linkages between MNCH, HIV and drug addiction services for women who use drugs in Ukraine, which led to a new model of integrated health and social care for women who use drugs to be scaled up in collaboration with local authorities and CSOs.[40]

There are important opportunities afforded by UNICEF's 'second decade' activities among adolescents for the primary prevention of HIV among girls and young women and the provision of comprehensive care and treatment, including family planning services, for those living with HIV. Yet planning seems to be conducted separately for the first and the second decades of life in the UNICEF country offices visited as part of the case studies, with no identified 'joined up' programming in the countries. This is a concern for the future, particularly in settings where HIV prevalence among pregnant women (and therefore children's exposure to HIV infection) remains high.

5.2 RESOURCE MOBILIZATION

This section responds to KEQs 10–13, examining UNICEF's Strategic Directions 5 and 6 from the theory of change and the extent to which these have contributed to meeting resource needs for PMTCT and paediatric HIV care and support in a predictable and sustainable manner.

KEY MESSAGES:

In the context of increasing global financing for HIV/AIDS and UNICEF total revenues, UNICEF's other resources[41] for HIV/AIDS have declined since 2008. UNICEF's expenditure on HIV/AIDS has also declined over time, accounting for just 2 per cent of UNICEF's total programme expenditure in 2015. Fundraising for PMTCT and paediatric HIV has been a key challenge and has become more difficult in recent years, particularly since 2008. The high proportion of UNICEF's resource base that is tightly earmarked is likely to have incurred additional transaction costs in the monitoring and reporting on donor agreements and restricted UNICEF's ability to flexibly programme resources. While global financial resources for PMTCT and paediatric HIV have increased over time, UNICEF has not played a prominent role in leveraging these funds at the global level, and there have been significant resource gaps in some countries for the achievement of high-level targets. UNICEF has, however, played a valuable role in supporting countries to access external resources, particularly from the Global Fund, and increasing domestic financial resources in some places.

5.2.1 Internal resource mobilization functions

UNICEF REVENUE FOR HIV/AIDS

UNICEF's revenue for HIV/AIDS has declined even in the context of increasing total revenue for UNICEF and financing for HIV/AIDS. As detailed in Annex K (*see Figures K.5 and K.6*), UNICEF's revenue increased significantly between 2005 and 2015 (revenue increased for regular resources, other resources - regular and other resources - emergency, as well as from the public and private sectors). Global resources for HIV/AIDS in LMICs also more than doubled from less than US$10 billion in 2005 to more than US$20 billion in 2014 and an estimated

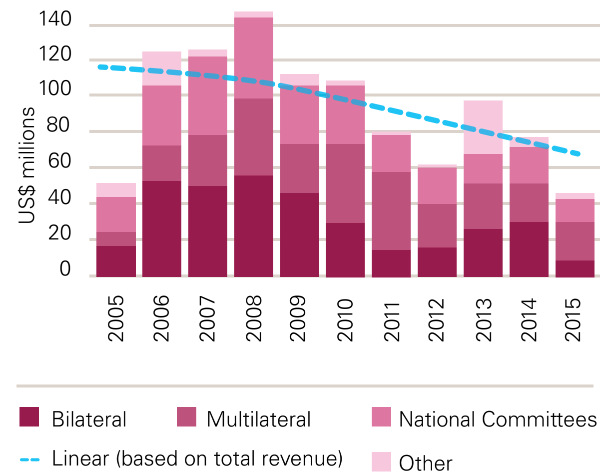
[40] Gotsadze, Tamar, 'Prevention of Mother-to-Child Transmission and Improving Neonatal Outcomes Among Drug-Dependent Pregnant Women and Children Born to them in Ukraine', UNICEF, October 2014.

[41] Other resources - regular are earmarked contributions for programmes that supplement the regular resources and are made for a specific purpose such as a particular programme or project or an emergency response.

US$21.7 billion in 2015, including increases in resources from domestic and international sources (*see Annex K, Figure K.1*).[42]

Figure 4 presents other resources received by UNICEF for HIV/AIDS. This includes contributions from bilateral and multilateral agencies, UNICEF National Committees and other agencies/ instruments. As shown, resources for HIV/AIDS have increased dramatically since 2005 to a peak of US$148 million in 2008, before decreasing to US$45 million in 2015.[43] Other resources in 2015 would have been even lower had it not been for a grant by the Global Fund of US$3.7 million for the emergency provision of HIV supplies for adults and children living in non-government-controlled areas in eastern Ukraine.[44]

Figure 4: UNICEF other resources for HIV/AIDS[45]



The decline in UNICEF's revenue and resources for HIV/AIDS since 2008 has been due to cuts in funding from many of UNICEF's largest donors and declines of more than 50 per cent in funding from UNICEF National Committees and the Global Fund between 2010 and 2015, alongside the highly variable nature of funding from UNICEF's major bilateral donors (*see Annex K, Figure K.9*). Although in 2013, UNICEF National Committees agreed to increase annual resources for HIV to US$45 million p.a. by 2017, declining contributions from National Committees for HIV/AIDS in 2015 suggest that this target will not be met. UNICEF will also face a 50 per cent cut in funding from the UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) in 2016 due to UNAIDS budget constraints. This has been an increasingly important source of income, accounting for almost 24 per cent of UNICEF's total income for HIV/AIDS in 2015 (up from 7 per cent in 2008) (*see Annex K, Figure K.10*).

UNICEF EXPENDITURE ON HIV/AIDS

UNICEF's expenditure on HIV/AIDS has also declined in recent years and has not reached expected levels. As shown in Figure 5, UNICEF's expenditure on HIV/AIDS initially grew from US$157 million in 2005 to US$188 million between 2008 and 2010. It then fell to US$103 million in 2012 and subsequently plateaued. This level of expenditure is significantly lower than UNICEF's own expectation of the levels required to meet the accountabilities set out in the Strategic Plan 2014–2017. A 2013 costing exercise estimated that UNICEF would require approximately US$185 million per year for HIV programming (i.e. a return to 2008–2010 levels of expenditure).[46] However, total HIV expenditure in 2014 and 2015 was US$107 million, achieving only 58 per cent of the annual target. HIV/AIDS has also accounted for a declining proportion of UNICEF's total programme expenditure, falling from 8 per cent in 2005 to 2 per cent in 2015, significantly lower than expectations under the Strategic Plan (*see Annex K*).

[42] Note that a more recent Kaiser Family Foundation and UNAIDS study found that donor government funding for HIV actually fell in 2015, although the actual estimates are yet to be confirmed. See: <www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/july/20150815_kaiser>.

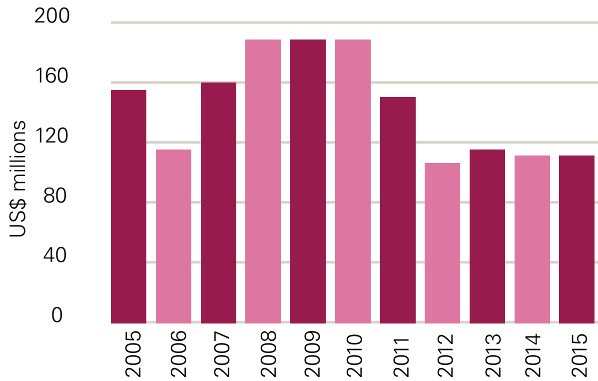
[43] The trend analysis is somewhat distorted by the inclusion of funds where UNICEF has acted as an intermediary for financial flows. For example, the increase in funding in 2013 was largely due to a US$30 million contribution from Fonds de Soutien aux Activités en matière de Population in relation to a Global Fund grant in Chad for PMTCT, for which UNICEF was the sub-recipient.

[44] See: <www.theglobalfund.org/en/news/2015-08-17_Life-saving_HIV_tretment_for_adults_and_children_arrives_in_Ukraine/>.

[45] The trend line is based on total resources for HIV/AIDS between 2005 and 2015. Source: analysis of internal UNICEF data.

[46] United Nations Children's Fund, 'Costing the HIV Response', UNICEF National Committee Meeting, Paris, November 2013; United Nations Children's Fund, *2014 Annual Results Report for HIV/AIDS*, UNICEF, New York, 2015; and United Nations Children's Fund, *Thematic Report 2013: HIV/AIDS and Children*, UNICEF, 2014.

Figure 5: UNICEF expenditure on HIV/AIDS, 2000-2015[47]

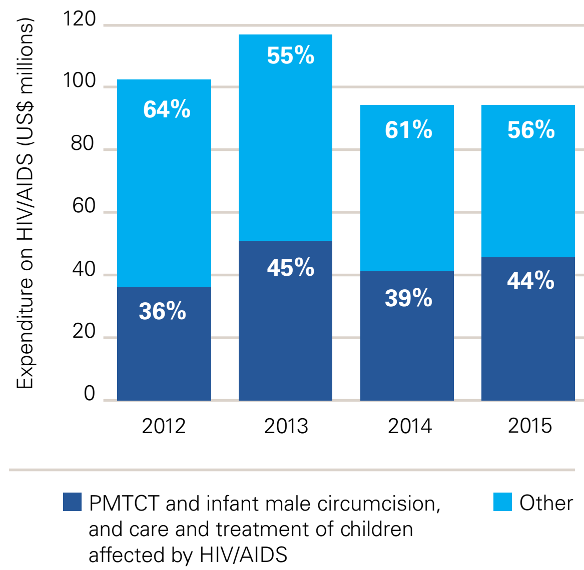


UNICEF EXPENDITURE ON PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT

UNICEF's expenditure on PMTCT and paediatric HIV has accounted for a growing proportion of its total HIV/AIDS programme expenditure. As shown in Figure 6, in recent years, the expenditure on PMTCT and care and treatment of children affected by HIV/AIDS increased as a proportion of UNICEF's total HIV/AIDS programme expenditure, from 36 per cent in 2012 to 44 per cent in 2015. This corresponded with reductions in funding for other programme areas.[48] However, the recent general increase in funding for PMTCT and care and treatment of children affected by HIV/AIDS (from US$37 million in 2012 to $47 million in 2015) largely contrasts with the experiences of case study countries. With the exception of Zimbabwe, UNICEF's expenditure on PMTCT and care and treatment of children affected by HIV/AIDS declined in all case study countries between 2012 and 2015.

There is a positive correlation between the estimated number of pregnant women living with HIV in 2014 and UNICEF's expenditure on PMTCT and paediatric HIV between 2012 and 2015 (*see Annex K, Figure K.17*). UNICEF has expended funds in a mix of countries, both with very low numbers of pregnant women living with HIV, such as Sri Lanka (100), and high numbers of pregnant women, including Nigeria (210,000) and South Africa (240,000).[49] The majority of UNICEF's expenditure on PMTCT and paediatric HIV (75 per cent) has been spent in Eastern and Southern Africa and West and Central Africa (*see Annex K, Figure K.16*).

Figure 6: UNICEF expenditure on PMTCT and care and treatment of children affected by HIV/AIDS[50,51,52]



[47] UNICEF Programme Division HIV annual results reports from 2005 to 2014 and analysis of internal UNICEF data.

[48] Programme areas include adolescents; support for children orphaned or made vulnerable by HIV/AIDS; care and support for children/families affected by HIV/AIDS; and cross-cutting/general. De Bodt, T., 'HIV Financial Analysis 2010-2015', UNICEF Regional Advisor's Meeting, May 2016.

[49] Data sourced from the WHO Statistical Information System using the indicator "Estimated number of pregnant women living with HIV needing antiretrovirals for preventing mother-to-child transmission based on WHO methods".

[50] Based on analysis of internal UNICEF data.

[51] UNICEF's internal reporting follows the structure of its organizational strategic plans, and as such, the data reflects a change in the coding of expenditures between the Medium-Term Strategic Plan 2006-2013 and the Strategic Plan 2014-2017. More specifically, for 2012 and 2013, the figures for PMTCT and care and treatment of children affected by HIV/AIDS present expenditure to reduce the number of paediatric HIV infections; increase the proportion of HIV-positive women receiving ARVs; and increase the proportion of children receiving treatment for HIV/AIDS. For 2014 and 2015, the figures for PMTCT and care and treatment of children affected by HIV/AIDS present expenditure for two programme areas: a) PMTCT and infant male circumcision; and b) care and treatment of children affected by HIV/AIDS.

[52] There are difficulties in interpreting the data for PMTCT and care and treatment of children affected by HIV/AIDS, particularly as the use of funding for the 'HIV general' category, accounting for 42 per cent of total HIV expenditure, is unclear and it has not been possible to assess whether this has benefited PMTCT and paediatric HIV. As such, the data should be interpreted with caution.

There is mixed evidence on the extent to which UNICEF's country office resource needs have been met: some countries have been able to raise sufficient resources for PMTCT and paediatric HIV, while others have not. An informal survey conducted by UNICEF internally in 2016 found that on average, country offices faced an annual programme budget shortfall of US$670,000.[53] The country case studies have also highlighted issues in some countries with resource availability. For instance, in 2014 and 2015, the UNICEF Haiti Country Office had insufficient resources to finance an HIV programme to meet the objectives of the UNICEF Strategic Plan 2014–2017.[54] In contrast, the country case studies in India and Cambodia highlighted that while expenditure has been below planned budgets, this has not been because of the availability of resources but due to the evolution of the country programmes, where scale-up is well under way and there is a reduced requirement for UNICEF support.

FUNDRAISING

According to UNICEF's Planning, Management and Finance Department, the organization's approach to, processes for and transactions costs associated with fundraising are largely consistent across programme areas (*see Annex K*). UNICEF's fundraising efforts are well regarded. For example, UNICEF's approach to private sector fundraising – where it is estimated that for every US$1 invested in private sector fundraising, on average, US$4 is received back – is seen as a benchmark for other United Nations agencies.[55] Development partners have also commented that UNICEF has "done a good job trying to mobilize resources" and is "seen as a partner that is very strong when it comes to resource mobilization, [in part due to] its credibility as an organization."

While UNICEF has managed to raise resources from a wide spectrum of donors, only a few donors account for the majority of income received. Between 2005 and 2015, UNICEF has raised other resources for HIV/AIDS from 24 separate National Committees, 21 bilateral donors, 14 multilateral organizations, including eight United Nations agencies, and 26 other donors. However, UNICEF's resources have been relatively concentrated among a few donors, with more than 50 per cent of revenue being sourced from National Committees, the UBRAF and the Global Fund (*see Annex K, Figure K.7*).

Fundraising for PMTCT and paediatric HIV has been a key challenge in many countries, and has become more difficult in recent years. UNICEF's fundraising for PMTCT and paediatric HIV care and treatment was initially stimulated by the Unite for Children, Unite against AIDS campaign, which resulted in increased interest and resources for UNICEF's work on HIV/AIDS. However, fundraising has been noted as a key challenge since 2008, including in the run up to and launch of the Global Plan. Country case studies and stakeholder feedback suggest a number of reasons for fundraising challenges at the global, regional and country levels, such as:

- A sense within the global community that the job is done following the reduction in the number of new HIV infections among children;
- A shift in donor priorities away from HIV/AIDS (*see Annex K, Figure K.2*) following the progress made towards Millennium Development Goal (MDG) 6, as compared with MDGs 4 and 5, and the launch of the SDGs towards broader health systems strengthening activities, as well as the migrant crisis; and
- The Global Fund and PEPFAR leading in this area, giving the perception of a limited requirement for other donors/agencies.

Some countries, such as Cameroon, India and South Africa, have also struggled to raise resources from traditional donors, in part because of their middle-income status, and have, to varying degrees, adapted their fundraising approaches to focus on new donors.

The earmarked nature of UNICEF's resource base for HIV/AIDS is likely to have had implications for the quantity of funds raised, the transaction costs incurred and UNICEF's ability to flexibly programme resources. Other resources accounted

[53] The survey was referred to internally as the '2016 Strategic Reflection Survey on the Future of HIV Programming in UNICEF'. It should be noted that this survey did form part of the evaluation data collection and was conducted by the HIV/AIDS Section.

[54] In earlier years, the HIV programme was financed by emergency funds (categorized as other resources - emergency) in the wake of the 2010 earthquake, although these funds have decreased in recent years and the country office has not been able to raise alternative sources of other resources to compensate for this decrease.

[55] Achamkulangare, Gopinathan, 'An Analysis of the Resource Mobilization Function within the United Nations System', United Nations Joint Inspection Unit, Geneva, 2014.

for 68 per cent of UNICEF's expenditure on HIV/AIDS between 2012 and 2015. While all other resources are earmarked, by definition, some forms of other resources, for example global thematic resources,[56] are more flexible than other funds (*see Annex K, Figure K.10*).[57]

Drawing on the general literature and the experiences of UNICEF and other multilateral agencies, the acceptance of tightly earmarked contributions, as compared with flexible resources, is likely to have: 1) allowed UNICEF to stimulate new partnerships (e.g. related to innovations) and make additional funds available than it otherwise would not have been able to; but 2) led to an increase in the transaction costs associated with the preparation, implementation, monitoring, enforcement and reporting of donor agreements.[58] There is also a concern that the high proportion of UNICEF's resource base that is tightly earmarked will increase in the future as a result of cuts to UBRAF funding, and that unless flexible resources are used in its place, this may distort UNICEF's future decision-making processes for programming.

5.2.2 External resource mobilization functions

GLOBAL FINANCIAL RESOURCES FOR HIV/AIDS AND PMTCT AND PAEDIATRIC HIV

Financial resources for PMTCT and paediatric HIV care and treatment have increased over time, although UNICEF has not played a prominent role in leveraging these funds at the global level. As noted above, global resources for HIV/AIDS in LMICs more than doubled between 2005 and 2015 (*see Annex K*).[59] For PMTCT and paediatric HIV specifically, resources have also increased over time, particularly following the launch of the Global Plan in 2011. Although UNICEF participated in the Global Fund meetings for the reprogramming of unspent resources from rounds 10 and earlier towards PMTCT, UNICEF has not played a prominent role in leveraging any other donor resources at the global level. One global development partner noted that UNICEF's focus on fundraising is "much more for running their own programmes rather than funding a response", and this was echoed by others.

There have, however, been significant resource gaps in some countries for the implementation of national HIV programmes. In particular, a study by Zeng et al. (2016) estimates that 45 high-burden countries face a gap of providing PMTCT services to 500,000 clients to achieve a coverage rate of 80 per cent, corresponding to a resource gap of US$1.7 billion.[60] The country case studies have also highlighted resource gaps for HIV programmes. For example, in Cameroon and Cambodia, there are resource gaps of more than 50 per cent for the implementation of national HIV/AIDS strategic plans.[61,62] In South Africa, despite significant increases in domestic spending on health and HIV, alongside increasing support from the Government of the United States of America and the Global Fund, a substantial resource gap for the HIV and tuberculosis programme is projected for each of the next five years.

---

[56] Thematic resources are contributions where donors earmark to support strategic and pre-defined objectives for countries, regions, UNICEF's Strategic Plan focus areas or humanitarian response.

[57] For the purposes of this evaluation, earmarked resources are considered those where a donor restricts official development assistance to a specific sector, theme, country or region through a multilateral institution. See: <www.oecd.org/dataoecd/23/17/45828572.pdf>.

[58] United Nations Children's Fund, 'Funding Modalities: Quick reference', 2011; Organisation for Economic Co-operation and Development, *DAC Report on Multilateral Aid*, 2010; United Nations Secretariat, 'Strengthening the System-wide Funding Architecture of Operational Activities of the United Nations for Development', Discussion note, United Nations Secretariat, New York, 3 May 2009; Fozzard, A., et al., 'Aid Transaction Costs in Vietnam', December 2000.

[59] Joint United Nations Programme on HIV/AIDS, *How AIDS Changed Everything*, UNAIDS, 2016.

[60] Zeng, W. et al., 'Resource Needs and Gap Analysis in Achieving Universal Access to HIV/AIDS Services: A data envelopment analysis of 45 countries', *Health Policy Plan*, vol. 31, no. 5, 2016, pp. 624-633.

[61] In Cameroon, the financing gap is estimated at €44.1 million (US$50 million) for PMTCT (62.3 per cent of the total €70.8 million) and €159 million (US$180 million) for care and treatment of adults and children (61.1 per cent of the total €260.1 million) over the period 2014–2017.

[62] In Cambodia, the cost of implementing the National Strategic Plan III was estimated to be US$516 million between 2011 and 2015 (US$103 million p.a.). However, the available data suggests that expenditure in 2011 and 2012 was approximately US$50 million in each year. Joint United Nations Programme on HIV/AIDS, 'Case Study: The Royal Government of Cambodia at the Forefront in Applying New Investment Approach', 31st meeting of the Programme Coordinating Board, Geneva, 11-13 December 2012.

EXTERNAL FINANCIAL RESOURCES AT THE COUNTRY LEVEL

UNICEF has played a valuable role in supporting countries to access external resources. That role has varied but has included: supporting the preparation of practical, data-driven, costed strategic and operational plans to scale-up PMTCT services in the run-up to the launch and implementation of the Global Plan; demonstration of proof of concept for new approaches and technologies; and development of Global Fund and other donor applications. These roles/activities have provided a useful basis for country stakeholders to leverage financial resources from development partners and lobby for increased domestic allocations. For example, in Cambodia, Cameroon, India and Zimbabwe, UNICEF's support for the development of the Global Fund funding applications was widely appreciated, particularly in relation to the reprogramming of unspent Global Fund resources and around the prioritization and costing of activities.[63] One implementing partner at the country level noted, "UNICEF helped us to get funding from … Global Fund, CHAI and GIZ … mainly by brokering the relationships and encouraging us to submit proposals."

In Zimbabwe, UNICEF's role in shaping and leading a multi-donor health sector fund (the Health Development Fund), as well as its procurement function for the Expanded Support Programme for HIV/AIDS, gave the agency considerable influence to leverage funds for HIV and children. For example, in Lesotho, UNICEF supported the introduction of HIV counselling and testing services alongside immunizations, which is acknowledged to have served as a catalyst for leveraging additional resources from the United States Agency for International Development for nationwide scale-up.[64] UNICEF has also acted as the principal/sub-recipient for Global Fund grants in a number of countries, such as North Korea and Somalia, where it has not been appropriate for the government or other agencies to fulfil this role. This has facilitated the flow of Global Fund resources to these countries, including for PMTCT and paediatric HIV.[65]

DOMESTIC FINANCIAL RESOURCES

UNICEF has contributed to increasing domestic financial resources for PMTCT and paediatric HIV care and treatment in some countries, although experiences have varied. As shown in Annex K, 84 of 121 LMICs increased their domestic expenditure on HIV/AIDS between 2009 and 2014.[66] There have, however, been mixed observations from the country case studies on UNICEF's contribution to increasing domestic expenditures. In India, UNICEF's active advocacy supported the observed increase in domestic expenditure for the roll-out of PMTCT and paediatric HIV services. In Cambodia and Cameroon, observed increases in domestic financing for HIV/AIDS were attributed to the PEPFAR and Global Fund counterpart financing policies, rather than UNICEF's intervention.

While there is scope for further engagement, UNICEF has been involved in some high-level discussions on utilizing innovative financing mechanisms for PMTCT and paediatric HIV. For example, in Zimbabwe, UNICEF has advocated to increase the provision of funding generated through the National AIDS Trust Fund for the procurement of health commodities for paediatric HIV, though this has not yet been approved.[67] In other countries, however, while high-level discussions are underway to include HIV and AIDS services in health insurance schemes, UNICEF has not been as involved as WHO or UNAIDS. For example, in South Africa, UNICEF has only minimally engaged in discussions related to developing the National Health Insurance Plan, which aims to establish an equitable financing model for delivering and accessing health care, including for HIV.

FINANCIAL SUSTAINABILITY

UNICEF's role in identifying, testing and promoting efficiencies to reduce resource requirements for national programmes has been widely appreciated. This has included support for conducting efficiency analyses in Cambodia that led to cost savings by streamlining processes for sample collection and transportation and developing the South African HIV and Tuberculosis Investment Case, which will be

[63] Such support is aligned with the Memorandum of Understanding between UNICEF and the Global Fund on alignment of maternal, newborn and child health interventions.

[64] United Nations Children's Fund, *Report on Regular Resources 2015*, UNICEF, New York, June 2016.

[65] See Annex I, Table I.5.

[66] Joint United Nations Programme on HIV/AIDS, *How AIDS Changed Everything*, UNAIDS, 2016.

[67] This is administered by the National AIDS Council of Zimbabwe and funded by a 3 per cent tax on personal and corporate income.

used to guide programming and budget decisions, as well as Global Fund support to the country. UNICEF has also piloted various innovations to improve service delivery processes and quality (*see Section 5.1*).

While domestic expenditures for HIV/AIDS have increased in many countries, the country case studies highlighted that some countries are still heavily reliant on donor financing for PMTCT and paediatric HIV programmes and HIV/AIDS responses more generally.[68] For example, both Cambodia and Haiti are heavily dependent on external financing, with the majority of expenditure on HIV/AIDS coming from the Global Fund and PEPFAR. However, both countries are facing reductions in expenditure from PEPFAR, and Cambodia is also facing a significant reduction in anticipated resources from the Global Fund. This poses a key risk for the financial sustainability of these programmes. In contrast, given Indian and South African government ownership for resourcing their HIV/AIDS programmes, there is much stronger potential for these to be financially sustainable going forward. The e-survey also found a mixed response – 50 per cent of respondents strongly agreed or agreed that resources for PMTCT and paediatric HIV care and treatment are provided in a sustainable manner, and 37 per cent disagreed or strongly disagreed.[69]

5.3 STRATEGIC INFORMATION, KNOWLEDGE GENERATION AND DISSEMINATION

This section responds to KEQs 14–16, focusing on UNICEF's Strategic Directions 7–9 from the theory of change and how these have strengthened mechanisms to ensure accountability for the provision and scale-up of PMTCT and paediatric HIV care and treatment.

KEY MESSAGES:

UNICEF has made considerable investments in knowledge building to support advocacy, resource mobilization, prioritization, programming and monitoring and evaluation of HIV prevention and treatment among children, which has reinforced accountability processes at all levels. UNICEF's work on strategic information has had limited visibility, however, given the considerable investments that the organization has made. UNICEF has also provided valuable support to national authorities to manage rapid shifts towards evidence-informed and programmatically grounded approaches to HIV prevention and treatment in children and related policy changes, facilitating simpler and more effective regimens for PMTCT. UNICEF has also played an active and highly appreciated role in knowledge building and dissemination through the IATT and at the country level, with a useful focus on South-to-South sharing.

5.3.1 UNICEF's role in information systems development at the country level

UNICEF has built on its long-standing work in child health to support national monitoring and evaluation system improvements that have increasingly enabled the production of comprehensive data on HIV burden, service delivery and uptake facilitated by electronic district health information systems. These have been introduced in all case study countries, with the support of UNICEF and many partners. For example, UNICEF provided technical and financial support for the introduction of web-based systems in Zimbabwe, such as the District Health Information Software (DHIS) version 1.4, which was rolled out in 2011 and 2012, and the more efficient DHIS2, which was rolled out in 2013. DHIS2 is linked to the FrontlineSMS mobile phone-based system[70] that has

[68] Joint United Nations Programme on HIV/AIDS, *How AIDS Changed Everything*, UNAIDS, 2016.

[69] See Annex I, Table I.23.

[70] See <www.ictedge.org/tools/frontlineSMS>.

been introduced in Zimbabwe to promptly relay HIV early infant diagnosis information to health facilities.

In all case study countries, country office staff have contributed, within country-led working groups or through other mechanisms, to the production of annual national and sub-national HIV estimates of HIV prevalence, new HIV infections, HIV-related deaths and treatment needs (among different age groups). Through the collective work of partners such as WHO, UNICEF, UNAIDS and the CDC, the number of countries reporting on PMTCT coverage increased from 77 in 2005 to 134 in 2014.[71] A total of 162 countries reported on the number of children receiving ART that year, though only 81 countries were able to report on paediatric ART coverage. Stakeholders such as PEPFAR and the Global Fund rely on this information at the country level for advocacy, planning, prioritization and resource mobilization.

5.3.2 UNICEF's role in generating and building knowledge at the country level

UNICEF has strengthened country level capacity to generate data for learning on HIV and children. In many countries, UNICEF has provided technical and financial support for multiple indicator cluster surveys and demographic and health surveys. In Cameroon and Zimbabwe, these surveys enabled the estimation of key indicators at various levels to support final MDG reporting and contributions to the Global AIDS Progress Report in 2015 and provided a useful and up-to-date source of information on HIV for the preparation of Global Fund concept notes. In Zimbabwe, UNICEF has contributed to sub-analyses of this database, for example to identify populations who are not accessing health services for social, religious or other reasons.

UNICEF has provided technical and financial support for a number of programme assessments, focused programme reviews and thematic analyses in all case study countries. For example, in South Africa, UNICEF participated in a high-level United Nations review of the public health sector's HIV and AIDS response in 2009 in a situational assessment of the early infant diagnosis service in primary health care facilities in 2012, an assessment of gaps in paediatric HIV treatment in the same year, a joint national review of the HIV, tuberculosis and PMTCT programmes in 2013 and an eMTCT stocktaking exercise across all provinces and districts in 2014. These efforts all informed the development of action plans for programme scale-up.

UNICEF has also made substantial investments in clinical, epidemiological and social research to generate knowledge related to HIV prevention and treatment in children in support of policy and intervention development. In South Africa, UNICEF supported the University of Witwatersrand and the National Institute for Communicable Diseases on the development of early infant diagnosis approaches suitable for use in young infants and promoted their wide use at the programme level and in surveys, enabling the first population-based survey in the world that included children under 2 years and tracked the effectiveness of PMTCT. A range of respondents in Cameroon, India and Zimbabwe recognized UNICEF's support for research activities and indicated the value of these activities for programme learning and the development of innovative programming approaches.

5.3.3 UNICEF's support for data-driven approaches to improving programme performance and efficiency at the country level

Stakeholders in all in-depth case study countries commended UNICEF's use of evidence to guide priority-setting and programming at decentralized levels. For example, in South Africa, UNICEF provided guidance on processes for analysing programme performance and identifying bottlenecks in implementing the eMTCT framework, which were introduced across all provinces and districts in 2011. Simple monitoring tools such as visual dashboards and data for action reports were promoted to guide and track improvements along the PMTCT cascade. These were successfully used to improve provincial and district-specific programme performance and scale-up over the following years[72] and are now being replicated for local monitoring and work planning in other programme areas. Many other countries reported that UNICEF has provided critical support for the identification of gaps in programme coverage, the pinpointing of bottlenecks to service delivery and

[71] Idele P.A., et al., 'Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Treatment Monitoring: From measuring process to impact and elimination of mother-to-child transmission of HIV', article submitted to *AIDS and Behavior*.

[72] Bhardwaj S. et al., 'Elimination of Mother-to-Child Transmission of HIV in South Africa: Rapid scale-up using quality improvement', *South African Medical Journal*, vol. 104, no. 3, March 2014, pp. 239–243.

the use of equity analyses at local levels, which have guided programme focus and improvements.

UNICEF has also pioneered innovative data management approaches to improve service delivery for children affected by HIV. The innovations that UNICEF has worked on with its partners include approaches to data management that are suitable for use in low-resource settings. For example, in Cambodia, UNICEF supported the National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases to develop and introduce the Exposed Infant Database. This database was linked to the health management information system and was designed to improve the identification and follow-up of HIV-exposed infants and enable access to any health facility providing HIV services. Another example of innovation is the digitalization of the road to health booklet in South Africa as an application for mothers and caregivers to access key information about children, customized with the date of birth and linked to milestones and growth monitoring. This will be further built upon in 2016.

5.3.4 UNICEF's role in global reporting mechanisms

UNICEF has worked closely with partners at the global level on the generation, analysis and dissemination of strategic information on the HIV epidemic in children and on progress towards programme targets. Between 2004 and 2008, WHO and UNICEF jointly published yearly PMTCT and paediatric HIV report cards and universal access reports linked to the health sector response. These were in addition to the reports of the United Nations Special Session of the General Assembly, which also include PMTCT and paediatric care and treatment indicators and have been compiled by UNAIDS since 2003. In 2009, UNAIDS, UNICEF and WHO merged these processes using a unified tool for country reporting, renamed the Global AIDS Response Progress Reporting system in 2013. As a result, UNAIDS now issues a comprehensive annual global report.

UNICEF has worked closely with UNAIDS and WHO, and other partners in the IATT working group on monitoring and evaluation (co-chaired by UNICEF, the CDC and the International Center for AIDS Care and Treatment Programmes) to improve monitoring and evaluation processes. This collective work has served to improve monitoring and evaluation indicators and data collection and management processes to keep pace with shifting clinical and programmatic approaches to prevention and treatment of HIV in children. In particular, key indicators such as mother-to-child transmission rates, early infant diagnosis coverage and paediatric treatment coverage, together with related measurement or estimation approaches, have been developed and quickly introduced into country programmes to track progress along the continuum of care. UNICEF has also actively engaged in joint work to improve the quality and expand the range of programme data used for monitoring and evaluation purposes. This has resulted in an increasing focus on the measurement of programme outcomes and impact, leading to programme improvements and allowing more countries to move to case reporting rather than modelling to track numbers of children with HIV. UNICEF is particularly recognized for its push for age- and sex-disaggregated data, at both the global and country levels. This has supported gender and equity analyses and further programme refinements.

The visibility of UNICEF's work on strategic information has declined in recent years. This is a result of the ongoing effort to harmonize and streamline the analysis and reporting process and reduce the burden on countries, recognizing that many global reports on children and HIV have been published in recent years.[73] UNICEF now has less control over the development of global products focused on children and HIV that can be used to support advocacy, raise funds and support accountability for reducing the burden of infection and the treatment gap among children.[74] Its technical engagement in strategic information activities at the global, regional and country levels remains strong, however, and is valued by United Nations and development partners.

[73] These include the children and AIDS stocktaking reports (published annually by IATT partners from 2006–2010 and again in 2013), the Global Plan progress reports (published annually beginning in 2012 by UNAIDS and partners), as well as regional reports.

[74] For example, Joint United Nations Programme on HIV/AIDS, *Global AIDS Update*, UNAIDS, 2016, provides estimates for HIV prevalence and ART treatment coverage for all ages only.

5.3.5 UNICEF's role in supporting countries to interpret and translate evidence into sound policies, strategies and approaches to implementation

UNICEF has actively participated in efforts to review and translate evidence into national strategies, standards, guidelines and protocols at the country level. Country level government stakeholders and development partners have commented on the complementary roles played by WHO and UNICEF in managing the multiple policy and guideline shifts that have taken place since 2005 in response to the astonishing pace of scientific advances in the field of HIV/AIDS and growing programme experience. Successive recommendations for PMTCT since 2002 have taken on switches in ARV regimens for prophylactic use while progressively expanding eligibility criteria for ART for pregnant women and mothers (*see timeline in Annex H*). Over time, these have resulted in simpler and more effective regimens for PMTCT, facilitating programme scale-up and increasing performance. Critical advances in ARV drug formulations made it possible for first-line ART to be based on a daily fixed-dose, single-pill triple-drug regimen, helping to improve adherence, reduce costs and facilitate delivery. UNICEF is generally recognized as having played a key role, working closely with WHO and other partners to support the rapid adoption of evidence-informed policies at the country level. Particularly noteworthy is UNICEF's strong push for the Option B+ policy, which entailed the offer of ART for life to all pregnant women living with HIV, regardless of their immunological or clinical status and facilitated a surge in programme scale-up beginning in 2011. This is described as a case study in Annex H.

UNICEF has guided a range of other important policy changes at the country level that have facilitated programme scale-up and improved service quality. For example, in 2014 the West and Central Africa Regional Office and members of the Joint United Nations Regional Team on HIV/AIDS actively promoted the adoption of a task-shifting policy for ART in Chad and Côte d'Ivoire as part of a broader process of creating an enabling environment for the adoption and roll-out of Option B+ for PMTCT.[75] UNICEF has also provided valuable technical and financial support over the years for the development of guidelines related to infant and young child feeding, including HIV issues and related information and training activities. For example, UNICEF worked with the National Department of Health in South Africa and CSOs to publish and edit informational materials on breastfeeding and child nutrition in the context of HIV.[76]

5.3.6 UNICEF's role in knowledge sharing and dissemination

The IATT has played an important role in document and information sharing in recent years. From its base in UNICEF, the IATT Secretariat intensified information sharing and dissemination through its website, its 'eMTCT community of practice', regular webinars and special events such as regional and sub-regional stocktaking meetings organized by the IATT. Since its launch in 2012, the website has been visited by more than 40,000 individuals from 198 countries, with more than 1,000 users per month who are able to access regularly updated news, information and data dashboards. The Option B+ toolkit is the most frequently downloaded document, with more than 11,000 downloads. South-to-South learning is facilitated through discussion forums in the community of practice and webinars, both of which are very popular.[77] Region-specific websites and data-sharing platforms have also been developed. For example, the Regional Office for East Asia and the Pacific and UNAIDS have jointly set up an elimination of parent-to-child transmission website and data hub for the Asia Pacific sub-region on behalf of the bi-regional inter-agency task force.

[75] United Nations Children's Fund, *2014 Annual Report*, UNICEF, 2015.

[76] United Nations Children's Fund, 'Infant Feeding in the Context of HIV in South Africa', Yenzingane Network, 2010.

[77] The membership of the Community of Practice has lately grown by 40 per cent, from 1,850 in 2014 to 2,594 in 2015. Eighteen webinars were conducted over the past two years, with an average of 60 participants from different geographic locations. Source: Final IATT report to the Department of Foreign Affairs, Trade and Development, Canada, March 2016.

A few global respondents reflected that the IATT knowledge management function, which currently relies on ad hoc contributions and requests from interested members, would benefit from a more active and systematic search for innovative experiences in the field and audience profiling for a more strategic targeting to key stakeholders, while acknowledging that this would require additional funding.[78] One civil society partner noted, "The webinars, in my opinion, are extremely informative and also engaging. Again, the ones that work best are the ones that really talk to country examples and country experiences and bring that back to those who are sitting more at a global level. There's a lot of learning and sharing, and it's very practical." Improved knowledge generation, dissemination and utilization are at the core of UNICEF's corporate strategy. The range of activities is large, from plenary presentations in international AIDS conferences, to publications in peer-reviewed scientific journals, to the very popular 'brown bag' lunches in UNICEF's Harare office. e-Survey respondents agreed that UNICEF had played an important role in the generation and dissemination of data and knowledge (82 per cent and 81 per cent, respectively), while 76 per cent agreed that UNICEF's work on data and knowledge had contributed to progress in scaling up services in their country.[79] There is, however, no organized database to keep track of various outputs over time, in HQ or any of the country offices that were visited.

UNICEF's approach to knowledge generation and dissemination in this programme area has remained opportunistic. The overall impression is that of considerable willingness and energy in producing and distributing a broad range of technically solid outputs but on an ad hoc basis, rather than in a planned and systematic way guided by an appraisal of strategic needs. UNICEF has been very responsive to demand, which is high. Some country level stakeholders, including government representatives, indicated that they would welcome even greater attention by UNICEF to the dissemination of knowledge, while acknowledging the small number of technical staff in country offices who are responsible for covering many bases. A number called for greater investments in documentation of best practices and programme innovations and in South-to-South learning opportunities. Regional meetings were held in the early years in all regions for these purposes but have now become less frequent due to funding limitations. There is also a sense that the bulk of the knowledge generated thus far relates to the health facility components of PMTCT/paediatric HIV programmes as well as technology-driven innovations, with some stakeholders recommending that UNICEF invest more in building evidence on demand creation and community-based approaches to service delivery. One global development partner noted, "They're good at gathering strategic information, but they have much more space to work on the synthesis of that information and the dissemination of that information." A government respondent said, "We can learn more from other countries where UNICEF is working. Leveraging the good practices from throughout the world or in countries that are similar to ours would be something that we could benefit from."

[78] Current funding for the knowledge management function of the IATT is provided by the Department of Foreign Affairs, Trade and Development, Canada, through March 2017.

[79] See Annex I, Tables I.30, I.31 and I.32.

5.4 UNICEF ORGANIZATIONAL STRUCTURE

This section responds to KEQs on UNICEF's organizational structure and focuses on UNICEF's Strategic Direction 14 from the theory of change, considering how UNICEF as an organization has responded to changes in the external environment and leveraged its comparative advantage in PMTCT and paediatric HIV care and treatment.

KEY MESSAGES:

UNICEF has deployed diverse approaches to addressing its corporate priority on HIV/AIDS at different levels of the organization. Some regional strategic priority documents and many CPDs clearly single out HIV/AIDS as a major priority while others have incorporated HIV within other overarching priorities. However, over time, UNICEF has also faced challenges related to adapting to dwindling financial and human resources for its HIV/AIDS work. As a result, there is some evidence that UNICEF's ability to meet demands for HIV/AIDS results has been stretched.

5.4.1 UNICEF's adaptation to key shifts in the HIV/AIDS response

UNICEF has deployed diverse approaches to address its corporate priority on HIV/AIDS at different levels of the organization. HIV/AIDS (in the first and second decades of life) has been clearly defined as a corporate priority throughout the evaluation period and highlighted as one of five focus areas in the Medium-Term Strategic Plan 2006–2009 (which was subsequently extended to 2013) and one of seven outcome areas in the current Strategic Plan 2014–2017. This has sent a clear signal both internally and externally about the relevance of this programme area for children's health and development and the urgency of expanding the response. This corporate priority has been operationalized in diverse ways across the organization, making the most of its decentralized structure and decision-making processes. Some regional strategic priority documents and many CPDs clearly single out HIV/AIDS as a major priority while others have incorporated HIV within other overarching priorities. In general, this has enabled UNICEF to remain responsive to country needs and priorities, which is highly valued by a broad range of national and global stakeholders.

UNICEF's country planning processes have facilitated close collaboration and joint programming on HIV/AIDS with national authorities. In practice, the CPDs, results frameworks and country programme action plans developed at the country level reflect programme priorities and strategies, expected results and operational modalities governing the relationship between respective governments and UNICEF. Government stakeholders in case study countries have shown their strong appreciation for the opportunity to jointly sign off on CPDs and annual work plans and align results and indicated that this has enabled closer collaboration with UNICEF than with most of their other HIV/AIDS partners.

UNICEF has acquired a reputation for being a flexible and responsive organization in the global HIV/AIDS architecture, which has readily adapted to the rapid pace at which the response to HIV and children has developed since 2005. A number of government stakeholders in case country studies mentioned that they can rely on UNICEF to "step up to the plate" and meet urgent programme needs that other agencies cannot accommodate in their work plans. Most e-survey respondents (71 per cent internal and 75 per cent external) strongly agreed or agreed that UNICEF has responded appropriately to developments in PMTCT and paediatric HIV over time and made the necessary internal adjustments.[80] On the other hand, some UNICEF staff reflected on the difficulties of adjusting to rapid shifts in priorities and the need for UNICEF to maintain them for longer periods of time to generate real change.

The evaluation identified significant challenges faced by many country offices, particularly in high-burden

[80] See Annex I, Table I.50.

countries, related to the decline in funds for HIV/AIDS, even though expectations for the attainment of results remain unchanged. For example, the UNICEF Cameroon Country Office has faced a large resource gap for its HIV/AIDS work since 2013, which led to a decrease in the numbers and seniority of staff available to work on PMTCT/paediatric HIV care and treatment and a sharp decrease in the funds available for activities. Similarly, the UNICEF Haiti Country Office was unable to maintain its response to country technical and financial support needs in specific areas (for example, support to local NGO programming around HIV in children and associated implementation research). The unpredictability of funding when resources run low and the fact that a growing proportion is tied to specific projects can seriously undermine UNICEF's ability to respond.

Dwindling resources have put pressure on staff. Dedicated PMTCT and paediatric HIV care and treatment staff numbers decreased in some country offices included in the case studies over the evaluation period (notably Cameroon, Haiti, India and Ukraine), including international staff posts, as financial resources for HIV declined, resulting in fewer staff, at lower levels. The 2016 HIV Strategic Reflection Survey Results found that, on average, country offices have fewer than two staff members dedicating a majority of their time to HIV work, with an average of 1.7 staff per office dedicating more than 90 per cent of their time to HIV. In the evaluation e-survey, 34 per cent of survey respondents strongly disagreed or disagreed that the number of people working on PMTCT and paediatric HIV in the reference country office was appropriate.[81] Stakeholders reflected on the importance of continuing to have senior staff engaging in advocacy dialogue with governments, to navigate the positioning of HIV as part of the SDGs and within UNICEF's wider agenda, and where necessary for section chiefs to take on this role where international HIV positions no longer exist.

There are indications that the attention on HIV/AIDS and associated resources has declined in a number of country offices over the period of the evaluation. While this was not the case in any of the countries visited as part of the in-depth country case studies, UNICEF respondents in the light touch case study countries reflected on the way other pressing priorities have led to a gradual reduction in the priority accorded to HIV/AIDS work and related investments. This is predictably an issue in many countries with a low HIV burden and improved programme coverage levels. For instance, in the Latin America and the Caribbean region, 68 per cent of country offices do not have a specific budget dedicated to HIV, and 86 per cent do not have staff exclusively dedicated to HIV.[82] A significant minority (20 per cent) of e-survey respondents from within the organization disagreed or strongly disagreed that country office leadership gave adequate priority to PMTCT and paediatric HIV.[83]

5.4.2 UNICEF's capacity to deliver on its roles in PMTCT and paediatric HIV

In recognition of the importance of regional and country contexts and that 'one size does not fit all', UNICEF offices have diverse staff structures and tailor their engagement in the children and HIV response accordingly. Decisions about structures are linked to office CPDs and consider programme priorities and leverage. Some country offices have standalone HIV teams, others have included PMTCT and paediatric HIV care and treatment functions within health teams, and others have introduced a more formalized approach to supervising shared positions. The experience of the UNICEF Zimbabwe Country Office (*see Box 1*) demonstrates the need to weigh various factors and to find the appropriate balance between organizational linkages, visibility and the office's strategic positioning of the HIV function.

Some country offices have developed strategies to foster cross-sectoral collaboration and shared accountabilities, though more could be done in this regard. UNICEF South Africa has defined its programme around three office-wide results: early

---

[81] See Table I.46 in Annex I.

[82] Latin America and the Caribbean contribution to the vision for UNICEF work on HIV beyond 2017.

[83] See Table I.44 in Annex I. This question was only asked to UNICEF respondents and therefore the reported per cent is calculated as a proportion of UNICEF respondents only (n = 74).

child development (where 'survive and thrive' includes PMTCT), results for adolescents and ending violence against children. This places individual accountability at the output level and gives higher-level results cross-sectoral accountability. A majority of UNICEF e-survey respondents (65 per cent) agree that there are strong and effective linkages between UNICEF's work in PMTCT and paediatric HIV care and treatment and its work in other sectors.[84] Some UNICEF staff commented, however, that UNICEF's internal structures and operations tend to compartmentalize HIV work, even when HIV staff are part of a broader team. They reflected that indicators for tracking PMTCT progress were not evident when mainstreamed within MNCH and health. A few UNICEF staff pointed to a competition between work streams (one country office respondent said, "everyone had their own results including outcome results. They therefore didn't have to interact with others"), while others pointed to an internal culture focusing on 'what is mine, rather than ours' and the need for stronger internal collaboration. Of concern is the perception of some government stakeholders that UNICEF's structures do not favour the alignment and harmonization of its own programmes.

The HQ stand-alone HIV team with its matrix management approach has secured its high-level leadership functions while fostering linkages across sectors. The HQ HIV Section office management plans 2010–2012 and 2014–2017 noted the value of the matrix management approach in ensuring stronger collaboration and linkages with other divisions and sections in support of joint action to deliver on organizational Medium-Term Strategic Plan commitments. Staff at all levels referenced the value of matrix management for supporting collaboration and promoting the integration of HIV issues in other programmes, sectors and functions. However, the system is perceived to be unwieldy at times, particularly in regards to setting individual staff priorities and reviewing accountabilities. For example, some staff members noted the challenges of having two supervisors in terms of negotiating work and travel plans.

The UNICEF country, regional and HQ divisions of roles and responsibilities related to HIV/AIDS are generally perceived to be clear with strong coordination mechanisms and few reported instances of gaps or overlaps. In particular, HIV staff in the case study country offices commented on the value that they place on the technical support provided by regional offices and HQ, although it could be made more efficient through better communications and alignment of activities. Some stakeholders noted that language limitations have the effect of focusing HQ staff inputs on some regions, with others receiving less support. The majority (80 per cent) of internal survey respondents strongly agree or agree that there is effective coordination between UNICEF country offices, regional offices and HQ.[85] UNICEF respondents have nonetheless pointed out the need for strategies to improve efficiencies in the face of dwindling resources. In the context of the ongoing strategic planning effort, regional office staff are specifying approaches for differentiating country contexts and prioritizing their work and accountabilities across diverse settings. This is an important move to focus on countries with the greatest need and provides a useful planning framework in the context of diminishing resources.

UNICEF staff are widely respected for their technical and managerial competencies, with some areas identified for further development.

BOX 1 **THE EVOLUTION OF THE ORGANIZATIONAL STRUCTURE IN UNICEF ZIMBABWE**

Multiple organizational shifts have taken place in UNICEF Zimbabwe as the HIV programme has evolved. In 2005, a small team of people carried out HIV functions from their location in different sections across the office. As their numbers grew, they formed a separate HIV team between 2007 and 2009. This team was then situated within the health and nutrition section, with its senior member serving as a separate HIV advisor (working on higher level policy issues) reporting directly to the Deputy Representative. This stimulated the integration of HIV and health functions but led to reduced visibility and less engagement with some programme areas outside of health, such as child protection. A standalone HIV section was recreated in 2015 to increase focus and visibility for eMTCT.

[84] See Annex I, Table I.53.

[85] See Annex I, Table I.52. This question was only asked of UNICEF respondents and therefore the reported percentage is calculated as a proportion of UNICEF respondents only (n = 74).

UNICEF staff are described as having a generalist skillset, a hallmark of UNICEF's recruitment and deployment compared with the more specialist approaches of some agencies working in this programme area. In South Africa, some government stakeholders and implementing partners indicated their special appreciation of UNICEF staff related to their practical experience and willingness to contribute at local levels. Internal and external stakeholders in case study countries reflected that the mix of national and international staff has effectively supported implementation. However, some national stakeholders hinted at the limited capacity of HIV/AIDS staff in specialist areas related to HIV in children. They suggested that staff skills needed to be strengthened in the areas of HIV epidemiology and estimation approaches; strategic planning, monitoring and evaluation; and community mobilization. There also appears to be scope for increasing the emphasis and understanding of HIV outside of teams that work directly with HIV, for example in MNCH, early childhood development and child protection, to ensure that opportunities for collaboration and linkages are maximized.

5.5 CROSS-CUTTING ISSUES

This section responds to evaluation questions related to the four cross-cutting issues of gender, equity, human rights and the response in humanitarian situations – specifically, UNICEF Strategic Directions 10–13 from the theory of change and how these have contributed to the positioning of these issues within the PMTCT and paediatric HIV response.

KEY MESSAGES:

Gender: UNICEF's focus on women and children is evident and UNICEF has been vocal in advocating for the availability of sex-disaggregated data to inform programming. There is, however, scope for broader gender issues to be more fully integrated within the HIV response.

Equity: UNICEF's support for bottleneck analyses has made a valuable contribution to programme scale-up. As overall coverage increases, it will be critical that UNICEF maintains its focus on reaching the most vulnerable, marginalized and hard-to-reach populations.

Human rights: Although UNICEF has a clear mandate on human rights, this is not always visible externally. UNICEF could more vocally push for holistic approaches to human rights programming and support stronger civil society engagement in the response.

Humanitarian situations: UNICEF has advocated for and supported the inclusion of PMTCT/paediatric HIV care and treatment services in various emergency situations, reflected on areas of improvement and contributed to guidance on integrating HIV services into humanitarian response, though more could be done to facilitate more consistent integration.

5.5.1 Gender

The global PMTCT response is challenged by fundamental issues related to gender. There is compelling evidence that women are disproportionately at risk of contracting HIV. For example, adolescent girls and women aged 15–24 accounted for 20 per cent of new HIV infections among adults in 2015, despite accounting for only 11 per cent of the adult population. In sub-Saharan Africa, this trend was even more stark – 25 per cent of new infections were among adolescent girls and women aged 15–24, and, overall, 56 per cent were in women.[86] Deep-rooted gender inequality, poverty, gender-based violence and various other factors contribute to heightened risk among women.

[86] Joint United Nations Programme on HIV/AIDS, *Global AIDS Update*, UNAIDS, 2016.

Reducing the number of infections in women and preventing mother-to-child transmission of HIV, requires greater consideration of these broader social determinants and more significant involvement of men in the response.[87]

Respondents expressed diverse views regarding the extent to which UNICEF has emphasized a gender lens as part of its advocacy and programming approach to PMTCT and paediatric HIV. Although UNICEF is recognized as having an innate focus on women and children, some stakeholders (both internal and external to UNICEF) feel that the organization is not making "enough noise" on the issue of gender, as one regional office respondent said. Some external partners were not even aware of UNICEF's approach to gender, suggesting a lack of visibility, while others felt that the gender focus is implicit but not explicit. This mix of views also played out in the country case studies conducted as part of this evaluation. For example, in Cambodia and Ukraine, UNICEF is recognized as having a clear mandate for supporting gender-sensitive programming,[88] whereas in other case study countries this was less evident.

Respondents also highlighted key achievements in regards to UNICEF's engagement with gender issues, particularly in relation to the availability of data. For example, in Cambodia, UNICEF supported the Cambodia Ministry of Women's Affairs to conduct gender assessments in 2008 and 2014 and incorporate HIV/AIDS. UNICEF has also conducted information, education and communication campaigns and training to promote the equal needs of boys and girls for paediatric health services (including HIV) and contributed to ensuring the availability of sex-disaggregated health facility data as a way of targeting these efforts. In India, UNICEF vocally pushed for age-, caste- and gender-disaggregated data and supported research that identified gender inequities in relation to ART initiation among children. In Zimbabwe, UNICEF advocated for the Government to ensure that district health information system data is disaggregated by sex (*see also Section 5.4*).

UNICEF lacks a significant profile in terms of broader gender issues related to PMTCT and paediatric HIV, particularly the involvement of men in the response. While there are clearly areas where UNICEF is looking to engage men in the response – for example, in Cambodia, UNICEF supported the development of protocols to extend HIV testing from pregnant women, mothers and their children to partners and older siblings – respondents both internal and external to UNICEF generally felt that UNICEF was less attentive to programming for men as part of the paediatric HIV and PMTCT response. At the country level, there is also the sense that UNICEF could be more closely linking its work in PMTCT/paediatric HIV with its work in other areas. For example, in South Africa, gender-based violence was raised as a critical issue, and one that both UNICEF and other United Nations agencies could be engaging with more vocally.

While not a challenge unique to UNICEF, there is a perceived need for more gender 'transformative' approaches in relation to PMTCT that move beyond a focus on women and children.[89] Some staff felt that UNICEF programming does not draw routinely and comprehensively on a robust gender analysis – particularly an analysis that considers some of the more complex gender dynamics, such as power relations between men and women and how these affect behaviour. This was reflected in the Zimbabwe case study. A 2014 gender review of the country programme found that while the CPD was informed by sex-disaggregated data and assessment of the situation of women and children, it also "lacks an in-depth gender analysis."[90]

The Gender Action Plan sets financial targets[91] and provides guidance on staffing. However, challenges remain in regards to the operationalization of gender mainstreaming within the organization, with potential

[87] With the end of the Global Plan, the final report reflects that the Plan "could have done a better job of engaging male partners and fathers as parents who also desire healthy children and healthy families ... the perception of reproductive health as being primarily the domain of women needs to change." Source: Joint United Nations Programme on HIV/AIDS, *On the fast-track to an AIDS-free generation: The incredible journey of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive*, UNAIDS, 2016.

[88] These are approaches that acknowledge but may not address gender inequalities. See <http://promotinghealthinwomen.ca/online-course/unit-3-approaches-to-integrating-gender-in-health-promotion/gender-sensitive/>.

[89] A gender transformative approach is defined as one that "addresses the causes of gender-based health inequalities and works to transform harmful gender roles, norms and relations." See: <http://promotinghealthinwomen.ca/online-course/unit-3-approaches-to-integrating-gender-in-health-promotion/gender-sensitive/>.

[90] United Nations Children's Fund Zimbabwe, *Gender Review Report*, UNICEF, August 2014.

[91] For example, by 2017, 15 per cent of UNICEF programming expenditure will be for activities that advance gender equality/empowerment.

implications for how gender can be taken forward in UNICEF's programming for PMTCT and paediatric HIV. Some internal respondents flagged capacity and expertise gaps that challenge gender programming. For example, one staff member in South Africa noted that "gender has been mainstreamed almost out of existence … everybody thinks it is there, but in the absence of additional capacity it has been difficult to identify specific efforts on gender." However, there is a hope that the recent recruitment of seven regional gender advisors may increase the visibility of gender within the organization. In at least one region (Eastern and Southern Africa), there is also an effort to ensure that upcoming CPD development or mid-term review processes incorporate gender analyses.

5.5.2 Equity

The period 2005–2015 saw impressive gains in regards to preventing new HIV infections in children. Progress has been uneven across and within countries, however, demonstrating that equity challenges remain. Coverage of ARVs (excluding single dose nevirapine) for PMTCT in Global Plan countries more than doubled between 2009 and 2015 but remains highly variable – ranging from less than 50 per cent in Nigeria, Angola and Chad to more than 95 per cent in South Africa and Uganda.[92] As shown in Figure 7,[93] there are also substantial differences in ART coverage for pregnant women and children across countries,[94] with children lagging behind pregnant women. Within countries, inequities remain across a number of dimensions. For example, women living in rural areas often struggle to access high quality HIV and MNCH services and key populations such as female sex workers and women who inject drugs face a number of barriers.[95]

Equity,[96] and a focus on the most disadvantaged, is part of the UNICEF mission.[97] The organization further sharpened its emphasis on equity with the launch of the equity refocus in 2010. The equity refocus made the case that an equitable approach to development was both "right in principle" and "right in practice" (i.e. that a focus on the most disadvantaged was a cost-effective way to achieve the MDGs).[98] It was associated with the development and dissemination of a number of tools to support a heightened emphasis on equity in UNICEF programming, including the Monitoring Results for Equity System (MoRES), which is a set of approaches to identify and monitor barriers and bottlenecks to achieving effective coverage of interventions. PMTCT is recognized within UNICEF as a programme area that has embraced the use of MoRES,[99] and, following initial successes in applying PMTCT approaches, some countries have expanded their use to paediatric HIV care and treatment.

[92] Joint United Nations Programme on HIV/AIDS, *On the fast-track to an AIDS-free generation: The incredible journey of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive*, UNAIDS, 2016.

[93] Ibid.

[94] Ibid.

[95] Joint United Nations Programme on HIV/AIDS, *Global AIDS Update*, UNAIDS, 2016.

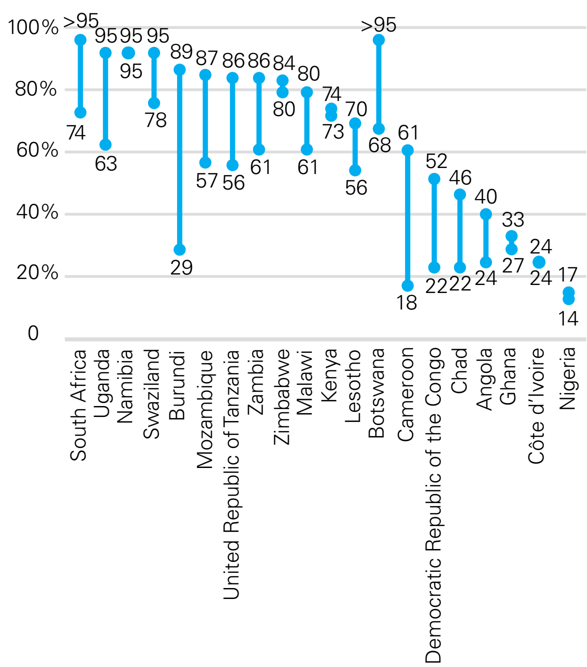
[96] For UNICEF, equity means that "all children have an equal opportunity to realize their rights, to survive, develop and reach their full potential, without discrimination, bias or favouritism, with the most disadvantaged receiving the extra care and support needed." Source: United Nations Children's Fund, 'Training Handbook on the Equity Focus in Programmes', UNICEF, 2011.

[97] United Nations Children's Fund, *Narrowing the Gaps to Meet the Goals*, UNICEF, September 2010.

[98] Ibid.

[99] Of the countries that were the 'early adopters' of MoRES, more than 40 per cent applied it to HIV, specifically eMTCT. Source: United Nations Children's Fund, *Accelerating Results for Deprived Children through Level Three Monitoring*, Workstream One Country Report, UNICEF, 2012.

Figure 7: Percentage of pregnant women and children (aged 0-14 years) living with HIV who are receiving lifelong antiretroviral therapy, by country (from the 2016 Global Plan Report)



Respondents both internal and external to UNICEF generally (though not universally) recognized UNICEF's mandate and focus on equity in relation to PMTCT and paediatric HIV. Among the UNICEF respondents interviewed as part of this evaluation, there was clear consensus that equity was a strong part of the programme. One country office respondent said, "equity is really part of UNICEF's DNA … making sure that no one is left behind." This was echoed by a number of global development partner respondents, who felt that an equity focus was prominent in UNICEF's engagement in PMTCT and paediatric HIV care and treatment. Similarly, more than 70 per cent of respondents to the e-survey felt that UNICEF had either a strong or a moderate focus on equity as part of its approach to PMTCT and paediatric HIV care and treatment at the country level.[100] The prominence of equity as part of UNICEF's mandate at the country level was also evident from the case studies conducted as part of the evaluation. For example, in India, UNICEF is recognized as one of the few organizations championing equity, leading to increased government commitment to universal testing and treatment. This view was not universal, however, with some global partners not identifying equity as a significant focus of UNICEF's activities, suggesting that UNICEF could do more to communicate this agenda externally.

At the country level, UNICEF's approach to equity often manifests as a focus on universal access, which has translated into a geographical focus on the most underserved or underperforming areas. For example, in Zimbabwe, UNICEF is recognized as a strong advocate for a geographical focus on specific districts, which has led the Government and partners to increase focus on these areas. In India, a government official similarly noted, "We have a composite index of the 184 high priority, poorly performing districts and UNICEF supports us in 75 per cent of these. They are very focused on equity." There is evidence that this geographical lens has helped sharpen programmatic focus in some countries, ensuring targeted allocation of resources and effort. What is less evident, however, is the degree to which the organization emphasizes inequity beyond universal access – for example, explicit consideration of dimensions such as socioeconomic status and targeting the most vulnerable and marginalized populations.

The use of bottleneck analysis tools (including through MoRES) is recognized as a critical contribution of UNICEF to the scale-up of national responses. Evidence is limited, however, on the degree to which these analyses are being deployed specifically to support the targeting of the most vulnerable. This was evident from the case studies in Cameroon, South Africa, Ukraine and Zimbabwe, where bottleneck analysis has strengthened decentralized planning processes and supported differentiated targeting of resources. In South Africa, UNICEF has been a key proponent of the use of bottleneck analysis to monitor progress towards increasing PMTCT coverage and define action plans to address barriers through the use of 'robot' dashboards for tracking progress at the district level.[101,102]

[100] See Annex I, Table I.41. A total of 69 out of 211 (33 per cent) felt that UNICEF had a moderate focus on equity and 82 out of 211 (39 per cent) felt that UNICEF had a strong focus on equity.

[101] For more details, see the South Africa case study report submitted as a supplementary annex to this report.

[102] United Nations Children's Fund, *Accelerating Results for Deprived Children through Level Three Monitoring*, Workstream One Country Report, UNICEF, 2012.

However, in Cameroon, Haiti, India, South Africa and Zimbabwe, there was evidence that more could be done to move beyond a geographical focus and target the most vulnerable and hard-to-reach. For example, in Zimbabwe, there was a perception from some partners that, while the most underserved and poorly performing districts are prioritized, within those districts, the most hard-to-reach, vulnerable and disadvantaged populations may be left behind. Although the bottleneck analysis tools have the potential to support the targeting of these groups, there is limited evidence that they are consistently being used in this way at the country level.

UNICEF has an evolving focus on adolescent girls, who account for a disproportionate number of new HIV infections among adults. Adolescent girls are prominent in the most recent Gender Action Plan 2014–2017, and their prioritization was also highlighted in some global interviews, with reference to the work of UNICEF on the 'All In' initiative.[103] There is a widespread recognition that adolescent girls have historically not been sufficiently prioritized in the PMTCT response, and the current momentum around adolescent girls represents an opportunity for UNICEF to push for greater integration of strategies and activities at every level to address this.

While there is some evidence of a strong focus on key populations in UNICEF's work, there is scope for more consistent engagement. In Ukraine, for example, UNICEF has worked to support the complex needs of women who inject drugs through working with health facilities to reduce stigma and improve access to services. Interviewees from within UNICEF also cited other examples such as in East Asia and the Pacific with people who use drugs and in Peru with indigenous populations. However, the majority of the evaluation case studies identified opportunities for UNICEF to engage more with marginalized populations such as migrants and displaced persons (Haiti); female sex workers (India, South Africa and Zimbabwe); women who inject drugs (India); low-caste women (India); disabled persons (South Africa, Zimbabwe); and Apostolic groups (Zimbabwe).

Although there is a recognized tension between focusing on equity and prioritizing yield, focusing on the most disadvantaged will become increasingly critical as coverage improves. Targeting the hardest-to-reach is significantly more resource intensive than reaching more accessible populations. Respondents noted that when resources are limited, the temptation is to focus on areas that will generate a big yield to demonstrate results. In Cameroon, for example, PEPFAR has exited some districts in order to concentrate on high-impact areas, which has left a number of districts with little support. Respondents also recognized the need for an equity-focused approach, however, and saw a niche for UNICEF in this space in terms of ensuring that equity remains on the agenda and that efforts in this vein complement the approaches of PEPFAR and its partners.

5.5.3 Human rights

A human rights-based approach is central to an effective response to HIV, including in children. The Committee on the Rights of the Child defines a number of elements of the Convention on the Rights of the Child (CRC), to which UNICEF is a signatory, that should guide the response,[104] and a review by Strode and Grant, found that "in the context of HIV, rights-based law and policy has been seen to play a vital role in creating effective national responses to the epidemic, reinforcing the interdependence of all of a child's basic human rights in reducing, or increasing, his or her vulnerability to HIV."[105] UNAIDS notes that while some progress has been made, there are ongoing challenges in relation to legal frameworks around HIV and that "ignorance and misunderstanding continue to undermine efforts."

---

[103] 'All In' is a partnership between UNICEF, UNAIDS, WHO, UNFPA and other stakeholders to develop a social movement and platform to address the issue of HIV infections and mortality in adolescents. The initiative aims to achieve its goals by "engaging adolescent girls and boys as leaders and agents of social change; sharpening national programmes and results through improved data collection, analysis and utilization; fostering innovation in approaches to reach adolescents with life-saving prevention and care; and advocating at global, regional and country level to generate political will and mobilize resources." Source: United Nations Children's Fund, Annual Report on the Implementation of the UNICEF Gender Action Plan, E/ICEF/2015/8, New York, 15 April 2015.

[104] "HIV/AIDS impacts so heavily on the lives of all children that it affects all their rights – civil, political, economic, social and cultural. The rights in the general principles of the Convention – the right to non-discrimination (article 2), the rights of the child to have her/his interest to be a primary consideration (article 3), the right to life, survival and development (article 6) and the rights to have her/his views respected (article 12) - should therefore be the guiding themes in the consideration of HIV/AIDS at all levels of prevention, treatment, care and support." Source: Committee on the Rights of the Child, 'General Comment No. 3 (2003) HIV/AIDS and the rights of the child', 32nd session, 13–31 January 2003.

[105] Strode, A. and K. Grant, 'Children and HIV: Using an evidence-based approach to identifying legal strategies that protect and promote the right of children infected and affected by HIV and AIDS', working paper prepared for the Third Meeting of the Technical Advisory Group of the Global Commission on HIV and the Law, 7–9 July 2011.

UNICEF's mandate on human rights is clear from its strategic documents at every level, from the Strategic Plan 2014–2017 to the CPDs examined for this evaluation. This emphasis on a rights-based approach was recognized by some respondents, both internal and external. In particular, examples were highlighted in regards to UNICEF's advocacy for children's access to treatment. One global development partner said, "I would probably say that for human and child rights, perhaps the voice has been stronger and louder from UNICEF … There's always been someone advocating for the rights of children or the rights … sort of building a voice for children who remain otherwise voiceless." Another global development partner noted, "When the elimination agenda came out initially, there were personalities at UNICEF that were really the voice behind saying 'hey, we forgot about kids' and sort of drove the child rights issue."

This was evident from some of the case studies, in which UNICEF support for rights-based approaches was considered a clear part of its work on HIV. For example, in India, UNICEF's voice in technical resource groups was perceived as having led to better inclusion of gender and rights issues in national policies and strategic plans over time.

However, there was also some sense that UNICEF could be more vocal on rights-based issues. This was a particular finding from the case studies in Zimbabwe and South Africa and was echoed by some global development partner respondents who did not see UNICEF as an organization that strongly articulates a human rights-based approach. One global development partner noted, "People look to UNICEF for that, but there is a sense that it's a bit tired and it needs to be more progressive. For me, personally, it has the opportunity to really claim the space around proper rights and protection around HIV and sexual and reproductive health for children and young people." A government respondent said, "They really are not very vocal as advocates for children. We realise that this is difficult. However, they focus so much on technical support but not enough on advocacy for children. This can be sensitive … but still they should think strategically about how to go about this."

There is evidence that UNICEF deploys a holistic approach to the rights of women and children in some programming approaches. For example, in Ukraine, UNICEF is working with health facilities to reduce stigma and improve access to services for women who use drugs, while supporting women to speak about their experience to health care providers when setting up new models. This helps service providers understand their needs, improve acceptance and reduce stigma. In Zimbabwe, UNICEF is supporting the training of cadres of community workers that are responsible for identifying child protection cases.[106] Following the recognition that a number of the cases were linked to HIV issues (including PMTCT and adherence), workers are now being trained on HIV-sensitive case management to strengthen linkages and increase referrals to health services.[107] Respondents also mentioned UNICEF's work with governments on deinstitutionalizing children, supporting family-centred programming for children affected by HIV, and working with orphans and vulnerable children.

Respondents also felt that UNICEF should better leverage existing opportunities for maximizing programme linkages. In a number of countries, respondents felt that UNICEF could more actively promote the positioning of human rights within the broader HIV response. Examples highlighted include ensuring that child protection issues are fully considered in school-based HIV testing programmes (Zimbabwe) and supporting a more integrated response that addresses how challenges such as teenage pregnancy, school drop-out and child marriage are linked to both the risk of contracting HIV and access to care and treatment (Cameroon). The need to link work in HIV with work in gender-based violence was noted at the country level in Cameroon and South Africa, as well as at the global level. Many respondents noted that UNICEF is well positioned to take up this mantle and support a holistic approach, given its mandate on rights and that it works across a variety of programme areas. However, particularly at the country level, there was a perception that opportunities for linkages are not being fully leveraged.

UNICEF is active in relation to some of the legal frameworks around rights and reporting at the country level, including the CRC and the Convention on the Elimination of All Forms of Discrimination Against Women. Between 2005 and 2013, the number of countries supported by UNICEF for CRC reporting increased from 80 to 137 and for the Convention on the Elimination of All Forms

[106] The National Case Management approach.

[107] For more details, see the Zimbabwe case study report submitted as a supplementary annex to this report.

of Discrimination Against Women, from 24 to 48.[108,109] In Zimbabwe, the scale-up of facilities offering PMTCT and increased service coverage for pregnant women were highlighted as important achievements in the most recent report to the CRC.[110] However, in some of the case studies, there was limited evidence of UNICEF engagement with some higher-level strategic challenges facing governments that are not HIV-specific but present substantial challenges to the response. For example, in many parts of Cameroon, the health system is not sufficiently robust to support the scale-up of HIV services for women and children. More upstream work is needed to address critical issues that challenge the programme – most notably, the user fees for basic services that, for some women, act as an almost insurmountable barrier to access to antenatal care and other services and directly lead to low coverage of PMTCT in underserved districts.[111]

Accountability and participation are core principles of a human rights-based approach.[112] While not specific to HIV, at the end of the last UNICEF Strategic Plan in 2013, 30 countries had "national child and youth policies that institutionalize participation of children", and in 41, adolescent girls and boys participated in the CRC reporting process.[113] Within UNICEF, there were somewhat mixed views on how these principles have been operationalized as part of the response. On the one hand, there was a perception that UNICEF is very concerned with ensuring that the voices of women and children are heard. For example, in Zimbabwe, UNICEF is recognized as supporting the inclusion of key populations in national processes, including adolescent participation in the 'All In' initiative and the representation of sex worker groups in Global Fund concept note development processes. However, some respondents (both internal and external) flagged challenges related to ensuring that participation, particularly of young people, is not, as one global development partner described it, "tokenistic".

There is an opportunity for UNICEF to support continued and strengthened civil society engagement in the response as a mechanism for increasing accountability. In the context of constrained resources, there are challenges related to ensuring that civil society maintains a voice in the response and that community mechanisms are given sufficient priority. For example, in South Africa, funding challenges are reported to have weakened the voice of civil society and its ability to maintain pressure on the Government. In Zimbabwe, although the health and development approaches favoured by international partners over the last several years have supported the health system through a major economic upheaval, an unintended consequence has been the weakened contribution of civil society to the HIV response.[114] UNICEF has provided valuable support to NGOs and CSOs in Zimbabwe, with an emphasis on seed funding, capacity building and technical support for delivering care and support services at the community level. However, there is an opportunity for UNICEF to play an even more active role that emphasizes strengthening community mobilization and accountability mechanisms. This would support efforts to combat stigma and discrimination, ensure the quality of services and improve adherence.

5.5.4 HIV in humanitarian situations

UNICEF has supported the inclusion of HIV services for women and children in various humanitarian settings, with some success stories. In Cameroon, for example, UNICEF has successfully advocated for an integrated emergency response package that includes HIV/AIDS. No parallel structures have been created in UNICEF intervention zones, but refugees from the Central African Republic, Chad and Nigeria have access to PMTCT services in local health structures where Option B+ and paediatric HIV treatment are free for all. After the

[108] United Nations Children's Fund, *Thematic Report 2008: Policy, advocacy and partnerships for children's rights*, UNICEF, 2009.

[109] United Nations Children's Fund, *Medium-term Strategic Plan 2006-2013: A data and results companion to the end of cycle review*, UNICEF, 2013.

[110] United Nations Children's Fund and the Government of Zimbabwe, Country Programme Action Plan 2016-2020.

[111] See the Cameroon case study report submitted as a supplementary annex to this report.

[112] See: <www.unicef.org/policyanalysis/rights/index_60319.html>.

[113] United Nations Children's Fund, *Medium-term Strategic Plan 2006-2013: A data and results companion to the end of cycle review*, UNICEF, 2013.

[114] The registration process for community-based organizations and small NGOs is also reported to be cumbersome, the context is not favourable, and most are unable to compete for the pooled health and development funds. In addition, Zimbabwe is under additional safeguard measures from the Global Fund, whereby the United Nations Development Programme was selected as the principal recipient for all grants in consultation between the Global Fund and the Country Coordinating Mechanisms, and as a result, the principle of dual-track financing to civil society does not apply.

2010 earthquake in Haiti, UNICEF supported the expansion of a decentralized public health system for MNCH services and developed the health section of the Haiti Post Disaster Needs Assessment, which raised awareness of the HIV component in the humanitarian response and led to its subsequent operationalization (*see Annex L*).

The most widely cited success story of integration of PMTCT and paediatric HIV care and treatment as part of a humanitarian response is UNICEF's engagement in Ukraine. During the 2014–2015 conflict, UNICEF played a critical role in the humanitarian response in non-government controlled areas in eastern Ukraine supporting the provision of HIV treatment to women, children and adults. Since 2015, UNICEF with Global Fund emergency resources has: provided ARV medications and diagnostic supplies; enabled continuity of services and uninterrupted access to ARV treatment for 8,000 people living with HIV at risk of treatment interruption (including 300 HIV-positive children and 600 pregnant women); and provided HIV testing for more than 31,000 pregnant women and their children.

Working with partners, UNICEF has also contributed to the development of a number of normative documents related to HIV in humanitarian situations. This literature draws attention to the need for HIV service provision, including PMTCT/paediatric HIV care and treatment, in emergency settings and provides guidance on operationalization. For example, together with the United Nations High Commissioner for Refugees and Save the Children, UNICEF steered the work that led to the publication of PMTCT guidelines in humanitarian settings by the Inter-agency Task Team for HIV in Humanitarian Emergencies in 2015 (*see Annex L for additional examples*).[115]

UNICEF has also made an effort to learn and capitalize on less positive experiences. The 2015 guidelines on PMTCT in humanitarian settings includes an entire section reflecting on lessons learned from recent crises.[116] In 2014, UNICEF conducted a specific learning exercise following the response to the 2013 floods in Gaza province, Mozambique. The floods affected an area with a 25 per cent HIV prevalence rate, and there was an associated high risk of disruption to ART services through damage to health facilities.[117] Despite this risk, HIV was not accounted for in the initial emergency response and assessments, and, as a result, treatment continuity and other services for people living with HIV were affected. A 'lessons learned' report concluded that "because HIV was not included in contingency planning, there was initially a great deal of confusion between partner organizations about roles and responsibilities. The National AIDS Commission was slow to react to the emergency, and some partners were unable to provide support during the emergency because it was not in their workplan."[118] After this incident, UNICEF worked with Save the Children to develop a case study, which has provided important lessons for UNICEF and the wider community in regards to addressing HIV issues in emergency settings.

Still more could be done to consistently integrate PMTCT/paediatric HIV/AIDS concerns into UNICEF's humanitarian response. Less than half of e-survey respondents believed that PMTCT and paediatric HIV care and treatment have been adequately integrated into humanitarian responses.[119] Moreover, out of the interview respondents that discussed this issue, most respondents from HQ and regional offices felt that PMTCT and HIV in general have not been a priority in emergency settings, in the face of more pressing challenges.[120] One regional office staff member noted, "Definitely there is improvement to be sought. Most of the time, where there is an emergency, the eMTCT component is not prioritized. And even in our regular planning, I think it is missing." An HQ staff member said, "I don't know that we've defined in a way that's been convincing how that integration [of HIV/AIDS in emergency settings] would work."

---

[115] Becher, Heidi, 'Interagency Task Team HIV in Humanitarian Emergencies: PMTCT in humanitarian settings – Part I: Lessons Learned and Recommendations', May 2015.

[116] Experiences from the Central African Republic, Cote d'Ivoire, Ethiopia, Haiti, Kenya, South Sudan and Uganda.

[117] United Nations Children's Fund, 'UNICEF's Lessons Learned for HIV programming: 2013 floods in Gaza province, Mozambique', UNICEF, June 2014.

[118] Ibid.

[119] Forty-nine per cent agreed or strongly agreed that PMTCT and paediatric HIV care and treatment have been adequately integrated into humanitarian responses. Forty-six per cent felt that PMTCT and paediatric HIV care and treatment in humanitarian situations is a moderate or strong focus for UNICEF. Full breakdown of the responses is included in Annex I, Tables I.38 and I.42.

[120] The main priorities during emergencies for UNICEF appear to be water, sanitation and hygiene, nutrition, health and education. For example, in terms of financial resources, the amount of funding requested for HIV/AIDS by UNICEF through its humanitarian appeals has been approximately 1 per cent for the period 2012–2014 (the time period for which the data was available).

6

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

UNICEF's contributions to programme scale-up evolved over the evaluation period. The past five years have been the organization's most productive in terms of expanding and improving HIV prevention programmes for children. Paediatric HIV treatment programmes have not been scaled up as efficiently, however.

Between 2005 and 2010, UNICEF invested in a broad range of activities focused on taking HIV prevention, care and treatment interventions to national scale and strengthening programme implementation. This contributed to steady, incremental increases in programme coverage globally and in many high-burden countries, though progress towards expected results remained insufficient. The Global Plan is widely viewed as a game changer, having mobilized high-level political commitment and resources around a set of ambitious targets for reducing new HIV infections in children. Although UNICEF involvement was more technical than political, the Global Plan enabled UNICEF to focus its contributions between 2010 and 2015 on supporting national stakeholders to develop plans for reaching the 2015 eMTCT targets and effectively leverage available resources from national budgets, the Global Fund and PEPFAR. UNICEF also built on scientific advances and programmatic experience to promote critical policy changes at the country level, including the rapid adoption of Option B+ in 2011, which facilitated impressive gains towards increasing PMTCT coverage and reducing transmission rates in high-burden countries. Although UNICEF has made important contributions to addressing technical and programmatic challenges related to the follow-up and diagnosis of HIV-exposed children and the care and treatment of young children living with HIV, large gaps in paediatric ART coverage persist in most settings.

UNICEF and partners have played a critical role in scaling up HIV prevention, care and treatment programmes for children through targeted advocacy, its convening role at the global, regional and country levels and substantive financial and technical support to country level partners in areas such as policy development, programme planning, implementation support and knowledge generation.

UNICEF has been a visible and prominent advocate for scaling up HIV prevention and treatment services for children, though this has been less on the political and more in the programmatic and technical arenas. The organization has forged strong strategic alliances with a range of key stakeholders and has devoted considerable resources to bolstering partner coordination arrangements within and outside of the United Nations system. UNICEF's decentralized decision-making, country presence and expertise in child health and development issues have served as a strong foundation for supporting the national scale-up of PMTCT and paediatric HIV care and treatment in diverse country contexts. UNICEF has supported the expansion of programmes, strategy and policy development as well as data-informed priority-setting and implementation at all levels of health systems. Finally, UNICEF has worked with partners to pioneer innovative programme approaches to improve the reach and quality of HIV services for women and children.

HIV/AIDS has been a corporate priority throughout the evaluation period, though it has been operationalized in diverse ways at different levels in an effort to tailor approaches to specific contexts.

In recognition of the importance of regional and country contexts and of the idea that 'one size does not fit all', UNICEF offices have employed diverse staff structures and tailored their engagement in the HIV response accordingly. Regional strategic priority documents and many CPDs clearly identify HIV/AIDS as a priority, while others incorporate HIV within other overarching priorities (e.g. child survival and development). Stakeholders value this flexibility and responsiveness to country needs and priorities.

The rapid and substantial decline in UNICEF's resources for HIV/AIDS since 2005 has put pressure on its PMTCT/paediatric HIV care and treatment work.

Despite increases in global financing for HIV/AIDS and UNICEF total revenues, UNICEF's expenditure on HIV/AIDS has decreased over time, severely curtailing UNICEF's ability to achieve results in many settings and limiting the visibility of the organization's HIV/AIDS work. In addition, a large proportion of UNICEF's HIV/AIDS resources are tightly earmarked, leading to high transaction costs and restricted flexibility of use. The future cuts to UBRAF funding and expected challenges in accessing other HIV/AIDS funds will further inhibit UNICEF's ability to contribute to this programme area in the future and may distort strategic approaches.

UNICEF is widely perceived as the organization that can support programme integration at all levels, from planning to service delivery. However, evidence of advances in this area remain limited.

UNICEF has made a significant effort to integrate HIV services within the MNCH platform in line with 'Double Dividend' principles. This integration effort has not yet been fully realized in all contexts, however, and there is little evidence of broader programme linkages. In some countries, UNICEF has struggled to manage vertical structures in which responsibilities for HIV and children are fragmented across various institutions and planning and budgeting processes are separate. Corporate policy and guidance has not translated into practice in such settings, with many missed opportunities for cross-sectoral collaboration. There is also a heavy reliance on health system solutions to increase programme reach and coverage within UNICEF and more broadly. Linkages must be developed at all levels, more widely across programmes and sectors and into the community. Part of the problem relates to UNICEF's internal structures and operations, which tend to compartmentalize HIV work, with limited examples of cross-sectoral collaboration and shared accountabilities.

Progress towards preventing new infections among children has been unequal between and within countries and remains fundamentally challenged by issues related to gender, human rights and inequality across the wider social determinants of health. Although UNICEF has the potential to inform and drive the agenda around these issues, the organization is not currently making the most of its position.

While impressive gains have been made, progress in scaling up PMTCT and paediatric HIV care and treatment has been uneven across and within countries, demonstrating that equity challenges remain. Although UNICEF has effectively advocated for approaches that support the geographical prioritization of underserved areas, there is less evidence that these tools are being used to focus attention on the most vulnerable, marginalized and disadvantaged. Maintaining emphasis on these populations will become increasingly critical as coverage increases and in the face of pressure to maximize yield. UNICEF is seen as an organization that can keep equity issues on the agenda. In regards to gender, although UNICEF is credited for its focus on women and children, its profile on broader gender issues in relation to the response is less evident. More gender-transformative approaches are required to address some of the key challenges in PMTCT, including how gender dynamics and power relations interact with the risks of contracting HIV and the ability to access care among women. There is an opportunity for UNICEF to position itself more integrally in regards to this agenda – for example, by building on its success in pioneering innovative approaches through exploring models for involving men.

Though much has been accomplished, many countries still face enormous challenges to achieving targets, and the demands on UNICEF remain high.

With the support of UNICEF and partners, a number of countries have made substantial advances in the prevention, care and treatment of HIV among children. Mother-to-child transmission rates have declined rapidly through high coverage of ARV-based interventions for pregnant women, mothers and their exposed children. Progress has been uneven, however, and many countries and marginalized groups still lack access to services and PMTCT and paediatric treatment coverage remains low. The expectation is that UNICEF will intensify its support in these areas to address major programme gaps.

UNICEF has also struggled to address the second decade of life, as evidenced by high risk of HIV infection among adolescent girls and young women aged 15–24 years. The organization has not actively promoted the second prong of the PMTCT framework regarding sexual and reproductive health services for young women living with HIV. As a result, children continue to face exposure to HIV at high levels and the risk of the epidemic rebounding among children is real. While of course UNICEF cannot cover all bases, as the de facto United Nations country lead for HIV and children, the organization must advocate for and facilitate a strategic approach that is truly comprehensive and sustainable over the longer term.

RECOMMENDATIONS

1. Expand UNICEF's advocacy efforts to keep HIV prevention, care and treatment among children high on the global agenda.

2. Clearly define UNICEF's unique role and contribution to the HIV response in the post-2015 era, building on its comparative advantages.

3. Tailor HIV programming carefully to country needs, capitalizing on UNICEF's decentralized mode of operations and its focus on making a difference at the country level.

4. Take the lead on the mainstreaming agenda, demonstrating how HIV can be effectively linked with work in other key programmes and sectors.

5. Develop strategic approaches to keep HIV visible as a key corporate priority within UNICEF, across diverse organizational structures.

6. Consider making equity the focus of continued programme scale-up, while strengthening UNICEF's programming approaches to more explicitly address gender and human rights.

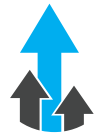
7. Clearly position UNICEF's work within existing partnership frameworks, which may need to be renegotiated or strengthened as required.

8. Invest effort in ensuring that the necessary funds for UNICEF's HIV response are mobilized.

The following recommendations will feed into the development of UNICEF's Strategic Plan 2018–2021. UNICEF's role should be defined in the context of the 2030 Agenda for Sustainable Development, the agreement of Member States to Fast-Track the response over the next five years and the new global targets and commitments: to ensure that 1.6 million children living with HIV access treatment by 2018 as part of the 90-90-90 treatment target and to eliminate new HIV infections among children by reducing new infections in every region by 95 per cent by 2020.[121,122]

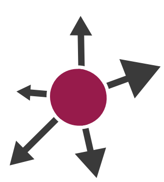
Recommendation 1: Expand UNICEF's advocacy efforts to keep HIV prevention, care and treatment among children high on the global agenda.

UNICEF should continue to leverage its unique position as the world's leading agency for children by strengthening its advocacy for addressing HIV among children as a key component of the sustainable development agenda. UNICEF's leadership and programme staff should make use of existing platforms and initiatives, such as the Secretary General's Global Strategy for Women's, Children's and Adolescents' Health 2016–2030 and the new Start Free, Stay Free, AIDS Free initiative led by UNAIDS and PEPFAR. At the global and regional levels, UNICEF should consider focused political advocacy efforts that engage the organization's high-level representatives in an effort to mobilize decision-makers, shift policies and raise funds for reaching global commitments. This requires utilizing UNICEF's capacity in strategic information to put forward clear evidence about HIV among children of all ages and the associated impacts on child and adolescent growth, development and survival, while clarifying the gaps and way forward. A communications strategy and materials that account for the current global context should be developed to increase momentum for addressing gaps related to HIV and children and raising UNICEF's visibility as a key player in the international development architecture in this regard.



Recommendation 2: Clearly define UNICEF's unique role and contribution to the HIV response in the post-2015 era, building on its comparative advantages.

UNICEF has already started an intensive process of reflection and planning to frame its future HIV work. The UNICEF HIV Section must take the opportunity to build on its comparative advantages and define its niche areas in line with its mandate on children's health and development, recognized leadership on child rights and equity issues, strong country presence, privileged access to government, civil society and development partners, experience across all key sectors and trusted technical expertise. In a context of constrained resources for its own HIV work, and given that other partners and countries are increasingly taking responsibility for HIV programming, UNICEF could seek to reduce some of its responsibilities for supporting implementation and related technical support and focus more attention on upstream policy issues. UNICEF is well placed to contribute to topical policy issues such as: clarifying the importance of integrating HIV within broader child health and development perspectives; planning for greater domestic contributions to programme budgets; and facilitating the inclusion of benefits for HIV-affected children in emerging national health insurance and social protection schemes. This will require the involvement of leadership at all levels of the organization, including country representatives, regional office directors and senior management in HQ, with support from technical staff across a range of programme areas. Such policy work would enable UNICEF to place its work on HIV firmly within its overall drive to improve outcomes for children, while retaining HIV as a visible and core component of its overall programme.



Recommendation 3: Tailor HIV programming carefully to country needs, capitalizing on UNICEF's decentralized mode of operations and its focus on making a difference at the country level.

In line with its global level advocacy, UNICEF's country level engagement should focus on advancing

---

[121] Resolution adopted by the United Nations General Assembly, 'Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030', A/RES/70/266, 8 June 2016.

[122] The 2016 Political Declaration on HIV and AIDS also includes regional targets.

the HIV and children agenda towards the new targets, especially in countries with continued high HIV incidence and prevalence among young women and children. Given the huge diversity of country situations – epidemiological, institutional and programmatic – and the uniqueness of each of UNICEF's country programmes, there is a clear need for selective and differentiated approaches. Specific HIV support should be tailored to country needs, while following the general principle of increasing attention on upstream policy issues and avoiding small, scattered investments that do not hold promise to break new ground and be taken to scale. In all instances, country offices should leverage UNICEF's strong presence in national decision-making and coordination forums to ensure that the needs of children affected by HIV and their families are fully considered in the development of key policies and strategies, across all sectors, as well as in evolving agendas. Regional offices and HQ can play a valuable role in guiding and supporting this prioritization process according to country contexts, identifying key policy and programme interventions that could be prioritized according to a typology based on HIV burden, programme coverage levels and other considerations.

Recommendation 4: Take the lead on the mainstreaming agenda, demonstrating how HIV can be effectively linked with work in other key programmes and sectors.

UNICEF is unique in terms of its high-level policy leadership and presence at the implementation level across key programmes and sectors. Its ability to 'connect the dots' represents a special asset and a tremendous opportunity in the sustainable development era. As a priority, UNICEF should continue to leverage linkages across HIV, health and nutrition, building on the A Promise Renewed initiative, to generate 'Double Dividends' for HIV and other results. Externally, UNICEF should seek to break down prevalent vertical approaches to planning and budgeting, foster policy dialogue across sectors and encourage linked approaches to service delivery. Another important step forward would be to forge stronger bridges between efforts on the first decade of life and those on the second decade – building on the 'All In' initiative and the Start Free, Stay Free, AIDS Free initiative – given the recognition that most HIV infections in adolescents were acquired in the early years of life and the huge HIV risks faced by adolescents, especially girls. This will also strengthen linkages between HIV, education and social protection sectors.

Recommendation 5: Develop strategic approaches to keep HIV visible as a key corporate priority within UNICEF, across diverse organizational structures.

UNICEF is expected to maintain HIV/AIDS as a corporate priority in its next strategic plan. However, given the organization's decentralized nature, the HIV/AIDS priority does not play out in the same way in all regional and country offices. With further reductions in UNICEF's financial and human resources for HIV/AIDS looming and other priorities taking over, it is important that UNICEF explore approaches to preserving capacity for critical HIV-specific actions while effectively mainstreaming HIV across different sectors. Internally, UNICEF should intensify its collaboration, joint planning and shared targets across programmes and sectors at all levels. Strategic and operational planning across the organization should take place with the understanding that HIV programming does not necessarily depend on the availability of HIV-specific funds but can move forward using other funding sources. For example, with the development and promotion of an integrated package of health and nutrition services (including HIV services for children). This will require that key staff competencies be built across country and regional offices and HQ to plan and manage the delivery of expected HIV results. Finally, leadership at every level should promote, facilitate and track changes. Guidance and support must be provided to all concerned staff, including those responsible for planning, to strengthen such joint planning, budgeting and accountability processes. Thought should be given to how to include HIV within cross-cutting functions. For example, in the area of knowledge management, the relevance and efficiency of UNICEF's considerable contributions should be maximized to build data and knowledge on HIV and children (among other issues) and develop an accessible database of UNICEF's participation in research activities and outputs that can be used for data-driven planning, monitoring and evaluation.

Recommendation 6: Consider making equity the focus of continued programme scale-up, while strengthening UNICEF's programming approaches to more explicitly address gender and human rights.

Equity has been the hallmark of UNICEF's work for many years and has been recognized as transformative when applied to issues such as health and education. The equity focus is a powerful way to keep children on the agenda, especially in regards to closing the treatment gap between adults and children and for intensifying efforts in countries, locations and populations that have made the least progress to date. Greater effort is needed to put equity at the centre of UNICEF's HIV and children response to guide programming in low-, middle- and even high-income countries and reverse the trend of rising inequities. The current dominant paradigm that requires targeting resources to address the largest coverage gaps in the areas of greatest need must be altered so that attention is also paid to reaching underserved populations, including those caught up in humanitarian disasters. The two objectives of achieving efficiency and equity are not incompatible,[123] and it is UNICEF's responsibility to make the case, with all key partners, including PEPFAR. This would also allow for greater consideration of broader human rights and gender issues, such as gender-based violence, stigma and discrimination, which threaten access to and uptake of services and remain at the core of the vulnerability of adolescent girls and boys to HIV. To accomplish this, UNICEF will need to ensure that staff working on HIV issues at every level have or can access the relevant expertise and capacities.

Recommendation 7: Clearly position UNICEF's work within existing partnership frameworks, which may need to be renegotiated or strengthened as required.

Recent shifts in global priorities have affected all United Nations agencies, including those working on HIV issues, leading to the need to define a new division of labour and negotiate new ways of working to maximize synergies and efficiencies. As an important corollary of the redefinition of its work priorities, UNICEF's HIV/AIDS teams at all levels (but especially in HQ) will need to strategically position themselves within a crowded institutional environment. They will need to clearly specify their own niche in HIV/AIDS, build strategic alliances with other partners, be attentive to reducing transaction costs and avoid duplication and transition project funding that is not tightly linked to identified corporate priorities. Existing partnerships, particularly with the Global Fund and PEPFAR, should be nurtured, both at the leadership and technical levels. A more formal partnership with PEPFAR should be sought, with an eye to harmonizing strategies and policies and facilitating action at the country level. New partnerships should also be explored, seeking to keep UNICEF positioned at the cutting edge of innovation and learning in the field. Partnerships with organizations working at the community level and CSOs may be particularly valuable in this regard.

Recommendation 8: Invest effort in ensuring that the necessary funds for UNICEF's HIV response are mobilized.

UNICEF needs to intensify its efforts at all levels to increase and diversify the resource base for its work on HIV/AIDS. More attention will need to be paid to non-traditional donors, given the difficulties involved in securing HIV resources in the past and the outlook for dwindling HIV resources in the future. Intensified discussions should take place between the HIV team and UNICEF's fundraising teams. At the country level, particularly in middle-income countries experiencing economic growth, new sources should be explored, including from the private sector. Building on the lessons learned in countries where this has been successful, specific guidance should be developed with case studies for encouraging and orienting country level staff. UNICEF will also have to consider how to use available resources as strategically and efficiently as possible to more fully explore new roles, spend less on implementation support and other areas where other partners are present and invest more in developing policy options and innovative programme solutions.

[123] United Nations Children's Fund, *Narrowing the Gaps to Meet the Goals*, UNICEF, September 2010.

ANNEXES

ANNEX A. EVALUATION TERMS OF REFERENCE

INTRODUCTION

UNICEF's Evaluation Office is commissioning an external evaluation of UNICEF's activity in the Prevention of Mother to Child HIV transmission and Paediatric HIV treatment, care and support. The evaluation is scheduled for implementation during 2016. This document outlines the scope of the evaluation, methodological options and operational modalities for an external evaluation team which will conduct the evaluation under the guidance of a Senior Evaluation Specialist in UNICEF's Evaluation Office. The team will have significant interaction with an Evaluation Reference Group which will be engaged in the evaluation process. The Evaluation Office seeks institutions and individuals with deep commitment and strong background in evaluation and relevant subject matter to undertake the evaluation which has major implications for UNICEF's future work and partnerships towards ending AIDS as a public health threat by 2030 (SDG 3.3).

BACKGROUND

Ending AIDS among children requires that all children are born and remain free of HIV for the first two decades of life, from birth through adolescence into adulthood. It also means that children and adolescents living with and affected by HIV have access to the treatment, care and support required for their good health and wellbeing.

Strengthening maternal, newborn and child health (MNCH) and integrating HIV services with MNCH platforms has been at the centre of UNICEF's efforts to eliminate new HIV infections in children, with an emphasis on expanding access to HIV testing and treatment access for pregnant and breastfeeding women living with HIV, making infant testing available to all HIV-exposed babies, and linking children living with HIV to treatment and care as early after infection as possible.

Since the launch of the global campaign 'Unite for Children, Unite against AIDS' in 2005, UNICEF has played a leading role, by galvanizing global commitment, action, and resources to mount a comprehensive response to HIV among children. The campaign had multiple objectives, including two that were operationalized in two of the four pillars of the AIDS response in UNICEF's 2005-2013 strategic plan, namely a) PMTCT and b) Paediatric HIV Treatment and Care.

Today, protecting children from HIV infection is one of seven corporate priority areas in UNICEF's 2014-17 Strategic Plan. UNICEF is working with partners the world over to help low- and middle-income countries scale up effective and efficient programmes to eliminate new HIV infections among children, provide HIV treatment to children and their families living with HIV, prevent and treat new infections among adolescents, provide protection, care and support to families affected by HIV and enable HIV services to affected children and their families during emergencies.

UNICEF's programming efforts in the first decade of a child's life focus on infants and children under five, pregnant women and mothers. These efforts are in line with the Global Plan strategy and targets towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. First Decade efforts also contribute to A Promise Renewed (APR), the Child Survival Call to Action movement to end preventable child deaths.

Eliminating HIV transmission from mother to child remains a global commitment in the post 2015 agenda. By adopting the SDGs, the global community dedicated to ending the HIV epidemic by 2030. This objective will be reach throughout the Target 3.3 of SDG 3, which focuses on universal health care (UHC).

The UNAIDS Strategy (2016-2021) outlines the fact that an approach in which "*the international community must urgently sustain and strengthen efforts to ensure all children can live free of HIV and keep mothers alive and well. Integrating services for elimination of mother-to-child HIV transmission into ante- and post-natal care will make services routinely available*". Guided by the UNAIDS Strategy and as part of a coordinated and cohesive UN response to HIV/AIDS, UNICEF is looking to amplify the integration of HIV/AIDS related services into large-scale routine services (e.g. integrating Paediatric AIDS care and treatment into child survival programmes). In this context, the evaluation comes at an important juncture in which available evidence and documentation can be consolidated and extended as needed. As part of this process, gaps and challenges can be identified for attention as UNICEF moves into the next phase of integrated programming.

PURPOSE AND OBJECTIVES OF THE EVALUATION

PURPOSE

The purpose of this evaluation is to support accountability and learning in relation to UNICEF's efforts to scale up PMTCT and Paediatric care and treatment programmes and to document its contribution towards elimination of mother to child HIV transmission and an AIDS-free generation for children. By looking over the past ten years of UNICEF's PMTCT and Paediatric HIV engagement, the evaluation will provide evidence and lessons learnt to enhance the understanding of the organization and other stakeholders on how strategies and programmes have evolved, what has worked, has not worked, and why; and to be able to employ these lessons to shape UNICEF's work in the post-2015 era.

The findings will be used to inform UNICEF participation in the United National General Assembly High Level Meeting on HIV which will be held in June 2016. In addition, the products of this evaluation will be present in various international events such as the upcoming International AIDS conference in (July 2016).

OBJECTIVES

The objectives of the evaluation are twofold:

1. To contribute to improving the organization's **accountability** for its performance and results by defining key achievements as well as missed opportunities in UNICEF's engagement with partners and countries in support of improved PMTCT/Paediatric outcomes over the past decade; and
2. To generate evidence and **learning** to guide i) effective action towards the achievement of the UNICEF strategic plan HIV outcome and ii) UNICEF positioning in the post 2015 agenda HIV agenda as guided by the UNAIDS 2016-2021 strategy.

The findings and recommendations generated by the evaluation will be used to influence strategic direction and partnerships/advocacy as well as programme strategies (sectoral and cross-cutting) to achieve the results and targets outlined in the Strategic Plan. In addition, the evaluation will provide smart recommendations on how UNICEF can best position the PMTCT and Paediatric programme vis-à-vis the UNAIDS Strategy and the 2030 Agenda for Sustainable Development. It is expected that the results will be of broad interest to the HIV-AIDS global community, including UNICEF's partners at all levels. UNICEF sections and offices at all levels (HQ, Regional and Country Offices) constitute an important audience as the evaluation will provide evidence on what works and why.

More precisely stated sub-objectives are contained in the Evaluation matrix that is presented later in this document.

SCOPE AND EVALUATION QUESTIONS

SCOPE

The evaluation will cover UNICEF PMTCT and Paediatric HIV care and support programmes and will examine organization engagement at global, regional, and country levels. While UNICEF's HIV response is known to be comprehensive, the evaluation will focus on the following.

Programmatic focus: The evaluation will assess four particular aspects of PMTCT and Paediatric HIV treatment programming:

1. **Thematic leadership, advocacy and partnership:** the ability to foster or to be effective within partnerships by leveraging corporate knowledge and assets to become a trusted advisor for donors, national governments, and other global and national stakeholders; the ability to influence global, regional, national PMTCT and Paediatric HIV agendas over time.
2. **Resource mobilization:** the ability to generate the required funds for PMTCT programmes and projects that UNICEF supports across levels; the ability to leverage major funders' resources to achieve UNICEF's strategic priorities; to be an effective support to governments attempting to access PMTCT and Paediatric HIV funds; and helping foster an adequate global resource base for these programme areas.
3. **Strategic information, knowledge generation and dissemination:** the contribution to global and national policies and strategies through evidence generated by UNICEF and partner supported research and programming as well as through its global data, estimation and progress reporting; and the translation of global policies and evidence into national plans, operational guidance and tools.

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

Within these four aspects of PMTCT and Paediatric AIDS programming, the evaluation will pay particular attention to three cross cutting issues:

1. Gender: gender inequality heightens the vulnerability of women and girls to HIV infection, particularly where access to age-appropriate HIV information as well as reproductive health services necessary to prevent HIV infection are unavailable or inaccessible, or where levels of sexual violence are high. It has also been demonstrated that male involvement to PMTCT services can enhance HIV testing and retention on treatment.
2. Child rights and HIV are closely linked. A lack of respect for human rights fuels the spread of HIV and exacerbates the impact of the epidemic on children and families.
3. Equity: promoting equity in service access and utilization for the most disadvantaged and excluded children is at the heart of UNICEF's work. Various factors such as geographic location, gender inequality, economic status, social and cultural norms have contributed to enduring disparities in the PMTCT response.

Institutional focus: the evaluation will focus on the UNICEF PMTCT and Paediatric care and treatment programme response. However, UNICEF accomplishes its mandate by building strategic and operational partnerships and leveraging resources at all levels. In addition, through its convening role in PMTCT and Paediatric HIV, UNICEF engages in joint planning, technical assistance, advocacy and field visits with partners. The evaluation must account for these dynamics while assessing UNICEF's contribution to global outcomes.

Geographic focus: the evaluation will assess the UNICEF PMTCT and Paediatric care and treatment programme response at global, regional and country level, both in development and humanitarian settings.

Time frame: the evaluation uses a ten year perspective in order to trace the evolution of thinking, strategies, policies, approaches, and resources over the course of 10 years. Specifically, it is important to examine key decision points and choices made over the decade in order to understand how well UNICEF and partners influence, learn and react, as well as to understand the basis of present choices. This ten year perspective is to be applied to all the key questions, including but not limited to changes in PMTCT policies, program guidance, therapy protocols, and global and national funding mechanisms.

OECD-DAC Criteria: Evaluation questions will be framed by standard evaluation criteria formulated by the OECD-DAC. Those to be used are relevance, effectiveness, efficiency, and sustainability. The evaluation will not attempt to assess the impact of the PMTCT programming on issues of mortality, cases averted, or indirect outcomes like education enrollment. It is known that there is insufficient data and that the multiplicity of contributing factors makes it impossible to isolate the effect of UNICEF or the strategies it has supported.

Also, the evaluation will not cover epidemiologic and service delivery aspects as these are addressed through publications done by UNICEF and other stakeholders on these topics.

EVALUATION QUESTIONS

As indicated above, the evaluation will apply the DAC criteria relevance, effectiveness, efficiency and sustainability to the four selected themes and the three cross cuttings issues: gender, human rights and equity.

A provisional set of evaluation questions appear in Annex 1 of the ToR.

EVALUATION METHODOLOGY

EVALUATION DESIGN: CONCEPTUAL AND ANALYTICAL APPROACH

The proposed methodology is based on internal scoping and experience in designing similar evaluations. There will be a need to develop a detailed design, analytical methods and tools during the inception phase based on key informant interviews and document review.

Methods: The evaluation will use a Theory of Change approach (ToC) that will essentially trace the resources programmed, the actions taken and results achieved against those anticipated in the relevant strategic plans. Programme theory on how PMTCT could be achieved and Paediatric AIDS combatted has been expressed in an explicit ToC for the present Strategic Plan (2014-2017) and implied for the previous strategic plan (MTSP 2009-2013). Therefore a reconstructed ToC will be needed which encompasses UNICEF's PMTCT and Paediatric AIDS response since 2005. The theory of change will enable analysis of desired outcomes and the outputs associated with those outcomes; examine resources available and activities implemented to produce these outputs; review the underlying assumptions and contextual factors that may have effected UNICEF's HIV activities; and clarify any opportunities and challenges to deliver desired outcomes.

The evaluation will employ a mix of qualitative and quantitative data and analytical methods. Quantitative methods will involve trends analysis that retrace the evolution of the global PMTCT/ Paediatric programming context including changes that occurred in resources, policies, strategies, guidance, etc. to assess whether and how UNICEF's response adapted to an evolving context. Qualitative methods will gather data from key informants and stakeholders for in-depth analysis and triangulation purposes. Documentation and secondary data generated over the period will be reviewed using structured methods.

The evaluation will also utilize a case study approach with a basis in the theory of change described above. The aim of the case studies will be to use a relatively intensive analysis of a small number of cases in order to understand a broader picture. The case studies, as linked to the ToC, will help to illuminate aspects most critical to the achievement of the intended outputs and outcomes as well as test the validity of the ToC. It is expected that the bidder will propose four case studies, justify the basis for selection and describe the methodology they intend to use. The approach will be further discussed and developed during the inception phase at which time methods and specific subjects will be agreed upon.

Two types of questions will be posed within the evaluation, and the evaluators must be capable of dealing with each. Some will be descriptive questions. Successful responses will involve well organized narratives about the visible and less visible facts of PMTCT programming and Paediatric AIDS. The consultants' ability to digest and streamline a wide range of material will be paramount. There will also be normative questions. Successful responses will require the application of explicit and defensible criteria for weighing evidence to identify what has worked or not, and why. For all normative questions, the evaluators will need to be clear on what is to be considered as a "good" standard and what is to be considered as a "poor" or "not met" standard.

Data sources: The HIV programme, in collaboration with other partners, has developed a robust monitoring system over the past 10 years in order to collect PMTCT and Paediatric HIV programme process, outcome and impact data. Internally, UNICEF specific inputs and outputs are also monitored on a regular basis allowing for their use in making reliable judgments. UNICEF country and regional programme documents, annual and progress reports as well as other internal materials will be available for use.

Additional data will be required to complement programme data and for triangulation purposes. It will be important to talk to key decision-takers and implementers at different levels. No original data gathering is anticipated beyond a potential survey of stakeholders, and a limited number of country visits to review documentation and speak to key informants.

The evaluation will be implemented through the four major following phases:

Phase 1: Scoping and Inception Phase (January – February 2016) – During the first phase of the evaluation, the Evaluation Team will conduct a rapid desk review of key qualitative and quantitative data and critical information available from country and regional offices and HQ as well as documents, data and reports from other stakeholders. Interviews with key informants at UNICEF HQ and external stakeholders will be conducted to provide orientation. Documents will be accessible in a team site link.

This phase of work will include the development of a Theory of Change for the PMTCT and Paediatric care and support programmes which will be used to guide the evaluations. A detailed evaluation methodology including an evaluation framework will be developed. Selection of cases for the case study elements of the evaluation will be finalized during this phase. The main output of the scoping and inception phase will be an Inception Report (inclusive of evaluation tools and templates), to be approved by the Evaluation Office in consultation with an Evaluation Reference Group (see section on Management and Governance Arrangements below).

Phase 2: Structured Field Work (February - April 2016) – In the second phase, the evaluation team will visit selected countries as well as Regional Offices to collect further qualitative and quantitative data in a structured manner.

A key part of the technical proposal will be an explanation of what the consulting team would accomplish during the country visit, including indication of the type of key informants to be sought and methods to be employ. The technical proposal must indicate how long a visit should be and why that duration is recommended. It can be assumed that regional and country offices will assist with arranging the visits, identifying respondents, gathering documentations etc.

Bidders may propose and justify other data collection methods in the proposal. However, we anticipate that the methods mentioned above (review of documents and secondary data from HQ as well as that gathered in the field; in-depth and light touch case studies; and key informant and stakeholder interviews) will largely encompass the needed data collection techniques.

The evaluation team will provide a de-briefing document (e..g.. PowerPoint presentation of observations and preliminary findings) with UNICEF offices visited prior to departure from the country.

Phase 3: Analysis and Report Preparation (April-June 2016) – This phase of the evaluation will include the preparation of a final report, based on systematic, impartial analysis of the information gathered in Phases 1 and 2. The expected output will be a concise synthesis report presenting findings, conclusions, lessons learnt and sound recommendations. The final report shall contain an executive summary of up to 5 pages written in English and French, and a main text of no more than 50 pages written in English (excluding executive summaries and Annexes).

Two rounds of review are anticipated for the final report. An early draft will be reviewed and comments provided by the Evaluation Office for further revision. Subsequently, a second draft will be submitted for review and commentary by the Reference Group.

Phase 4: Dissemination (July 2016) – The Evaluation Office and Evaluation Reference Group will develop a dissemination plan for the evaluation. This will include the provision of a management response which is mandatory for such evaluations. The evaluation team will be invited to present findings in a major dissemination workshop which will be organized after the completion of the evaluation.

MANAGEMENT AND CONDUCT OF THE EVALUATION

EVALUATION MANAGEMENT STRUCTURE

The evaluation will be conducted by an external evaluation team to be recruited by UNICEF's Evaluation Office (EO). The Evaluation Team will operate under the supervision of a dual-tiered evaluation management and oversight structure. Direct supervision will be provided by an Evaluation Specialist in the EO, working with the support and oversight of a Senior Evaluation Specialist. The Evaluation Office will be responsible for the day-to-day oversight and management of the evaluation including contracts and budgeting. It will assure the quality and independence of the evaluation and guarantee its alignment with UNEG Norms and Standards and Ethical Guidelines, provide quality assurance checking that the evaluation findings and conclusions are relevant and recommendations are implementable, and contribute to the dissemination of the evaluation findings and follow-up on the management response.

The advisory organ for the evaluation is the Evaluation Reference Group (ERG) which brings together a mix of UNICEF managers, advisors and external experts (to be confirmed) from among the key stakeholders. The ERG will be chaired by a senior Evaluation Specialist who will have the following role: a) contribute to the conceptualization, preparation, and design of the evaluation including providing feedback on the draft terms of reference, feedback and comments on the Inception Report and on the technical quality of the work of the consultants; b) provide comments and substantive feedback to ensure the quality – from a technical point of view - of the draft and final evaluation reports; c) assist in identifying UNICEF staff and external stakeholders to be consulted during the evaluation process; d) participate in review meetings organized by the EO and with the evaluation team as required; e) play a key role in learning and knowledge sharing from the evaluation results, contributing to disseminating the findings of the evaluation and follow-up on the implementation of the management response.

EVALUATION TEAM PROFILE

The evaluation will be conducted by engaging a committed and well-qualified team which possesses evaluation as well PMTCT and Paediatric AIDS subject matter expertise and related competencies required for a global evaluation. The team is expected to be balanced in terms of gender and geographic origin.

It is also envisaged that bidders propose a team with a complementary expertise, by justifying the size and the expertise to meet the evaluation requirement. We anticipate that the team leader will have the following expertise:

A TEAM LEADER WITH THE FOLLOWING CREDENTIALS:

- Strong team leadership and management track record and commitment to delivering timely and high-quality reports
- Extensive evaluation expertise (at least 15 years) of comprehensive scope with strong mixed-methods evaluation skills and flexibility in

using non-traditional and innovative evaluation methods

- Demonstrated experience within an evaluation in reconstructing decisions and program evolution over a 10-12 year period
- Familiarity with UNICEF's programming, policy and advocacy work and experience in evaluating multi-sectoral initiatives would be an asset
- Background in public health, HIV/AIDS including sound knowledge of policy and system aspects; familiarity with others sectors, namely health, education and social protection;
- Good interpersonal and communication skills; ability to interact with various stakeholders and to concisely express ideas and concepts in written and oral form
- Knowledge of the UN's human rights, gender equality and equity agendas and experience in applying these to evaluation
- Language proficiency: Fluency in English is mandatory; good command of French is desirable

The team leader will work on the evaluation full time from start to finish, and in a timely and high-quality manner. S/He will be responsible for managing and leading the evaluation team, undertaking information collection (through both interviews and documentation) from UNICEF and other sources, conducting analysis, drafting and finalizing the report and dissemination. The other team members will be responsible for carrying out information collection from UNICEF and other sources, analysis, and drafting elements of the report. A gender balanced team is encouraged in addition to the following expertise:

- Significant experience in evaluation and/or policy research with background in public health and HIV/AIDS or other areas relevant undertake PMTCT/Paediatric AIDS evaluation (at least 10 years relevant experience)
- Experience in evaluating multi-sectoral programmes or initiatives
- Ability to reconstructing decisions and program evolution over a 10-12 year period
- Strong conceptualization, analytical and writing skills and ability to work effectively in a team
- Hands-on experience in collecting and analyzing quantitative and qualitative data
- Knowledge of the UN's human rights, gender equality and equity agendas and application in evaluation
- Commitment and willingness to work in a challenging environment and ability to produce quality work under limited guidance and supervision
- Good communication and people skills; ability to communicate with various stakeholders and to express ideas and concepts concisely and clearly in written and oral form
- Language proficiency: Fluency in English is mandatory; good command of French is desirable
- Expertise in handling collaborate teamwork software, online surveys, document repositories, bibliography software and databases
- Commitment to handling back-office support and logistics as needed

The technical proposal should reflect a sound composition of the evaluation team, the appropriate number, and their complementarity to meet the evaluation requirement.

EVALUATION PHASES AND DELIVERABLES

INCEPTION PHASE

A detailed evaluation methodology including a detailed evaluation framework will be developed based on further consultation, document review and exploration of possible approaches that will yield credible and timely evidence. The Inception Report will:

- Present the final set of evaluation questions and sub-questions within the proposed scope of the evaluation
- Specify the detailed design of the evaluation, the tools that will be used for data collection and the analytical methods that will be used to respond to the evaluation questions
- Articulate an approach for reconstructing decisions and programme evolution over a ten year period
- Detail the framework for analyzing and synthesizing data collected from various sources including use of triangulation
- Elaborate a Theory of Change which will underpin the evaluation
- Confirm and provide rationale for the selection of cases for study and formulate precise specifications of the scope and design of case

studies (including data collection methods and analysis)
- Present a detailed work plan, specifying the organization and time schedule for the evaluation process including country visits, analysis and report preparation
- Present the approach to be used for quality assurance throughout the evaluation including of the country case study reports

The deliverable for this phase will be an Inception Report with a summary and annexes. The Inception Report will provide the agreed foundation for the conduct of the remainder of the evaluation. Accordingly, the evaluation will proceed to the next phase only after successful completion of the inception phase and approval of the Inception Report.

DATA COLLECTION AND ANALYSIS PHASE

Data collection will start as part of the inception phase and continue through the field visits, case study data collection, and interviews with various stakeholders. Detailed data collection and analysis plans will need to be developed for the desk review report, the case study reports and the synthesis report. Secondary data from various surveys and reports will constitute a key data source for the evaluation. Field visits will be planned systematically in consultation with UNICEF regional and country office counterparts. Briefing and debriefing meetings will be held with each of UNICEF country offices, with the participation of national counterparts.

Key deliverables for this phase will be de-briefing materials from each country visited and drafts of the case study reports for review and comment.

FINAL DATA ANALYSIS AND REPORTING PHASE

Evaluation findings are expected to be firmly substantiated by the methodologies described above (i.e. document review, interviews and case studies). Bidders should describe their proposed methodologies for the analysis and synthesis of source data.

A zero draft of the synthesis report will be provided for consideration and comment by the Evaluation Manager. A draft synthesis report will be prepared, addressing any comments made on the zero draft. The draft synthesis report will be presented to the ERG for comments. The final synthesis report will be prepared, responding to comments provided on the draft report.

The final deliverable from this phase includes a detailed summary of evaluation findings, conclusions and recommendations which appear in both a PowerPoint presentation and the final evaluation report with an executive summary and annexes.

DISSEMINATION AND FOLLOW-UP PHASE

The EO and the ERG will develop a dissemination plan for the evaluation. This will include the provision of a management response which is mandatory for such evaluations. The evaluation team will be invited to present findings in a major dissemination workshop which will be organized after the completion of the evaluation.

A key event for the dissemination of the evaluation findings is the dedicated UN General Assembly High Level Panel meeting on HIV which will be held in June 2016. Therefore, the evaluation team should anticipate that preliminary evaluation findings and recommendations will be requested as input for UNICEF's participation.

EVALUATION BUDGET AND TIMING

The evaluation is part of the EO's Annual Work Plans for 2015/16 and required funds have been allocated as part of the EO's budget. The implementation of the evaluation is expected to follow the following time schedule.

Date	Milestone
October 2015	Finalization of the Terms of Reference;
November 2015	Issuance of Request for Proposals to selected firms (with four weeks for submission of proposals)
December 2015	Selection and contracting of evaluation team
January- February 2016	Inception phase; report finalized by mid-February
February-April 2016	Field missions
April-June 2016	Analysis and drafting of the evaluation synthesis report
June 2016	Draft review and revision
Mid July 2016	Final report submission

TO BE READ WITH RFPS

A. We estimate that the evaluation can be duly executed by a team of evaluators/consultants constituting an appropriate mix of needed skills and expertise. Bidders may propose teams of varying size with justification for allocation of work and cost. At country level, the bidder might want to partner with a local institution with a good knowledge of the country context to conduct case studies.

To that end, this contract will be offered under institutional arrangements. This section presents guidelines for submission.

B. Background Information: Bidders are required to provide background information about their institutions as follows:

- Date and country of incorporation
- Summary of corporate structure and business areas
- Corporate directions and experience
- Location of offices or agents relevant to this proposal
- Number and type of employees
- Financial statements of the two most recent financial years

C. Institutional expertise and experience: Bidders are required to provide a minimum of two (2) references from clients for whom evaluations, or related projects of a similar scope of were carried out. Reference information should be organized as follows:

- Name and description of client company/ organization
- Names of senior individuals in the client companies who were involved in projects (referred to) who are knowledgeable
- Scope and scale of projects
- Services provided to client UNICEF may contact referees for feedback on services provided to them by bidders.

D. The bidder should submit at least two sample reports of evaluations undertaken by the team leader (or links where the reports can be found on the internet). Preferably, these evaluations should be evaluations undertaken in a large scale emergency context.

E. **Technical Proposal - General issues:**

- The technical proposal should emphasize the conceptual thinking and methods proposed for the evaluation, and minimize repeating information stated in this TOR document.
- The technical proposal should describe proposed approaches to reconstruct decisions and program evolution over a 10-12 year period.
- The methodology should stipulate, as clearly as possible, questions that will be explored at the different levels, global, regional and country level. The methodology should also present the mix of qualitative and quantitative analysis to be used.
- The bidders must demonstrate their capacity to conduct the proposed case studies or the rationale of partnering with others institutions or experts to conduct them.
- There is no minimum or maximum length for the technical proposal. However, sufficient detail and clarity are required.
- The proposal should stipulate the level of effort to be committed by the different team members in each work phase (inception, document review, field-based data collection, analysis and reporting). The same information should be featured in the financial proposal, associated cost data. Bidders may be asked to provide additional information at the proposal assessment stage.
- The technical proposal should state what ethical issues the team has seen in the TOR and how their methods will deal with them. This should include a description of the ethics review processes they propose to use.

F. **Technical Proposal - Specific requirements:** In addition to whatever other approaches and methods are proposed, the following specific items must be present in the technical proposal:

- The methodology section should include a description of key components including an approach for development of a Theory of Change, field-based data collection and incorporation of secondary data, an approach for the use of evaluation criteria for normative questions; and methods for the analysis and synthesis of data from multiple sources
- The rationale for selection of the four cases and methodology to be used should be clearly described in the technical proposal

- CVs for team members, highlighting experiences that are relevant to the evaluation under consideration
- Basic information about the organization submitting the bid including, the organization's evaluation profile, highlighting the organization's experience with the UN and UNICEF;
- Requirements and /or assurances (e.g. non-use of child labor) must also accompany the submission package; and
- A declaration for intended participation of any former UNICEF staff

G. While all contents of the technical proposal are important, special attention will be paid to the composition and strength of the proposed evaluation team, and the rigor of the proposed methodology and work plan. These two elements account for 70 percent of the points awarded for the technical proposal as indicated of the RFPS document. The proposer's capacity and sample report will account for the remaining 30 percent

H. **Cost Proposal - General issues**

- Bidders must submit a firm-fixed price bid, in US Dollars
- The quotation will not subject to revision unless officially invited to re-submit by UNICEF
- All prices/rates quoted must be exclusive of all taxes as UNICEF is a tax-exempt organization
- Bidders will suggest a payment schedule, linked unambiguously to contract milestones
- Invoicing and payment will be effected by bank transfer, in US Dollars

BUDGET CATEGORIES AND DETAILS

I. The budget should be presented in three categories: personnel costs, project costs, and overhead costs (in the case of institutional submissions). Sub-headings within the categories may be done at bidder's discretion.

- Personnel Costs: These should include classification (i.e. job title/function) and rates for team members; duration of work for each. This information may be contained within a table showing expected level of effort per team member, by phase. The level of effort must be visible in both the technical and the financial proposals, albeit without associated cost in the technical proposal.
- Evaluation costs: These should include cost of travel, including subsistence allowances, travel by air, train, road, etc., telecommunication and miscellaneous expenses. Travel to selected destinations will be on a cost-reimbursable basis. This is the sole budget component that will be charged this way; other elements will be firm-fixed price. Travel costs and subsistence rates (lodging, food, local transport, and incidentals) will be based on the lower of the rates proposed by the bidder, or the official and prevailing United Nations rates. Bidders are encouraged to submit economical travel and subsistence costs.
- Overhead costs: In the case of institutional contracts, general and administrative costs should include institutional overhead and fee/profit over and above overhead. Otherwise, the cost proposal must include detailed item-wise quotations, based on the terms of reference and other relevant documents.

Experience has shown that bidders often submit data using their own cost rubrics and not according to the three categories described next. This is acceptable, as long as the proposed clustering into the three headings is reflected in the cost summary.

J. **Specific requirements:** In addition to whatever other approaches and methods are proposed, the following specific items must be present in the cost proposal:

- Presentation of a work plan in four work phases (inception, document review, field-based data collection and reporting)
- The level of effort for all team members as was reflected in technical proposal, repeated in the financial proposal with costs. All costs will be fixed, except for travel to selected destinations, which will be on a cost-reimbursable basis.

A payment schedule, linked unambiguously to contract milestones.

AWARDING THE CONTRACT AND PAYMENT

K. UNICEF will award the contract after considering both technical and cost factors, on the principle of best value-for-money. Payment will be made only upon UNICEF's acceptance of the work performed in accordance with agreed schedule of payment and/or contract milestones. The terms of payment **are net 30 days, after receipt of invoice and acceptance of work**. Where the need arises, earlier payment may be negotiated between UNICEF and the contracted institution, on the terms indicated in the RFPS.

Evaluation Matrix:

Evaluation Themes	Evaluation Objectives	Key components / Evaluation criteria	Illustrative evaluation questions
Thematic leadership, advocacy and partnership	Under the leadership, advocacy and partnership, the evaluation will seek to assess: • UNICEF's comparative advantage and added value of its role in leading and convening the PMTCT /Paediatric AIDS vis a vis other others stakeholders including UN agencies (i.e. UNAIDS Unified Budget, Results and Accountability Plan) • Effectiveness of UNICEF's ability to advocate and leverage appropriate partnerships to galvanize the global community toward eliminating mother to child HIV transmission • Strengths and weaknesses of mechanisms in place to support appropriate approaches to joint advocacy programming, management, planning, monitoring and evaluation (e.g. the 3 Ones)	Thematic leadership, advocacy and partnership will be gauged against the following: • The **relevance** of UNICEF's leadership role for PMTCT/ paediatric AIDS vis a vis its own strategic priorities as well as others stakeholders including UN agencies • The **effectiveness** of UNICEF advocacy to galvanize the global community towards eliminating MTCT • The **effectiveness and efficiency** of UNICEF's efforts to leverage partnerships at global, regional and country level to support national PMTCT/Paediatric programmes in reaching their intended results as well as the global eMTCT targets • The **effectiveness** (Strengths and weaknesses) of mechanisms put in place to ensure an appropriate approach to joint advocacy programming, technical assistance, management, planning, monitoring and evaluation	• To what extent does UNICEF have a comparative advantage and demonstrate added value in taking a leadership role in PMTCT/ Paediatric forums vis-a-vis others players? **Relevance** • To what extent does UNICEF's leadership role in PMTCT/ Paediatric forums contribute to the achievement of its strategic priorities? **Relevance** • How does UNICEF view its leadership priorities? How does it view its role and focus? Do these views vary across the organization? Is there coherence in its leadership vision? **Relevance** • What is the return on investments in the areas of advocacy and partnerships? To what extent do these efforts "pay off" in a tangible manner? **Efficiency** • To what extent have UNICEF's advocacy efforts led to increasers or changes in global commitment and awareness to eliminating mother to child HIV transmission and to accelerating access to paediatricPaediatric AIDS treatment? **Effectiveness** • What trade-offs were made to ensure that partnership arrangements work as intended and to what risks were involved? **Effectiveness** • To what extent have these partnerships helped national PMTCT/Paediatric programmes achieve their national goals and targets? To what extent have partnerships contributed to the achievement of global PMTCT targets? **Effectiveness** • To what extent has UNICEF contributed to the building of national systems? How have focus on achieving goals been balanced with the drawbacks of vertical programmes? **Effectiveness**

Evaluation Themes	Evaluation Objectives	Key components / Evaluation criteria	Illustrative evaluation questions
UNICEF organizational structure	Under the organizational structure theme, the evaluation seeks to assess: • UNICEF's role and responsibilities in PMTCT and Paediatric HIV care across levels: global, regional and country and the degree to which there is coherence in its approach to PMTCT and Paediatric HIV care programs ("fit for purpose") • Comparative advantages that may arise from UNICEF's mandate, structures and resources and recommendations on how to make full use of any comparative advantage	Organizational structure will be gauged against the following: • The **relevance** of UNICEF actions in terms of the coherence and coordination across organizational structures to achieve the goals of UNICEF Strategic Plan (2014-2017) as well as the Global Plan for elimination of maternal to child transmission • The **efficiency** with which UNICEF produces results (at output level) in relation to investment of resources, both human and financial, across organizational levels and makes program decisions informed by value for money considerations • The **effectiveness** of UNICEF organizational policies, procedures and practices as factors influencing progress towards/achievement of its intended goals • The **sustainability** of country-led PMTCT and Paediatric care programs resources and results as related to UNICEF's efforts at global, regional and country levels	• How has UNICEF organized internally to address PMTCT and Paediatric AIDS? **Relevance** • To what extent has UNICEF utilized its structures and resources across levels in a coordinated manner to achieve its intended results as per the Strategic Plan and Global Plan for elimination? **Relevance** • To what extent are there gaps, overlaps and/or missed opportunities in programming that arise from UNICEF's organization structure? **Relevance** • To what extent has UNICEF capitalized on its structures and presence between sectors to achieve its intended results as per the Strategic Plan and Global Plan for elimination? **Relevance** • To what extent are there comparative advantages based on UNICEF's mandate, structures and resource? To what extent that there are such advantages, has UNICEF leveraged them fully in in pursuit of its intended results? **Relevance** • To what extent does UNICEF's global, regional and country-level programs pursue and attain output-level results through the least costly means? **Efficiency** • To what extent are intended results being attained? At country level? regional level? global level? **Effectiveness** • To what extent have UNICEF's mandate, structures and resources contributed to sustainable country-led PMTCT and paediatric care programs? **Sustainability**

Evaluation Themes	Evaluation Objectives	Key components / Evaluation criteria	Illustrative evaluation questions
Resource mobilization	Under the resource mobilization theme, the evaluation seeks to assess: • UNICEF's effectiveness in securing sufficient financial resources for PMTCT and paediatric programmes internally • UNICEF's role in supporting governments to allocate domestic resources and to access external HIV funds for national programmes • the extent to which relevant mechanisms created and put in place to ensure sustainable funds for PMTCT and Paediatric AIDS programmes	Resource mobilization will be gauged against the following: • The **relevance** of UNICEF approaches in resource mobilization in relation to country context, Global Plan goals and targets, and its own organizational advantages • The **efficiency** of UNICEF efforts in mobilizing resources and value for money considerations in program choices • The **effectiveness** of UNICEF resource mobilization efforts in terms of supporting countries to increase domestic spending and access external resources, and meeting Global Plan goals and targets; • The **sustainability** of resources for PMTCT and Paediatric AIDS based on country capacities to predict, plan and budget for at scale program implementation	• To what extent has UNICEF supported national governments to leverage funds, both domestic and external, in a manner consistent with country context (e.g. middle-income, low-income)? **Relevance** • To what extent has UNICEF capitalized on inter-sectoral linkages to bolster resources for PMTCT and paediatric AIDS (e.g. social protection, education, health)? **Relevance** • To what extent do UNICEF's resource mobilization efforts garner funds relative to the investment of time and resources? **Efficiency** • To what extent is value for money considered in decision-making? **Efficiency** • To what extent has UNICEF supported the development of costed national plans for the elimination of MTCT in the 22 priority countries? How has UNICEF addressed issues of program funding for PMTCT and Paediatric AIDS in other countries? **Effectiveness** • To what extent has UNICEF provided effective support for countries to access funds for PMTCT and Paediatric AIDS programs from other sources (e.g. Global Fund)? **Effectiveness** • To what extent have the resource mobilization goals of the Global Plan been achieved? **Effectiveness** • To what extent has UNICEF incorporated sustainability considerations in its work at country, regional and global levels? **Sustainability**

Evaluation Themes	Evaluation Objectives	Key components / Evaluation criteria	Illustrative evaluation questions
Strategic information, knowledge generation and dissemination	Under the resource mobilization theme, the evaluation seeks to assess: • the adequacy and the effectiveness of UNICEF's PMTCT/Paediatric AIDS knowledge management systems and its ability to generate, collect and disseminate strategic information and knowledge to improve programme performance and accountability	Strategic information, knowledge generation and dissemination will be gauged against the following: • The **relevance** of UNICEF efforts in strategic information, knowledge management and dissemination in relation to country needs and global priorities • The **relevance** of UNICEF efforts in strategic information, knowledge management and dissemination in relation to organizational capacity and its own strategic priorities • The **efficiency** of UNICEF efforts in strategic information, knowledge management and dissemination in terms investments made and benefits derived • The **effectiveness** of UNICEF strategic information, knowledge management and dissemination in terms of supporting countries to adopt effective treatment and prevention strategies • The **sustainability** of strategic information, knowledge management and dissemination activities based on country capacities to identify gaps, prioritize information needs, generate information and act on it accordingly	• To what extent has UNICEF identified and addressed priority needs for SI/KM products and services in support of national PMTCT/Paediatric programmes? **Relevance** • To what extent UNICEF has utilized evidence from trials/ pilot tests interventions to inform scaling up of proven effective approaches? **Effectiveness** • Has UNICEF facilitated learning and knowledge sharing between partners and national counterparts to inform adoption and scaling up of proven effective approaches? **Effectiveness** • To what extent has UNICEF translated global policies and strategies through user friendly platforms and tools for use in national PMTCT/Paediatric programmes? **Effectiveness** • To what extent has UNICEF strengthened national M&E capacity? To what extent have these efforts strengthened countries' ability to focus on issues of equity? To what extent have these efforts strengthened countries' ability to generate and use data for accountability and learning for PMTCT/Paediatric programmes? **Sustainability**
Cross-cutting	• To assess the relevance, effectiveness and efficiency of UNICEF approach to targeting the most in need and the hard to reach • To assess UNICEF efforts towards universal access to PMTCT/Paediatric AIDS services	Gender: the involvement of males on PMTCT services: Equity: targeting the most vulnerable, the most in need and the hard to reach (customized PMTCT services for pregnant adolescents, HIV+ children access to treatment, demand driven services) Human rights based approach Universal access to PMTCT/ Paediatric services, attentiveness to ethical concerns **Relevance, effectiveness, efficiency, sustainability**	

Key reference documents

GLOBAL PLAN

http://www.emtct-iatt.org/wp-content/uploads/2012/11/Global-Plan-EMTCT.pdf

IATT REPORT - AND WEBSITE

http://www.emtct-iatt.org/

UNIVERSAL ACCESS (LAST ONE)

http://www.who.int/hiv/pub/2010progressreport/report/en

CHILDREN AND AIDS STOCKTAKING - 6TH

https://www.unicef.org/publications/index_70986.html

DOUBLE DIVIDEND

http://www.emtct-iatt.org/wp-content/uploads/2014/04/Double-Dividend-Synthesis1.pdf

UNICEF HIV VISION, 2014-17

https://www.unicef.org/aids/files/2079-UNICEF-HIV_VisionPaper_IA_Final.pdf

UNICEF STRATEGIC PLAN 2014-2017

http://www.unicef.org/strategicplan/

UNICEF STRATEGIC PLAN 2009-2013: END OF CYCLE REVIEW

https://www.unicef.org/about/execboard/files/2013-4-End-of-cycle_review-MTSP-ODS-English.pdf

ANNEX B. EVALUATION FRAMEWORK

Strategic directions	Key evaluation questions	Indicative criteria for judging performance	Data collection approaches	Analytical approaches	Main section of the report in which EQ is addressed
SD1: Coordinate programme design, planning and implementation among partners at all levels	**KEQ1:** How have UNICEF's leadership, convening and coordination roles evolved since 2005 vis-à-vis that of other partners? (**relevance**) **KEQ2:** To what extent did UNICEF's leadership, convening and coordination efforts lead to improved alignment and coherence of strategies, policies and implementation plans for addressing HIV in children? (**effectiveness/ efficiency**)	• Recognition of UNICEF as a growing authority and lead player on issues related to HIV in children. • Perceptions of the importance and effectiveness of UNICEF as a convenor and coordinator of key partners. • Perceived contributions over time to improving alignment and coordination among partners.	**Structured document review** • Information on shifts in the global architecture around HIV in children since 2005. • Documentation of UNICEF's specific contributions and responses to key campaigns and events over last decade. • IATT documentation. • UNICEF strategic plans, reports and reviews. **Key informant interviews, group discussions and online survey** • Assessment of UNICEF's leadership, convening and coordination roles, and key results (and missed opportunities) at all levels. • Assessment of IATT mechanisms and results. **Country case studies** • Country plans and reports. • Tracking of UNICEF's leadership, convening and coordination activities vis-à-vis that of other partners at country level. • Review of UNICEF's specific contributions and responses to key events over last decade as played out at country level. • -Assessment of UNICEF's leadership, convening and coordination roles and identification of key results (and missed opportunities) in terms of improved alignment and coherence of strategies, policies and implementation plans at country level.	Timelines Cross case-study analysis Analysis of document review information, of stakeholder perceptions and accounts, and of survey data	6.1

Strategic directions	Key evaluation questions	Indicative criteria for judging performance	Data collection approaches	Analytical approaches	Main section of the report in which EQ is addressed
SD2: Broker partnerships at all levels, including among private sector, civil society and multi-sector stakeholders, and encourage South-South as well as triangular cooperation among partners	**KEQ3:** To what extent did UNICEF's efforts to broker partnerships contribute to building a strong base for programme scale-up towards targets? (**effectiveness**) **KEQ4:** To what extent were UNICEF's efforts to promote South-South and triangular cooperation among partners helpful for ensuring alignment and coherence and securing commitments? (**relevance/ effectiveness**) **KEQ5:** What trade-offs were made to ensure that partnership arrangements worked as intended and what risks were involved? (**effectiveness/ efficiency**)	• UNICEF's contributions to brokering strong partnerships among diverse stakeholders, who work together in supporting programme scale-up. • Increase over time in the number of partners active in the area of children and HIV. • Evidence of UNICEF support to South-South cooperation. • Improvements in alignment and coherence, in support for scale-up, and in commitments secured. • Challenges successfully addressed.	**Structured document review** • Partnership frameworks and agreements, and progress reports. • IATT documentation. **Key informant interviews, group discussions and online survey** • Exploration of UNICEF's role in brokering partnerships at global, regional and country levels. • Exploration of UNICEF's role in brokering South-South and triangular cooperation among partners. • Assessment of the results in terms of ensuring alignment and coherence, supporting programme scale-up and securing commitments. • Exploration of trade-offs and risks. **Country case studies** • Documentation of UNICEF's role in brokering partnerships at country level. • Assessment of the results in terms of ensuring alignment and coherence, building synergies and supporting programme scale-up towards targets. • Exploration of trade-offs and risks.	Trend analysis (e.g., number of partnerships secured in support of programme scale-up) Cross case-study analysis Analysis of document review information, of stakeholder perceptions and accounts, and of survey data	6.1

Strategic directions	Key evaluation questions	Indicative criteria for judging performance	Data collection approaches	Analytical approaches	Main section of the report in which EQ is addressed
SD3: Ensure that HIV services for children receive adequate priority in global, regional and national decision-making	**KEQ6:** To what extent did UNICEF's advocacy efforts lead to increased prioritisation of, and commitments for HIV services for children? (**effectiveness**) **KEQ7:** How has the focus on achieving HIV goals been balanced with the drawbacks of vertical programming? (**effectiveness/ efficiency**) **KEQ8:** To what extent has UNICEF contributed to the building of national health and community systems that serve women and children? (**effectiveness**)	• Increased prioritisation of and commitments for HIV services for children associated with UNICEF's advocacy efforts. • Perceived coherence between UNICEF's focus on reaching HIV goals and global, regional and national priorities. • UNICEF contributions to integration of PMTCT and paediatric HIV care and support into MNCH platforms.	Structured document review • UNICEF's advocacy and guidance materials. • IATT documentation. • UNICEF key campaign materials and associated commitments for HIV in children over the last decade. • Documentation of UNICEF's contributions and responses to key events over last decade. • Documentation of senior staff statements and commitments. Key informant interviews, group discussions and online survey • Exploration of UNICEF's advocacy activities. • Exploration of UNICEF's contributions and responses to key events over the last decade. • Assessment of UNICEF's specific contributions to setting priorities and building commitments at global, regional and country levels. • Assessment of UNICEF's roles related to building national systems that serve women and children, and to fostering integrated programming. Country case studies • Tracking of UNICEF's advocacy activities at country level. • Assessment of UNICEF's contribution to leveraging key shifts in political commitment and setting targets at country level. • Assessment of UNICEF's role in positioning HIV in overall decision-making around children's health. • Assessment of UNICEF's specific contributions to building national systems that serve women and children, and to fostering integrated programming.	Trend analysis (e.g., number of partnerships secured in support of programme scale-up) Cross case-study analysis Analysis of document review information, of stakeholder perceptions and accounts, and of survey data	6.1

Strategic directions	Key evaluation questions	Indicative criteria for judging performance	Data collection approaches	Analytical approaches	Main section of the report in which EQ is addressed
SD4: Support key stakeholders at all levels to plan, resource and implement HIV services for children	KEQ9: To what extent was UNICEF successful in enabling key stakeholders, including civil society stakeholders and PLWHIV, to build coalitions in support of HIV services for children, strengthen programme planning and implementation, and reinforce accountability mechanisms at all levels? (**effectiveness**)	• Strengthened civil society in support of HIV services for children associated with UNICEF support. • Strengthened platform for delivery of HIV services for children associated with UNICEF support. • Strengthened accountability mechanisms with regard to HIV for children associated with UNICEF support.	Structured document review • UNICEF progress reports. • IATT documentation. Key informant interviews, group discussions and online survey • Exploration of UNICEF's capacity-building and support activities directed at civil society and other key stakeholders at all levels. • Assessment of the contribution of these activities to building coalitions in support of HIV services for children, strengthening programme planning and implementation, and reinforcing accountability mechanisms. Country case studies • Exploration of UNICEF's capacity-building and support activities directed at civil society and other key stakeholders at the country level. • Assessment of the contributions of these activities to building coalitions in support of HIV services for children, strengthening programme planning and implementation, and reinforcing accountability mechanisms.	Trend analysis Cross case-study analysis Analysis of document review information, of stakeholder perceptions and accounts, and of survey data	6.1

Strategic directions	Key evaluation questions	Indicative criteria for judging performance	Data collection approaches	Analytical approaches	Main section of the report in which EQ is addressed
SD5: Initiate, support and coordinate movements, campaigns, and investment plans to mobilise financial resources	**KEQ10:** To what extent has UNICEF been effective in securing sufficient financial resources for planned activities in support of HIV in children (internally)? (**effectiveness**) **KEQ11:** To what extent has UNICEF been able to mobilise resources in a timely and efficient manner? (**efficiency**)	• Upward trend in UNICEF revenue and expenditure for HIV/AIDS (in the context of trends in UNICEF total revenue and expenditure). • Internal targets on resource allocation for HIV/AIDS met. • Increased internal financial prioritisation of PMTCT and paediatric HIV/AIDS. • Perceived transactions costs and staff burden associated with resource mobilisation activities. • Perceptions on the timeliness of financial resources raised, and gaps for UNICEF's PMTCT and paediatric HIV/AIDS programme.	Document and data review • UNICEF plans and budgets. • UNICEF incoming funds in total and HIV/AIDS. • UNICEF programme expenditure in total and for HIV/AIDS (total and for the first decade of life). Key informant interviews, group discussions and online survey • Exploration of UNICEF's role in resource mobilisation, both internally and more generally for HIV in children. Country case studies • UNICEF country annual plans, budgets and reports. • Exploration of UNICEF's role in resource mobilisation, both internally and more generally for national programmes directed at HIV in children. • Analysis of whether resources have been raised in a timely and efficient manner.	Trend analysis Cross case-study analysis Analysis of document review information, of stakeholder perceptions and accounts, and of survey data	6.2

Strategic directions	Key evaluation questions	Indicative criteria for judging performance	Data collection approaches	Analytical approaches	Main section of the report in which EQ is addressed
SD6: Engage with donors, governments and country stakeholders to leverage additional global and domestic resources, and support countries to access external resources	**KEQ12:** What has been UNICEF's role and contribution to: (a) mobilizing financial resources globally; (b) increasing domestic spending on PMTCT and paediatric HIV care and treatment; and (c) supporting countries to access external resources? (**effectiveness**) **KEQ13:** To what extent has UNICEF supported countries to establish a sustainable resource base for PMTCT and paediatric HIV/AIDS programme? (**sustainability**)	• Upward trend in global financial resources for HIV/AIDS (and PMTCT and paediatric HIV/AIDS where possible). • Upward trend in domestic financial resources for HIV/AIDS in country case studies. • Perceptions of UNICEF's role and contribution to country resource mobilisation efforts. • Perceptions of sustainability of country PMTCT and paediatric HIV/AIDS programmes, and perceptions on UNICEF's role and contribution in supporting this.	**Document and data review** • Resource needs for HIV/AIDS and PMTCT as set out in investment framework for HIV/AIDS. • Financial resources allocated to HIV/AIDS by DAC donors through the OECD CRS database. • Data on domestic AIDS spending and partner contributions through through OECD CRS database, AIDSinfo and NASA reports. **Key informant interviews, group discussions and online survey:** • Exploration of UNICEF's role and contribution to securing greater domestic and external financial resources for countries, in a manner consistent with country context. **Country case studies** • Costed national plans for PMTCT. • Country HIV/AIDS spending through AIDSinfo and NASA reports. • Exploration of UNICEF's role in advocating for greater domestic resources. • Assessment of UNICEF's contribution to securing greater domestic financial resources and to leveraging financial resources from external partners. • Assessment of UNICEF's role and contribution to establishing a sustainable PMTCT and paediatric HIV/AIDS programme (e.g., related to country capacity for budgeting and planning; the levels and trends in domestic financing; the number of donors; and the length and quantum of donor financial commitments).	Trend analysis Cross case-study analysis Analysis of document review information, of stakeholder perceptions and accounts, and of survey data	6.2

Strategic directions	Key evaluation questions	Indicative criteria for judging performance	Data collection approaches	Analytical approaches	Main section of the report in which EQ is addressed
SD7: Generate, collate and disseminate high-quality global and national data for scaling up effective approaches to address HIV among children	**KEQ14:** To what extent has UNICEF – directly and through partners – contributed to the generation, collation, and dissemination of strategic information (SI) and other forms of knowledge on HIV and children at national and global level? (**effectiveness**)	• UNICEF contributions to generating, collating and disseminating SI and other forms of knowledge, vis-à-vis that of other players (particularly WHO and UNAIDS). • Perceived importance and effectiveness of UNICEF in this area over time. • Increase in IATT outputs such as webinars, and of visits to the IATT website.	**Document and data review** • Tracking of UNICEF's role in the generation, collation and dissemination of SI (e.g., progress reports; modelling) and knowledge (e.g., research findings) related to HIV in children at the global level. • Review of types of SI and research findings collected under the leadership of, or with the involvement of UNICEF, and how these were disseminated and used. • Scoping of information available on UNICEF websites (country data, reports, multi-country evaluations and research publications). **Key informant interviews, group discussions and online survey** • Assessment of UNICEF's role in generating, collating and disseminating high quality data on HIV and children, at global and national level. **Country case studies** • Assessment of UNICEF's role in generating, collating and disseminating high-quality data on HIV and children at the national level. • Scoping and review of information generated by UNICEF country offices.	Timelines of SI/research activities Trend analysis of knowledge dissemination activities and uptake. Cross-country case studies Analysis of document review information, of stakeholder perceptions and accounts, and of survey data Inventories and typologies of different kinds of SI/research publications available at the global level	6.3
SD8: Provide support for governments and country partners to generate and collate strategic information and knowledge	**KEQ15:** To what extent has UNICEF strengthened country-level ability to generate and collate data for accountability and learning around HIV and children? (**effectiveness/ sustainability**)	• Recognition of UNICEF's contributions to supporting countries in SI/knowledge generation, collation and dissemination.	**Document and data review** • Training activities and guidance materials in support of SI/ knowledge generation. **Key informant interviews, group discussions and online survey** • Assessment of UNICEF's role in supporting countries in SI/ knowledge generation, collation and dissemination. **Country case studies** • Assessment of UNICEF's role in supporting SI/knowledge generation at regional and country level. • Capacity-building activities and related training and guidance materials related to SI/knowledge generation at regional and country level.	Timelines (e.g., change in indicators and data collection methods to meet global guidelines over time in case study countries) Cross-case study analysis Analysis of document review information, of stakeholder perceptions and accounts, and of survey data	6.3

Strategic directions	Key evaluation questions	Indicative criteria for judging performance	Data collection approaches	Analytical approaches	Main section of the report in which EQ is addressed
SD9: Support global- and country-level interpretation and translation of SI and evidence into sound policies, strategies and programmes	**KEQ16:** To what extent has UNICEF strengthened global- and country-level ability to use SI and research findings to inform policies and strategies for scaling up proven effective approaches to address HIV among children? (**relevance/ sustainability**)	• Recognition of UNICEF's contributions to enabling timely and evidence-informed shifts in policies, guidelines and strategies. • Evidence of translation of findings into policies and strategies at country level.	**Document and data review** • Review of UNICEF's role in helping countries to shift their policies, guidelines and strategies based on research findings, modelling and global guidelines. • Tracking of global policy and guideline shifts. • Documents related to the use of data for policy development, strategic planning and building accountability. **Key informant interviews, group discussions and online survey** • Assessment of UNICEF's role in helping governments to shift their policy guideline and strategies based on research findings and global guidelines. **Country case studies** • Tracking of country-level policy and guideline shifts in relation to the release of scientific information and global guidelines. • Scoping and review of SI, research, guidelines and other kinds of documents. • Documentation of UNICEF-supported activities related to the discussion of various kinds of knowledge. • Assessment of UNICEF's role in helping country to shift their policy guideline and strategies based on research findings and global guidelines.	Timelines (global guideline and policy shifts in relation to the release of scientific information), at global and country levels. Cross-case study analysis Analysis of document review information, of stakeholder perceptions and accounts, and of survey data Case study of UNICEF's activities in support of the introduction of Option B+	6.3
SD10: Work to ensure that effective interventions are adequately integrated within humanitarian responses	**KEQ17:** To what extent has UNICEF been able to promote the inclusion of HIV services for women and children in humanitarian settings? (**effectiveness**) **KEQ18:** How has the focus on HIV services been balanced with other priorities in humanitarian settings? (**effectiveness**)	• Inclusion of HIV services for women and children in humanitarian settings as a result of UNICEF advocacy or actions. • Evidence of integration of humanitarian considerations into UNICEF PMTCT and paediatric HIV documents.	**Structured document review** • Review of country reports (for selected countries only). **Key informant interviews, group discussions and online survey** • Exploration and assessment of UNICEF's work to promote the inclusion of HIV services in humanitarian settings. **Country case studies (as appropriate)** • Exploration and assessment of UNICEF's work to promote continued HIV services in times of crisis.	Country case studies, as appropriate Analysis of document review information, of stakeholder perceptions and accounts, and of survey data	6.5

Strategic directions	Key evaluation questions	Indicative criteria for judging performance	Data collection approaches	Analytical approaches	Main section of the report in which EQ is addressed
SD11: Advocate for and support gender-equitable policies, budgeting and resource allocations, and gender-sensitive approaches to HIV programming and monitoring	**KEQ19:** To what extent has UNICEF been able to support gender-sensitive HIV programming? (**effectiveness**)	• Appropriate gender content of materials produced by UNICEF. • Perceived role of UNICEF as a proponent of gender-sensitive and human rights-based HIV programming. • Increase in the application of MoRES and other equity-focused instruments in HIV programming. • Stakeholders' perceived usefulness of equity approaches in guiding programme scale up. • Increased UNICEF support to strengthening equity-based accountability mechanisms.	**Structured document review** • Gender analysis of key materials. • Identification of guidance and other materials supporting gender-sensitive and human rights-based programming. • Review of application of MoRES and other equity-focused instruments. **Key informant interviews, group discussions and online survey** • Exploration and assessment of UNICEF's specific contributions to gender-sensitive and human rights-based programming at global, regional and country levels. • Exploration of the role of the equity focus in HIV programme scale up. **Country case studies** • Stakeholder perceptions of UNICEF's role in promoting gender-sensitive and human rights-based programming and supporting accountability mechanisms at country level. • Tracking of use of equity-related instruments and analyses by country office. • Exploration of the role of the equity focus in programme scale up.	Cross case-study analysis Analysis of document review information, of stakeholder perceptions and accounts, and of survey data	6.5
SD12: Ensure that human rights and child rights are protected, promoted and fulfilled in HIV policies and programmes, and build related accountability mechanisms	**KEQ20:** To what extent has UNICEF promoted human rights-based programming and accountability setting in relation to children and HIV? (**effectiveness/ relevance**)				6.5
SD13: Promote an equity focus in HIV services for children, and build related accountability mechanisms	**KEQ21:** To what extent has UNICEF's increasing focus on equity shaped its response to children and HIV? (**relevance**) **KEQ22:** To what degree has this equity focus contributed to programme scale-up? (**effectiveness**)				6.5

Strategic directions	Key evaluation questions	Indicative criteria for judging performance	Data collection approaches	Analytical approaches	Main section of the report in which EQ is addressed
SD14: UNICEF as an organisation responds to changes in the external environment and leverages its comparative advantage in PMTCT and paediatric HIV care and treatment	**KEQ23:** To what extent has UNICEF leveraged its comparative advantage based on mandate, structure, and resources to achieve sustainable country-led PMTCT and paediatric HIV care and treatment programmes? (**relevance/ sustainability**)	• Recognition of UNICEFs leadership and influence in supporting sustainable country-led PMTCT and paediatric HIV programmes? • Evidence of UNICEF's 'continuous improvement' and innovation in its leadership role to achieve sustainable country-led PMTCT and paediatric HIV programmes • Changes to organisational structure over time in response to context.	**Structured document review** • Review of mandate and objectives. • Strategic plans/reviews 2001-2015. • Organigrams – NY, regional and country offices 2005-2015. • Budgetary decision processes on funds allocated to specific programmes plus minutes of key decisions. • Organisation reviews or structural change documents 2005-2015. • PMTCT and paediatric HIV care and treatment programme documents. **Key informant interviews, group discussions and online survey** • Assessment of comparative advantages, and of organisational strengths and weaknesses 2005-2015. **Country case studies** • Analysis of country office readiness and capacity to deliver programme elements as planned and in response to country needs. • Stakeholder perceptions of organisational strengths and weaknesses	Cross case-study analysis of efficiencies and effectiveness of organisational structures in relation to country level results Analysis of responses of internal and external key informants, and of survey data Analysis of normative organisational models – Mckinsey 7S and INK management tool – to explore how UNICEF's structures and resources have been applied	6.4
	KEQ24: To what extent are there synergies, gaps, overlaps, and/or missed opportunities in programming that arise from UNICEF's organisational structure? (**relevance/ efficiency**)	• Extent to which UNICEF fully utilised its knowledge and expertise to achieve PMTCT and paediatric HIV care and treatment goals • Extent to which UNICEF fully optimised and applied its resources to achieve PMTCT and paediatric HIV care and treatment goals • Extent to which UNICEF engaged in cooperative approaches with key actors.	**Structured document review** • General and HIV-specific organisational structures and staffing patterns within UNICEF/ HQ 2005-2015. **Key informant interviews, group discussions and online survey** • Strengths and weaknesses of organisational structure to carry the desired response. **Country case studies** • Review of shifts in organisational structures and staffing patterns within UNICEF regional and country office 2005-2015.		6.4

Strategic directions	Key evaluation questions	Indicative criteria for judging performance	Data collection approaches	Analytical approaches	Main section of the report in which EQ is addressed
SD14: UNICEF as an organisation responds to changes in the external environment and leverages its comparative advantage in PMTCT and paediatric HIV care and treatment	**KEQ25:** To what extent has UNICEF been able to adapt internally (at country, regional, and global level) to respond to key shifts in PMTCT/ paediatric AIDS? **(efficiency/ effectiveness)**	• Responsiveness in adapting internal approaches and knowledge to external change e.g. new developments in science and policy • Responsiveness in adapting internal structures and skills in response to changing priorities and new developments. • Recognised extent to which UNICEF has been 'results orientated' with internal measures for success. • Extent to which internal systems were developed for reviewing and measuring success.	**Structured document review** • Shifts in UNICEF organisation and activities in respect to key event timeline. • Organigrams – HQ, regional and country offices 2005-2015. • Budgetary decision processes on funds allocated to specific programmes plus minutes of key decisions. • Organisation reviews or structural change documents 2005-2015. **Key informant interviews, group discussions and online survey** • Capacity (and strengths/ weaknesses) of the organisation to adapt over time. **Country case studies** • Stakeholder perceptions of UNICEF's flexibility in responding to key shifts at country level.	Cross case-study analysis of efficiencies and effectiveness of organisational structures in relation to country level results Analysis of responses of internal and external key informants, and of survey data Analysis of normative organisational models – Mckinsey 7S and INK management tool – to explore how UNICEF's structures and resources have been applied	6.4
	KEQ26: To what extent has UNICEF developed its capacity to deliver on its leadership, SI, and resource mobilisation roles? **(effectiveness)**	• -Extent to which UNICEF developed its internal leadership and technical capacities in PMTCT and paediatric HIV, SI and RM. • Evidence of internal systems for developing leadership and technical capacities in PMTCT and paediatric HIV, SI and RM at all levels.	**Structured document review** • Relevant Human Resources planning or review documents. • Any analysis of skills base or talent management approaches across NY, regional and country offices. **Key informant interviews, group discussions and online survey** • Capacity (and strengths/ weaknesses) of the organisation in relation to the 3 roles, and changes over time.		6.1, 6.2, 6.3, 6.4

ANNEX C. SELECTION PROCESS FOR COUNTRY CASE STUDIES

In-depth country case studies

As proposed in the ToR, field visits were conducted in four countries to develop country case studies for the evaluation. The key purpose of these case studies was to record how UNICEF has delivered its programme on HIV in children at country level, in order to contextualize our analysis of the ToC.

The four countries were selected from the 22 high burden countries prioritised in the Global Plan. A shortlist was initially prepared, based on a review of key characteristics of each country detailed in Table C.1 below. These included: geographical focus, HIV burden, progress in meeting the Global Plan targets, latest programme coverage levels, policy environment (constraining/fair/enabling), presence of a recent humanitarian emergency or economic crisis, and level of UNICEF technical and financial investments in the programme area. The presence of significant partners such as PEPFAR was also noted for each country. The evaluation team provided a shortlist of countries with contrasting features for UNICEF comment and, following consultation with regional advisors, selected **Cameroon, India, South Africa** and **Zimbabwe**. This choice balanced the objective criteria, as well as practical considerations such as security concerns and the special features of UNICEF's investments in those countries vis-à-vis those of other partners.

Light-touch case studies

The evaluation team also conducted three LT case studies. The purpose of the LT studies was to develop a better understanding of how UNICEF's response to HIV in children played out in lower prevalence countries, and the ToC to be explored for the broader range of countries in which UNICEF works. The selection of the countries for the LT case studies was purposive, seeking to include one country for another three regions, including CEE/CIS, EAP and LAC. Following consultation with regional advisors, the evaluation team selected **Cambodia, Haiti** and **Ukraine**. This enabled the documentation of certain features of UNICEF's work (such as its approach to working with people who use drugs, in Ukraine, or its approach to integrating services, in Cambodia).

TABLE C.1: SELECTED CHARACTERISTICS OF THE 22 PRIORITY GLOBAL PLAN COUNTRIES (AS OF MARCH 2016)

Countries	UNICEF region	Estimated no of new HIV infections in children due to MTCT at 2009 baseline*	Progress made 2009–2015 (% decline**)	ART coverage among children 0–14 years***	Policy environment	Humanitarian emergency or economic crisis in last 10 years	Level of UNICEF financial and technical investments in this programme area****	Comments
Angola	ESAR	5,200	25%	14%	fair		+	PEPFAR presence (current)
Botswana	ESAR	<1,000	58%	53%	enabling		+	PEPFAR focus country 1st phase (2003–08) and presence of many other partners
Burundi	ESAR	2,500	57%	17%	constraining	✓	+	
Cameroon	WCAR	8,800	27%	11%	constraining	✓	+	PEPFAR presence (current)

Countries	UNICEF region	Estimated no of new HIV infections in children due to MTCT at 2009 baseline*	Progress made 2009–2015 (% decline**)	ART coverage among children 0–14 years***	Policy environment	Humanitarian emergency or economic crisis in last 10 years	Level of UNICEF financial and technical investments in this programme area****	Comments
Chad	WCAR	4,800	19%	8%	constraining	✓	+	
Côte d'Ivoire	WCAR	5,600	26%	16%	constraining	✓	+	PEPFAR focus country 1st phase
DRC	WCAR	19,000	27%	15%	constraining	✓	+++	PEPFAR presence (current) Practical and security concerns about travel
Ethiopia	ESAR	---	65%	22%	enabling		+++	PEPFAR focus country 1st phase
Ghana	WCAR	4,200	51%	22%	enabling			PEPFAR presence (current)
India	SAR	--- (7,900–23,000)	---	---	fair		+++	Only Global Plan priority country outside of sub Saharan Africa. Epidemic mostly affects high-risk groups. Prevalence particularly high in Southern states. PEPFAR presence (current). Case study could focus on central and state (one state) level
Kenya	ESAR	23,000	29%	41%	fair	✓	++	PEPFAR focus country 1st phase. Location of ESARO
Lesotho	ESAR	3,900	42%	29%	enabling		+	
Malawi	ESAR	--- (19,000–26,000)	53%	30%	constraining		++	PEPFAR presence (current)

Countries	UNICEF region	Estimated no of new HIV infections in children due to MTCT at 2009 baseline*	Progress made 2009–2015 (% decline**)	ART coverage among children 0–14 years***	Policy environment	Humanitarian emergency or economic crisis in last 10 years	Level of UNICEF financial and technical investments in this programme area****	Comments
Mozambique	ESAR	30,000	69%	37%	enabling		++	PEPFAR focus country 1st phase
Namibia	ESAR	1,500	64%	66%	enabling		+	PEPFAR focus country 1st phase
Nigeria	WCAR	72,000	15%	12%	constraining	✓	+++	PEPFAR focus country 1st phase Outlier on many aspects. Practical (and some security) concerns about covering such a large country
South Africa	ESAR	61,000	76%	49%	enabling		+++	PEPFAR focus country 1st phase. Good data and many analyses to draw on. Case study could focus on central and provincial (one province) level
Swaziland	ESAR	1,700	63%	43%	enabling		+	PEPFAR presence (current)
Tanzania	ESAR	29,000	72%	29%	enabling		++	PEPFAR focus country 1st phase
Uganda	ESAR	28,000	69%	37%	enabling		++	PEPFAR focus country 1st phase
Zambia	ESAR	20,000	38%	42%	enabling		++	PEPFAR focus country 1st phase
Zimbabwe	ESAR	15,000	57%	38%	fair	✓	++	PEPFAR presence (current)

* Source: WHO and UNICEF 2012. Global monitoring framework and strategy for the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive.
** Source UNAIDS 2015. Progress Report on the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive.
*** Source: IATT website
****Based on the evaluation team's rapid documentation review and appraisal of the size of the UNICEF country programmes and their HIV focus.

ANNEX D: TERMS OF REFERENCE FOR IN-DEPTH COUNTRY CASE STUDIES

D.1 Visits to South Africa, Zimbabwe, and Cameroon

OVERVIEW OF THE EVALUATION

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

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

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

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

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

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

PURPOSE OF THE COUNTRY CASE STUDIES

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

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

APPROACH TO DATA COLLECTION AND ANALYSIS

Each mission will last seven working days[124] (over a period of two weeks). Each team will arrive in-country with a clear case study ToR, detailed draft agenda, and having already performed a remote desk study and stakeholder listing to ensure that the time the evaluators spend in-country can be used as effectively and efficiently as possible. Figure 1 below summarizes the proposed process through which each of the country studies will be implemented. However, the first country case study visit will be used as an opportunity to refine the process. This will be attended by four members of the core team to gain consensus and maximise consistency of approach.

STEP 1

Prior to the visit, a **desk review phase** will focus on enabling the team to gain a comprehensive understanding of the background to PMTCT/Paediatric HIV/AIDS programme activities in

[124] In the case of Zimbabwe, in consultation with EO and the Zimbabwe CO, this has now been reduced to five days given that four team members are attending and therefore can cover double the number of interviews.

Figure D.1 Process for conducting country studies

each case study country, and extracting available secondary evidence – for example on key events.

STEP 2

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

STEP 3

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

STEP 4

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

STEP 5

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

STEP 6

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

THE TEAM

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

GUIDANCE TO CASE STUDY COUNTRY OFFICES

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

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

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

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

Day 1	Monday	AM: Meeting with UNICEF CO PM: Stakeholder interviews (UNICEF staff)
Day 2	Tuesday	Stakeholder interviews (UNICEF staff)
Day 3	Wednesday	Stakeholder interviews (external – government and partners)
Day 4	Thursday	Stakeholder interviews (external – government and partners)
Day 5	Friday	Stakeholder interviews (external – government and partners)
Day 6	Saturday	Stakeholder interviews (as required) and internal team working
	Sunday	
Day 7	Monday	Presentation of initial findings to CO (plus additional interviews as required)

D.2 Visit to India

OVERVIEW OF THE EVALUATION

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

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

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

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

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

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

PURPOSE OF THE COUNTRY CASE STUDIES

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

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

APPROACH TO DATA COLLECTION AND ANALYSIS

The mission will last 10 working days (over a period of two weeks). The team will arrive in-country with a clear case study ToR, detailed draft agenda and having already performed a remote desk study and stakeholder listing to ensure that the time the evaluators spend in-country can be used as effectively and efficiently as possible. Figure F.2 below summarizes the proposed process through which each of the country studies will be implemented.

STEP 1

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

STEP 2

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

STEP 3

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

STEP 4

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

STEP 5

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

STEP 6

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

THE TEAM

The country case studies will be conducted by a team of two consultants belonging to the core evaluation team, over a total input period of 10 working days in the field per country. This team will be complemented by a national expert who will be normally resident in-country and can support on collation of documents and identification and contacting of stakeholders, and will bring in-depth understanding of the country context. One consultant will act as lead consultant to ensure that responsibility for delivery of the report is clearly located.

Figure D.2 Process for conducting country studies

GUIDANCE TO CASE STUDY COUNTRY OFFICES

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

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

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

Day 1	Monday	AM: Meeting with UNICEF CO PM: Stakeholder interviews (UNICEF staff)
Day 2	Tuesday	Stakeholder interviews Delhi (UNICEF staff)
Day 3	Wednesday	Stakeholder interviews Delhi (external – government and partners)
Day 4	Thursday	Stakeholder interviews Delhi (external – government and partners)
Day 5	Friday	Stakeholder interviews Delhi (external – government and partners)
Day 6	Saturday	Stakeholder interviews (as required) and internal team working
	Sunday	Travel to state
Day 7	Monday	Stakeholder interviews at state level (UNICEF, government, partners)
Day 8	Tuesday	Stakeholder interviews at state level (UNICEF, government, partners)
Day 9	Wednesday	Return to Delhi, additional interviews as required
Day 10	Thursday	Presentation of initial findings to CO

(Note that the timing of the state visit could be shifted as required.)

ANNEX E: DATA COLLECTION INSTRUMENTS

E.1 Interview guides

COUNTRY LEVEL – UNICEF INTERVIEW GUIDE

AT THE START OF THE INTERVIEW

- Introductions – interviewer and interviewee.
- Introduce the evaluation – including the focus on PMTCT and paediatric HIV care and treatment, and that we are interested in the whole time period from 2005–15.
- Explain the objectives of the evaluation and the four thematic focus areas.
- Explain the purpose of the interview and stress the learning focus of the evaluation and that it is not an evaluation of any individuals.
- Ask for permission to record if you are recording.
- Tell the informant that the interviews are confidential and they will not be identifiable unless permission is specifically requested.
- Note that interviews can be tailored and questions skipped according to the areas of expertise of the interviewee.

BACKGROUND

1. Please can you give us a brief overview of your role in UNICEF and how long you've been working on issues related to PMTCT and HIV in children? (*check on past roles if relevant*)

2. How would you describe UNICEF's role in PMTCT and paediatric HIV care in [country X]?
   - Do you have a sense of how has this role has changed over time since 2005?
   - What has this been in response to?

PARTNERSHIPS AND ADVOCACY

3. How have country-level priorities for HIV in children changed in the last decade?
   - To what extent do you think UNICEF has contributed to any shifts in priorities and increasing commitments for children and HIV?

4. How would you describe UNICEF's approach to brokering partnerships at country level?
   - Does this include South-South and triangular cooperation among partners? (*give examples*)
   - What do you see as the main strengths and weaknesses of UNICEF's approach to partnerships?

5. How would you describe UNICEF's role in leadership, convening, and coordination in HIV in children in comparison to other partners?

6. How has UNICEF's leadership, convening, and coordination roles evolved over time vis-à-vis that of other partners? (*probe about UNAIDS and WHO*)
   - Do you think that UNICEF's coordination efforts have led to improved alignment and coherence in relation to strategies, policies, and implementation plans? Can you give any examples?
   - What have been the key challenges that UNICEF has faced in undertaking this role?

STRATEGIC INFORMATION

7. How would you describe UNICEF's approach to generating, collating, and disseminating data and knowledge in relation to HIV in children?
   - Between 2005 and 2015, in what ways has UNICEF's work around data and knowledge contributed to progress with regard to HIV in children?

8. How has the translation of global evidence into national programming decisions functioned in [country X] over the past decade?
   - How does UNICEF support the translation of global monitoring or research data into decision-making at the national level? (*e.g. funding decisions, policy guidelines, programme improvements*)
   - What have been the challenges? (*e.g. in relation to the past decade and some of the big global shifts in recommendations on HIV in children*)

9. What has been UNICEF's role in supporting governments in terms of the data being generated at country level and how that translates in to policy and resourcing decisions?
   - Are UNICEF doing capacity building in relation to M&E in [country X]? (*e.g. the mix of data on*

coverage of PMTCT interventions, maternal health and on HIV-free survival of children)

- To what extent has UNICEF strengthened national monitoring and evaluation (M&E) capacity to identify inequities, and thus a country's ability to focus on issues of equity?
- How successful has UNICEF been at assisting national governments to alter their policies and programmes based on the findings SI/KG in their countries?

SUPPORT TO GOVERNMENT AND STRENGTHENING SYSTEMS

10. To what extent has UNICEF contributed to the building of national systems that serve women and children?
    - How does UNICEF deal with the need to balance a focus on achieving goals with the drawbacks of vertical programming?

11. What is UNICEF's approach to capacity building in [country X]?
    - What have been the priority focus areas and recipients? (*probe about civil society stakeholders*)
    - What have been UNICEF's main achievements in this area? What has changed as a result of UNICEF support?

RESOURCE MOBILISATION

12. From an internal perspective, has UNICEF been effective in generating sufficient financial resources to meet its strategic objectives in relation to HIV in children and fully implement the programmes and projects that it supports?
13. Can you describe the role that UNICEF has had in resource mobilisation for HIV in children in [country X] since 2005?
    - To what extent has this translated into changes in the amount and type of funding available for PMTCT/paediatric HIV over time, either from domestic sources or from external sources? (*explore issues like number of donors, diversification of donors, multiyear commitments, innovative financing mechanisms etc.*)
    - What have been the key challenges in terms of resource mobilisation in [country X]?
    - What is your perspective on the potential for funding for HIV in children to be sustained in future?

ORGANISATIONAL STRUCTURE

14. What do you see as the key competencies and skills that people involved in UNICEF's PMTCT and Paediatric HIV programs need at country level?
    - How does UNICEF organise itself to ensure that these skills and competencies are present in its teams at national, regional, and global levels?
    - Are there additional key skills or competencies that UNICEF's PMTCT and Paediatric HIV programme should develop to support achievement of its objectives?
    - How is UNICEF's work on HIV coordinated or integrated with other sectors or workstreams?
    - What are the mechanisms for coordination between global, regional and national levels and between different sectoral teams, in relation to HIV in children?

CROSSCUTTING ISSUES

15. [HUMANITARIAN SETTINGS ONLY] To what extent has UNICEF promoted the inclusion of HIV services for women and children in humanitarian settings?
    - What were the main challenges faced in relation to this?
    - How has the focus on HIV services been balanced with other priorities in humanitarian settings?

16. To what extent do you think that UNICEF's focus on equity has shaped its response to children and HIV?
    - If *yes*, in what ways? If *no*, why do you think that is the case?
    - What do you see as the key strengths and weaknesses of an equity focus to scaling up HIV services for children?
17. To what extent has UNICEF supported human- and child-rights-based programming and gender-sensitive programming in relation to children and HIV?
    - What more could UNICEF do in these areas to increase the prominence given to human rights and gender in PMTCT and paediatric HIV programming?

CLOSING QUESTIONS

18. Looking forward, what do you see as the critical things that UNICEF could do to maximise its

contribution to PMTCT and paediatric HIV programming?

19. Before we close the interview, do you have any questions for us?

20. If there is one piece of advice you would give us in terms of how to ensure that this evaluation adds value, what would it be?

COUNTRY LEVEL – DEVELOPMENT PARTNER INTERVIEW GUIDE

BACKGROUND

1. Please can you give us a brief description of your role in [organisation], and an overview of how you interact with UNICEF on issues related to HIV in children?

2. How would you describe UNICEF's role in HIV in children (*first decade*) in [country X]?
   - Do you have a sense of how has this role has changed over time since 2005?
   - What has this been in response to?

PARTNERSHIPS AND ADVOCACY

3. How have country-level priorities in relation to HIV in children changed in the last decade?
   - To what extent do you think UNICEF has contributed to any shifts in priorities and increases in commitments for children and HIV?

4. How would you describe UNICEF's approach to working with partners at country level?
   - What do you see as the main strengths and weaknesses of UNICEF's approach to partnerships?

5. How would you describe UNICEF's role in leadership and coordination in children and HIV in comparison to you and other partners?
   - How has this leadership role evolved over time vis-à-vis that of other partners? (*probe about UNAIDS and WHO*)
   - Do you think that UNICEF's coordination efforts have led to improved alignment and coherence, with respect to strategies, policies, and implementation plans? Can you give any examples?
   - Do you see any further opportunities for improvement that UNICEF could be leveraging?

STRATEGIC INFORMATION

6. How would you describe UNICEF's approach to generating, collating, and disseminating data and knowledge in relation to HIV in children in [country X]?
   - How has this evolved over time since 2005?

7. How has the translation of global evidence into national programming decisions functioned in [country X] over the past decade?
   - How does UNICEF support the translation of global monitoring or research data into decision making at the national level? (e.g. funding decisions, policy guidelines, programme improvements)
   - Thinking back over the past decade and some of the big global shifts in recommendations on HIV in children, what have been the challenges in terms of their implementation at country level?

8. What has been UNICEF's role in supporting governments in terms of the data being generated at country level and how that translates in to policy and resourcing decisions?
   - Have you seen evidence of improvements in terms of M&E capacity at country level as a result of UNICEF support?

SUPPORT TO GOVERNMENT AND STRENGTHENING SYSTEMS

9. To what extent has UNICEF contributed to the building of national systems that serve women and children?
   - What is your perspective on how UNICEF balances the need to focus on achieving goals with the drawbacks of vertical programming?

10. What is UNICEF's approach to capacity building at country level?
    - What do you see as UNICEF's main achievements in this area over the past decade? What has changed as a result of UNICEF support?

RESOURCE MOBILISATION AND SUSTAINABILITY

11. Can you describe the role (if any) that UNICEF has had in resource mobilisation for PMTCT and paediatric HIV in [country X] since 2005?
    - To what extent has this translated into changes in the amount and type of funding available for PMTCT/paediatric HIV over time? (*explore issues like number of donors, diversification*

of donors, multiyear commitments, innovative financing mechanisms etc.)

- What, if any, has been UNICEF's contribution to changes in domestic spending?
- What is your perspective on the potential for funding for HIV in children to be sustained in future?

ORGANISATIONAL STRUCTURE

12. What do you see as the key competencies and skills that people involved in UNICEF's PMTCT and Paediatric HIV programs need at country level?
    - Is the composition and structure of the country team appropriate to the needs of the context?
    - Are there additional key skills or competencies that might support UNICEF's work at country level?

CROSSCUTTING ISSUES

13. [HUMANITARIAN SETTINGS ONLY] To what extent has UNICEF promoted the inclusion of HIV services for women and children in humanitarian settings?
    - What were the main challenges faced in relation to this?
    - How has the focus on HIV services been balanced with other priorities in humanitarian settings?

14. To what extent do you think that UNICEF's focus on equity has shaped its response to children and HIV?
    - If *yes*, in what ways? If *no*, why do you think that is the case?
    - What do you see as the key strengths and weaknesses of an equity focus to scaling up HIV services for children?

15. To what extent has UNICEF supported human- and child-rights-based programming and gender-sensitive programming in relation to children and HIV?
    - Has this worked well?
    - What more could UNICEF do in these areas, to increase the prominence given to human rights and gender in PMTCT and paediatric AIDS programming?

CLOSING QUESTIONS

16. Looking forward, what do you see as the critical things that UNICEF could do to maximize its contribution to PMTCT and paediatric HIV programming?

17. Before we close the interview, do you have any questions for us?

18. If there is one piece of advice you would give us in terms of how to ensure that this evaluation adds value, what would it be?

COUNTRY LEVEL – GOVERNMENT

BACKGROUND

1. Please can you give us a brief description of your role, and an overview of how you interact with UNICEF on issues related to HIV in children?

2. How have country-level priorities for HIV in children changed in the last decade?

3. How would you describe UNICEF's role in HIV in children (*first decade*) in [country X]?
    - How has this role changed over time since 2005?
    - What has this been in response to?

PARTNERSHIPS AND ADVOCACY

4. How would you describe UNICEF's approach to working with partners at country level?
    - What do you see as the main strengths and weaknesses of UNICEF's approach to partnerships?

5. How would you describe UNICEF's role in leadership and coordination role in HIV in children in comparison to other development partners?
    - How has this leadership role evolved over time vis-à-vis that of other partners? (*probe about UNAIDS and WHO*)
    - Do you think that UNICEF's coordination efforts have led to improved alignment and coherence in relation to strategies, policies, and implementation plans? Can you give any examples?

STRATEGIC INFORMATION

6. In [country X] what is the process by which global monitoring or research data is incorporated in decision making processes?

- How does UNICEF support this process? (*e.g. tools, platforms, guidance*)
- How applicable do you find the guidance from UNICEF related to HIV in children to the context here?
- Thinking back over the past decade and some of the big global shifts in recommendations on HIV in children, what have been the challenges in terms of their implementation at country level?

7. What do you see as the key strengths and weaknesses of the SI systems that you currently have to collect data on HIV in children?
   - Is this an area in which UNICEF supports? If so, what changes have occurred over time as a result of UNICEF support?
   - Is the system set up in a way to track things like equity? How have the UNICEF tools on equity (for example, MoRES) been used to support efforts to reduce disparities in service access?

SUPPORT TO GOVERNMENT AND STRENGTHENING SYSTEMS

8. What is UNICEF's approach to capacity building at country level?
   - What has changed in relation to programming for HIV in children as a result of UNICEF's support?

9. To what extent has UNICEF contributed to the building of national systems that serve women and children?
   - How does UNICEF balance achieving goals with the drawbacks of vertical programming?

RESOURCE MOBILISATION

10. How have the resources available for PMTCT and paediatric HIV in [country X] changed since 2005? For example, in terms of the amount of funding or its source?
    - How, if at all, are UNICEF working with you on resource mobilisation? What has been the outcome of this work? (*explore issues like number of donors, diversification of donors, multiyear commitments, innovative financing mechanisms etc.*)
    - What is your perspective on the potential for funding for HIV in children to be sustained in future?

ORGANISATIONAL STRUCTURE

11. What do you see as the key competencies and skills that people involved in UNICEF's PMTCT and paediatric HIV programs need at country level?
    - Is the composition and structure of the country team appropriate to the needs of the context?
    - Are there additional key skills or competencies that UNICEF's HIV team should develop that would increase the utility of their work with you?

CROSSCUTTING ISSUES

12. [HUMANITARIAN SETTINGS ONLY] To what extent has UNICEF promoted the inclusion of HIV services for women and children in humanitarian settings?
    - What were the main challenges faced in relation to this?
    - How has the focus on HIV services been balanced with other priorities in humanitarian settings?

13. To what extent do you think that UNICEF's focus on equity has shaped the response to HIV in children?
    - If *yes*, in what ways? If *no*, why do you think that is the case?
    - What do you see as the key strengths and weaknesses of an equity focus to scaling up HIV services for children?

14. To what extent has UNICEF supported human- and child-rights-based programming and gender-sensitive programming in relation to children and HIV?
    - What more could UNICEF do in these areas to increase the prominence given to human rights and gender in PMTCT and paediatric HIV programming?

CLOSING QUESTIONS

15. Looking forward, what do you see as the critical things that UNICEF could do to maximise its contribution to PMTCT and paediatric HIV programming in [country X]?

16. Before we close the interview, do you have any questions for us?

17. If there is one piece of advice you would give us in terms of how to ensure that this evaluation adds value, what would it be?

GLOBAL LEVEL – UNICEF

BACKGROUND

1. Could you give us a brief overview of your current role in UNICEF and how it interfaces with work on HIV in children? (*check on past roles if relevant*)

2. How would you describe UNICEF's role on children and HIV (*first decade*) in the global arena?
   - Do you have a sense of how has this role has changed over time since 2005?
   - What has this been in response to?

LEADERSHIP, COORDINATION, PARTNERSHIPS, AND ADVOCACY

3. How have global priorities related to children and HIV changed in the last decade?
   - To what extent do you think UNICEF has contributed to any shifts in priorities and increases in commitments for addressing HIV in children?

4. How would you describe UNICEF's leadership, convening, and coordination roles in HIV in children in comparison to that of other partners?
   - How has UNICEF's leadership, convening, and coordination roles evolved over time vis-à-vis that of other partners? (*probe about UNAIDS and WHO*)
   - Do you think that UNICEF's coordination efforts have led to improved alignment and coherence in relation to strategies, policies, and implementation plans? Can you give any examples?

5. How would you describe UNICEF's approach to brokering partnerships at different levels?
   - What have been the main strengths and weaknesses of UNICEF's work on partnerships?
   - What measures does UNICEF take to ensure that partnership arrangements work as intended?

PLANNING AND BUDGETING PROCESSES

6. What is the place of HIV in the first decade in the current strategic planning and budgeting processes at all levels of the organisation?

7. To what extent has UNICEF's work on HIV been coordinated or integrated with that in other sectors or workstreams?

8. How has UNICEF dealt with the need to balance the focus on achieving goals with the drawbacks of vertical programming?

STRATEGIC INFORMATION

9. How would you describe UNICEF's approach to generating, collating, and disseminating data and knowledge with regard to HIV in children?

10. Between 2005 and 2015, in what ways has UNICEF's work around data and knowledge contributed to progress with regard to HIV in children?

RESOURCE MOBILISATION

11. From an internal perspective, has UNICEF been effective in generating sufficient financial resources to meet its strategic objectives in relation to HIV in children and fully implement the programmes and projects that it supports?

12. To what extent has UNICEF played an effective role in leveraging financial resources from external partners to meet global resource needs?
    - What do you see as the key UNICEF activities (*e.g. global movements, campaigns, investment plans*) that have led to additional financial resources from external partners?
    - What have been the key challenges in terms of resource mobilisation?

13. What has been UNICEF's role in resource mobilisation at country level, either supporting countries to increase domestic spending or to access external resources?
    - Do you feel that there are opportunities for UNICEF to support countries more effectively?

ORGANISATIONAL STRUCTURE

14. What do you see as the key competencies and skills that people involved in UNICEF's PMTCT and paediatric HIV care and treatment programmes need at different levels?
    - How does UNICEF organise itself to ensure that these skills and competencies are present in its teams at national, regional, and global levels?
    - What are the mechanisms for coordination between global, regional, and national levels and between different sectoral teams in relation to HIV in children?
    - How has this organisational structure evolved over time?

CROSSCUTTING ISSUES

15. How, if at all, has UNICEF's focus on equity shaped the global response to children and HIV?
    - If *yes*, in what ways? If *no*, why do you think that is the case?
    - What do you see as the key strengths and weaknesses of an equity focus to scaling up HIV services for children?

CLOSING QUESTIONS

16. Looking forward, what do you see as the critical things that UNICEF could do to maximise its contribution to PMTCT and paediatric HIV programming?
17. Before we close the interview, do you have any questions for us?
18. If there is one piece of advice you would give us in terms of how to ensure that this evaluation adds value, what would it be?

GLOBAL LEVEL – DEVELOPMENT PARTNER

BACKGROUND

1. Please can you give us a brief description of your role in [organisation], and an overview of how you interact with UNICEF on issues related to HIV in children?
2. How would you describe UNICEF's role on children and HIV (*first decade*) in the global arena?
    - Do you have a sense of how has this role has changed over time since 2005?
    - What has this been in response to?

PARTNERSHIPS AND ADVOCACY

3. How have global priorities in relation to HIV in children changed in the last decade?
    - To what extent do you think UNICEF has contributed to any shifts in priorities and increasing commitments for children and HIV?
4. How would you describe UNICEF's leadership, convening, and coordination roles in HIV in children in comparison to other partners?
    - How has UNICEF's leadership, convening, and coordination roles evolved over time vis-à-vis that of other partners? (*probe about UNAIDS and WHO*)
    - Do you think that UNICEF's coordination efforts have led to improved alignment and coherence in relation to strategies, policies, and implementation plans? Can you give any examples?
    - Do you see any further opportunities for improvement that UNICEF could be leveraging?
5. How would you describe UNICEF's approach to brokering partnerships at different levels?
    - What have been the main strengths and weaknesses of UNICEF's work on partnerships?

SUPPORT TO GOVERNMENT AND STRENGTHENING SYSTEMS

6. To what extent has UNICEF contributed to the building of national systems that serve women and children?
    - How has UNICEF dealt with the need to balance the focus on achieving goals with the drawbacks of vertical programming?
7. How would you describe UNICEF's approach to capacity building at global, regional, and country levels (*tailor to respondent*)?
    - What do you see as UNICEF's main achievements in this area over the past decade? What about any potential missed opportunities?

STRATEGIC INFORMATION

8. How would you describe UNICEF's approach to generating, collating, and disseminating data and knowledge in relation to HIV in children?
    - How has this evolved over time since 2005?
9. Between 2005 and 2015, in what ways has UNICEF's work around data and knowledge contributed to progress in relation to HIV in children?
    - What is your perspective on the added value of UNICEF's approach to SI/data/knowledge in relation to your approaches and those of other development partners?
10. What is your perspective on how UNICEF supports the translation of global monitoring or research data into decision making at the national level?
    - What do you see as the main challenges?

RESOURCE MOBILISATION

11. To what extent has UNICEF played an effective role in leveraging financial resources from external partners to meet global resource needs?

- What do you see as the key UNICEF activities (*e.g. global movements, campaigns, investment plans*) that have led to additional financial resources from external partners?
- What have been the key challenges in terms of resource mobilisation?

12. What is your perspective on the potential for global levels of funding for HIV in children to be sustained in future?

ORGANISATIONAL STRUCTURE

13. What do you see as the key competencies and skills that people involved in UNICEF's PMTCT and Paediatric HIV programs need at different levels?
    - Is the composition and structure of the UNICEF HIV/AIDS programme appropriate for the areas in which it is currently working?
    - Are there additional key skills or competencies that UNICEF's HIV team should develop that would increase the utility of their work with you?

CROSSCUTTING ISSUES

14. To what extent has UNICEF been able to support gender-sensitive programming in relation to HIV in children?
    - What more could UNICEF do to promote gender-sensitive programming in relation to children and HIV?

15. To what extent has UNICEF promoted human- and child-rights-based programming in relation to HIV in children, and the global response?
    - Do you see opportunities to increase the prominence given to human rights and gender in PMTCT and paediatric HIV programming?

16. How, if at all, has UNICEF's focus on equity shaped the global response to children and HIV?
    - If *yes*, in what ways? If *no*, why do you think that is the case?
    - What do you see as the key strengths and weaknesses of an equity focus to scaling up HIV services for children?

17. To what extent has UNICEF supported the inclusion of HIV services for women and children in humanitarian settings?
    - How has the focus on HIV services been balanced with other priorities in humanitarian settings?

CLOSING QUESTIONS

18. Looking forward, what do you see as the critical things that UNICEF could do to maximise its contribution to PMTCT and paediatric HIV programming?

19. Before we close the interview, do you have any questions for us?

20. If there is one piece of advice you would give us in terms of how to ensure that this evaluation adds value, what would it be?

REGIONAL LEVEL – UNICEF INTERVIEW GUIDE

BACKGROUND

21. Please can you give us a brief overview of your role in UNICEF and how long you've been working on issues related to PMTCT and HIV in children? (*check on past roles if relevant*)

22. How would you describe UNICEF's role in PMTCT and paediatric HIV care in [region X]?
    - Do you have a sense of how has this role has changed over time since 2005?
    - What has this been in response to?

PARTNERSHIPS AND ADVOCACY

23. How have priorities for HIV in children changed in the last decade across the region?
    - To what extent do you think UNICEF has contributed to any shifts in priorities and increasing commitments for children and HIV?

24. How would you describe UNICEF's approach to brokering partnerships at a regional level?
    - How do you engage with regional organisations? (*probe for who these are – e.g. AU*)
    - What do you see as the main strengths and weaknesses of UNICEF's approach to partnerships?

25. How has UNICEF's leadership, convening, and coordination roles evolved over time vis-à-vis that of other partners? (*probe about UNAIDS and WHO*)
    - Do you think that UNICEF's coordination efforts have led to improved alignment and coherence in relation to strategies, policies, and implementation plans within the region? Can you give any examples?
    - What have been the key challenges that UNICEF has faced in undertaking this role?

STRATEGIC INFORMATION

26. What is the role of the UNICEF regional office in generating, collating, and disseminating data and knowledge in relation to HIV in children?
    - Between 2005 and 2015, in what ways has UNICEF's work around data and knowledge contributed to progress with regard to HIV in children?
    - How does UNICEF support the translation of global monitoring or research data into decisionmaking at the regional level? (*e.g. probe – to what extent does this happen regionally vs. nationally*)
    - What have been the challenges? (*e.g. in relation to the past decade and some of the big global shifts in recommendations on HIV in children*)

RESOURCE MOBILISATION AND PLANNING

27. What is the place of HIV in the first decade in the current strategic planning and budgeting processes at all levels of the organisation?

28. From an internal perspective, has UNICEF been effective in generating sufficient financial resources to meet its strategic objectives in relation to HIV in children and fully implement the programmes and projects that it supports?
    - What is the role of the regional offices in this, in comparison to HQ and country offices?

29. Can you describe the role that UNICEF RO has had in resource mobilisation for HIV in children in since 2005?
    - To what extent has this translated into changes in the amount and type of funding available for PMTCT/paediatric HIV over time, either from domestic sources or from external sources? (*explore issues like number of donors, diversification of donors, multiyear commitments, innovative financing mechanisms etc.*)
    - What have been the key challenges in terms of resource mobilisation in [country X]?

ORGANISATIONAL STRUCTURE

30. How does UNICEF organise itself to ensure that the right skills and competencies are present in its teams at national, regional, and global levels to address the needs of the PMTCT and paediatric HIV programs?
    - What are the roles of the HQ, RO and CO within the UNICEF PMTCT and paediatric HIV program? How do they differ from each other?

31. What are the mechanisms for coordination between global, regional and national levels and between different sectoral teams, in relation to HIV in children in UNICEF?
    - How is UNICEF's work on HIV coordinated or integrated with other sectors or workstreams at a regional level?

CROSSCUTTING ISSUES

32. [HUMANITARIAN SETTINGS ONLY] To what extent has UNICEF promoted the inclusion of HIV services for women and children in humanitarian settings?
    - What were the main challenges faced in relation to this?
    - How has the focus on HIV services been balanced with other priorities in humanitarian settings?

33. To what extent do you think that UNICEF's focus on equity has shaped its response to children and HIV?
    - If *yes*, in what ways? If *no*, why do you think that is the case?
    - What do you see as the key strengths and weaknesses of an equity focus to scaling up HIV services for children?

34. To what extent has UNICEF supported human- and child-rights-based programming and gender-sensitive programming in relation to children and HIV?
    - What more could UNICEF do in these areas to increase the prominence given to human rights and gender in PMTCT and paediatric HIV programming?

CLOSING QUESTIONS

35. Looking forward, what do you see as the critical things that UNICEF could do to maximise its contribution to PMTCT and paediatric HIV programming?

36. Before we close the interview, do you have any questions for us?

37. If there is one piece of advice you would give us in terms of how to ensure that this evaluation adds value, what would it be?

E.2 Survey questionnaire

Introduction

UNICEF has commissioned an evaluation of its activity in the Prevention of Mother to Child Transmission of HIV (PMTCT) and paediatric HIV care and treatment during 2005-2015. The purpose of this evaluation is to support accountability and learning in relation to UNICEF's efforts to scale up PMTCT and paediatric care and treatment programmes.

We would value your contribution to this evaluation through completion of this short survey. It should take no more than 10 minutes to complete and all responses will be kept confidential. We would be very grateful if you could complete the survey by Monday 6th June.

Thank you very much

Background

Please select what type of organisation you work for:

a. UNICEF

b. Government

c. cWHO

d. UNAIDS

e. Academic institution

f. Other UN agency (please specify) __________

g. Other development partner, donor or non-governmental organisation (please specify)________

Please select which country you are based in:

What is your job title?

Please indicate how many years you have been working in PMTCT and/or paediatric HIV care and treatment in the country?

a. less than 1

b. 1 – 3

c. 4 – 6

d. 7 – 9

e. 10 or more

Please indicate your degree of familiarity with UNICEF's work in PMTCT and paediatric HIV care and treatment in your country?

a. Very familiar

b. Somewhat familiar

c. Not familiar

UNICEF's role

To what extent have each of the activity areas listed below been **key areas of focus** for UNICEF in your country, during the period of 2005-2015, in relation to PMTCT and paediatric HIV care and treatment? Please provide your best estimate for each area, based on your knowledge and the time period in which you have been working in the area:

None: No role in this kind of activity in the country

Minimal: Small role, but not instrumental in comparison to the work of others

Significant: Participated in the activities and contributed to progress in the area

Critical: Initiated and/or led on the activities and has remained an active and vital player throughout

	None	Minimal	Significant	Critical	Don't know
Support in mobilising financial resources for programme implementation from development partners					
Support in mobilising financial resources for programme implementation from domestic sources					
Advocacy for increased access for women and children to care and treatment					
Support for development of evidence-informed policies, strategies and plans					
Support for programme implementation of PMTCT and/or paediatric HIV care and treatment					
Capacity development in relation to PMTCT and/or paediatric HIV care and treatment					
Production and dissemination of strategic information or technical guidance					
Production and dissemination of new knowledge derived from research, evaluations or reviews					
Procurement of HIV commodities - including paediatric ARVs and diagnostics					

Leadership, partnerships and advocacy

Please indicate whether you strongly agree, agree, disagree or strongly disagree with each of the following statements in your country currently:

- There is political commitment to plan for and support the scale-up of PMTCT and paediatric HIV care and treatment services
- Strategies, policies and implementation plans for PMTCT and paediatric HIV care and treatment are aligned and coherent across partners
- There is adequate capacity among national stakeholders to plan for and support the scale-up of PMTCT and paediatric HIV care and treatment services

Please state whether you strongly agree, agree, disagree or strongly disagree with each of the following statements:

During 2005-15, in your country

- UNICEF has contributed to shifts in priorities and increasing commitments in relation to PMTCT and paediatric HIV care and treatment
- UNICEF has built effective partnerships around PMTCT and paediatric HIV care and treatment
- UNICEF has played an important role in coordinating program design, planning and implementation among partners
- UNICEF has built capacity of country level stakeholders for planning, resourcing and implementing PMTCT and paediatric HIV care and treatment services.
- UNICEF has played an important role in supporting the scale up of PMTCT and paediatric HIV care and treatment services

Please provide any reasons for your answers

Resource mobilisation

Please indicate whether you strongly agree, agree, disagree or strongly disagree with each of the following statements in your country currently:

- The resources for PMTCT and paediatric HIV care and treatment are provided in a predictable manner.
- The resources for PMTCT and paediatric HIV care and treatment are provided in a sustainable manner.

Leadership, partnerships and advocacy

Please state whether you strongly agree, agree, disagree or strongly disagree with the following statements:

During 2005-15, in your country:

- UNICEF has made an important contribution to increasing domestic spending on PMTCT and paediatric HIV care and treatment
- UNICEF has made an important contribution to increasing the amount of external resources for PMTCT and paediatric HIV care and treatment
- UNICEF has initiated, supported and coordinated movements, campaigns or investment plans to mobilise financial resources for PMTCT and paediatric HIV care and treatment.
- UNICEF has had an important contribution to establishing and building a sustainable programme for PMTCT and paediatric HIV care and treatment

Please provide any reasons for your answers

Strategic information

Please indicate whether you strongly agree, agree, disagree or strongly disagree with the following statements in your country currently:

- There are mechanisms to ensure accountability for provision and scale-up of PMTCT and paediatric HIV care and treatment at country level.
- Strategies, policies and approaches to implementation are informed by evidence on what does and does not work and why in relation to PMTCT and paediatric HIV care and treatment

Please state whether you strongly agree, agree, disagree or strongly disagree with the following statements:

During 2005-15, in your country:

- UNICEF has had an important role in the generation of data and knowledge related to PMTCT and paediatric HIV care and treatment
- UNICEF has had an important role in the dissemination of data and knowledge related to PMTCT and paediatric HIV care and treatment
- UNICEF's work on data and knowledge has contributed to progress in scaling up PMTCT and paediatric HIV care and treatment services
- UNICEF has strengthened country-level ability to generate and collate data for accountability and learning around PMTCT and paediatric HIV care and treatment

Please provide any reasons for your answers

Cross cutting issues

Please state whether you strongly agree, agree, disagree or strongly disagree with the following statements:

In your country currently:

- PMTCT and paediatric HIV policies and programmes are resourced and implemented in a gender-sensitive manner
- PMTCT and paediatric HIV policies and programmes are resourced and implemented in a geographically equitable manner
- PMTCT and paediatric HIV policies and programmes are resourced and implemented in a manner that prioritises the most disadvantaged populations
- PMTCT and paediatric HIV policies and programmes are resourced and implemented in a human-rights based manner
- PMTCT and paediatric HIV care and treatment is integrated into any humanitarian responses.

In the period 2005-15, to what extent have gender, human rights, equity and delivery of services in humanitarian situations been a focus of UNICEF's approach to PMTCT and paediatric HIV care and treatment programming in your country?

	1 (not a focus)	2 (limited focus)	3 (moderate focus)	4 (strong focus)	Don't know
Gender					
Human rights					
Equity					
PMTCT and paediatric HIV care and treatment in humanitarian situations					

What more could UNICEF do to strengthen the prominence of gender, human rights and equity in relation to PMTCT and paediatric HIV care and treatment?

Organisational structure

UNICEF Internal questions

Please state whether you strongly agree, agree, disagree or strongly disagree with the following statements:

- UNICEF Country Office has a clear strategy in relation to its work in PMTCT and paediatric HIV
- PMTCT and paediatric HIV are given adequate priority by the leadership of the Country Office
- UNICEF focuses its activities in PMTCT and paediatric HIV where it adds most value
- The number of people working on PMTCT and paediatric HIV in the Country Office is appropriate for the areas in which it is working
- The structure of the team that works on working on PMTCT and paediatric HIV in the Country Office is appropriate
- UNICEF staff have the right skills and competencies for the areas in which they are working
- UNICEF has been effective in securing sufficient financial resources for its activities.
- UNICEF has responded to developments in PMTCT and paediatric HIV over time, making necessary internal adjustments
- There is effective coordination between the UNICEF Country Office, Regional Office, and Headquarters
- There are strong and effective linkages between UNICEF's work in PMTCT and paediatric HIV and its work in other sectors

External questions

Please state whether you strongly agree, agree, disagree or strongly disagree with the following statements:

- UNICEF Country Office has a clear strategy in relation to its work in PMTCT and paediatric HIV
- UNICEF focuses its activities in PMTCT and paediatric HIV where it adds most value
- UNICEF has responded to developments in PMTCT and paediatric HIV over time, making adjustments to its ways of working
- The number of people working on PMTCT and paediatric HIV in the Country Office is appropriate for the areas in which it is working
- UNICEF staff have the right skills and competencies for the areas in which they are working
- There are strong and effective linkages between UNICEF's work in PMTCT and paediatric HIV and its work in other sectors

Please provide any reasons for your answers

Achievements and areas for improvement

What do you see as the most important achievements of UNICEF in relation to PMTCT and paediatric HIV care and treatment in your country during 2005-15?

If UNICEF was to limit its ongoing activities on PMTCT and paediatric HIV care and treatment in your country to 2-3 areas where it adds greatest value, what do you think these should be? Are there any activities that it should stop investing in?

Thank you very much for taking part in this survey. Your responses will be a valuable contribution to the evaluation.

ANNEX F: METHODOLOGY NOTE FOR RESOURCE MOBILIZATION ANALYSIS

This annex sets out the methodology for the data analyses conducted as part of the evaluation

Global HIV financing landscape

Estimates for global resources for HIV/AIDS in low- and middle-income countries were derived from the 2015 UNAIDS report "How AIDS Changed Everything". The level of global resources reflected in this report is significantly higher than in data available in publicly available databases (i.e. the AIDSinfo and OECD CRS databases). It is understood that this data was generated from UNAIDS estimates from June 2015, based on UNAIDS-KFF reports on financing the response to AIDS in low- and middle-income countries until 2014; the OECD CRS database; GARPR/ UNGASS reports; and the 2014 FCAA Report on Philanthropic Funding. While the evaluation team has not had access to the database used to generate these estimates, it is felt to be a credible source of information given the expertise held by UNAIDS in this area.

The OECD CRS database was further used to:

- Reference the proportion of total Official Development Assistance (ODA) and ODA for health that is allocated to HIV/AIDS.
- Analyse ODA disbursements for HIV/AIDS by donor.
- Analyse ODA disbursements for HIV/AIDS by UNICEF region.

Estimates for HIV/AIDS were calculated using the OECD CRS sector codes 13040 (STD control, including HIV/AIDS) and 16064 (Social mitigation of HIV/AIDS).

Country HIV financing analysis

For case study countries, data on total public, private and international expenditures on HIV/AIDS was collected from the AIDSinfo Online database. This presents country-reported Global AIDS Response Progress Reporting (GARPR) data. It should be noted that there are often substantial differences between GARPR country-reported data and donor-reported data through the OECD CRS database; and that data reporting is likely to have improved over time and, as such, changes over time may not be fully representative of actual funding flows.

The OECD CRS database was further used to analyse ODA disbursements for HIV/AIDS by donor, and over time. Estimates for HIV/AIDS were calculated using the OECD CRS sector codes 13040 (STD control, including HIV/AIDS) and 16064 (Social mitigation of HIV/AIDS).

Data on UNICEF's expenditure on PMTCT and paediatric HIV care and treatment was analysed for each country (see below).

Total country expenditures on PMTCT were also analysed, where information was available through the country National AIDS Spending Assessment (NASA) reports. This was cross-referenced against the estimated resource requirement for PMTCT set out in the 2011 Investment Framework for HIV/AIDS.[125]

UNICEF income

Data on UNICEF's total revenue by category (i.e. Regular Resources and Other Resources) and source (i.e. public sector and private sector) between 2005 and 2015 was obtained from the UNICEF 2014 Annual Report and the 2015 HIV/AIDS Results Report.

Data on UNICEF's income for HIV/AIDS between 2005 and 2015 was derived from the UNICEF 'income cube' and was provided by the Planning, Management and Finance Department. We understand that this data from 2010 onwards has been cleansed, and reflects the same data used to present the 'HIV Financial Analysis (2010–2015)' at the May 2016 UNICEF Regional Advisors Meeting.

This data was used to analyse resources received by UNICEF for HIV/AIDS over time, by category (Regular Resources and Other Resources), and by source (i.e. bilateral and multilateral agencies, national committees, and other agencies/instruments).

This information was supplemented with further data on thematic resources (as obtained through

[125] Schwartländer, B. et al. 2011. "Towards an improved investment approach for an effective response to HIV/AIDS", *Lancet*, DOI:10.1016/S0140- 6736(11)60702-2.

the UNICEF 2013 and 2014 Annual Reports, and the UNICEF 2014 and 2014 Annual Results Report for HIV/AIDS), and the UNAIDS Unified Budget, Results and Accountability Framework (UBRAF; as obtained through the UNAIDS 2015 report "2016–2021 UBRAF"). It is noted, however, that the data in these reports does not entirely match the data derived from the UNICEF 'income cube'. The reasons for this are not clear.

It is, however, noted that because of a change in accounting policy from UNSAS to IPSAS, trend analysis including data from pre-2012 should be interpreted with caution as historical trend data could not be restated.

UNICEF expenditure on HIV/AIDS

Data on UNICEF's expenditure for HIV/AIDS was obtained from successive UNICEF Annual Reports from 2005 to 2014. This was used to analyse trends in expenditure on HIV/AIDS, relative to total programme assistance and revenues for HIV/AIDS, and by category (Regular Resources and Other Resources).

It is, however, noted that because of a change in accounting policy from UNSAS to IPSAS, trend analysis including data from pre-2012 should be interpreted with caution as historical trend data could not be restated.

UNICEF expenditure on PMTCT and paediatric HIV care and treatment

Data on UNICEF's expenditure on PMTCT and paediatric HIV care and treatment between 2012 and 2015 was provided by the Evaluation Office, as confirmed by the Planning, Management and Finance Department. This reflects the same data used to present the 'HIV Financial Analysis (2010–2015)' at the May 2016 UNICEF Regional Advisors Meeting.

This data set was used to:

- Analyse UNICEF expenditure on PMTCT and care and treatment of children affected by HIV/AIDS by category (Regular Resources and Other Resources) and by UNICEF region over time.
- Plot UNICEF's expenditure on PMTCT and care and treatment of children affected by HIV/AIDS between 2012 and 2015 by country, against the WHO estimated number of pregnant women living with HIV needing ARVs for PMTCT in 2014.
- Analyse expenditure in individual case study countries.

There are, however, two caveats to the data.

- First, it has not been possible to obtain expenditure data for HIV/AIDS before 2012 because of the change in accounting policy from UNSAS to IPSAS.
- Second, we understand that the structure of UNICEF's internal reporting system has followed the structure of UNICEF's organisational strategic plans. The period between 2012 and 2015 crosses the 2006–13 Medium-Term Strategic Plan and the 2014–17 Strategic Plan. As such, the data reflects a change in the coding of expenditures. More specifically, for 2012 and 2013 the figures present expenditure to reduce the number of paediatric HIV infections; to increase the proportion of HIV-positive women receiving antiretrovirals (ARVs); and to increase the proportion of children receiving treatment for HIV/AIDS. For 2014 and 2015 the figures present expenditure on two programme areas: (a) PMTCT and infant male circumcision; and (b) care and treatment of children affected by HIV/AIDS.

ANNEX G: LIST OF PEOPLE INTERVIEWED

Global key informants

Name	Title	Organisation
UNICEF		
Susan Bissell	Chief, Child Protection	UNICEF
Ted Chaiban	Director, Programme Division since 2014	UNICEF
Dick Chamla	Paediatric HIV, Health section	UNICEF
Mickey Chopra	Previous Chief, Health	UNICEF
Thilly De Bodt	Representation from Finance	UNICEF
Peter Frobel	Associate Director, DHR	UNICEF
Geeta Rao Gupta	Deputy Executive Director, Programmes	UNICEF
Yasmin Haque	Deputy Director, EMOPS	UNICEF
Priscilla Idele	Senior Advisor, Data and Analytics	UNICEF
Sarah Kamin	HIV/AIDS specialist, EMOPS	UNICEF
Ken Legins	Senior Advisor on Children, Adolescents and HIV	UNICEF
Chewe Luo	Senior Advisor & Team Leader, Country Scale-up Programme	UNICEF
Dorothy Mbori-Ngacha	Nigeria	UNICEF
Craig McClure	Previous Chief, HIV/AIDS Section	UNICEF, WHO
Eva Mennel	Director HR	UNICEF
Doreen Mulenga	Deputy Director Supply Division, and previously PMTCT/HQ	UNICEF
Jeff O'Malley	Director of Policy and Strategy	UNICEF
Luwei Pearson	Former Regional Advisor, Health, ESARO	UNICEF
Jessica Rodrigues	HIV Specialist, Knowledge Management	UNICEF
Braeden Rogers	HIV/AIDS specialist, Health section	UNICEF
Sostena Romano	Senior Advisor, HIV/AIDS	UNICEF
Tin Tin Sint	Nutrition Specialist, HIV and nutrition	UNICEF
Guy Taylor	Communications	UNICEF
Partners and other external respondents		
Lynn Collins	Lead, PMTCT, UNFPA	UNFPA
Shaffiq Essajee	Previously CHAI, now PMTCT/WHO	WHO
Peter Ghys	Director, Strategic Information	UNAIDS
Sam Kalibala	Project Director, HIV Core, PC since 2012	Population Council

Peter Kazembe	Executive Director, Malawi	Baylor
Jimmy Kolker	Assistant Secretary for Global Affairs	UNICEF, HHS
Stephen Lee	Vice President	EGPAF
Anna Levine	Ray Chambers office, working with private sector on PMTCT	Ray Chambers Office
Kate Lorpenda	Senior Advisor on Children and HIV	International HIV/AIDS Alliance
Viviana Mangiaterra	Senior technical coordinator, MNCH, GFATM	GFATM
Robert Matiru	Director of Operations	UNITAID
Surbhi Modi	Representative on IATT	CDC
Phillippa Musoke	Associate Professor	Makere, Uganda
Marie-Goretti Harakeye Ndayisaba,	Social Affairs Department, Africa Union	Africa Union
Carol Presern	Head of the Office of Board Affairs	Global Fund
Nathan Schaffer	Retired	WHO
Joyce Seto	Direction génerale de la santé et de la nutrition | Health and Nutrition Bureau (MND)	DFATD
Aditi Sharma	GNP+ and IATT CEWG Co-chair	IATT
Mark Stirling	Retired	UNICEF, UNAIDS
Nandita Sugandhi	Clinical Advisor	CHAI
Elhadj As Sy	Secretary General	IFRC
Denis Tindyebwa	Executive Director	ANECCA
Fatima Tsiouris		ICAP
Heather Watts	Representative of the Office of the Global AIDS Coordinator, State Department	OGAC

Regional key informants

Name	Title	Organisation
UNICEF		
Anurita Bains	Regional Advisor HIV	UNICEF ESARO
Luisa Brumana	Regional Health Advisor	UNICEF TACRO
Wing-Sie Chen	EAPRO Regional Advisor for HIV/AIDS (2005–15)	UNICEF EAPRO
Edward Eddai	Regional Chief Programme Planning, Monitoring and Evaluation	UNICEF ESARO
James Elder	Communications Regional Advisor	UNICEF ESARO
Nina Ferencic	HIV/AIDS Regional Advisor	UNICEF CEE/CIS
Leisa Gibson	Gender Regional Advisor	UNICEF ESARO
Laurie Gulaid	Senior Health Specialist	UNICEF ESARO

Mark Hereward	Deputy Regional Director	UNICEF ESARO
Claudes Kamenga	Regional Chief, HIV/AIDS	UNICEF WCARO
Janet Kayita	Regional MNCH Advisor	UNICEF ESARO
Annefrida Kisesa	Regional HIV Advisor	UNICEF ROSA
Ruslan Maluta	HIV/AIDS Specialist	UNICEF CEE/CIS
Joan Matji	Nutrition Regional Advisor	UNICEF ESARO
Ralph Midy	HIV / AIDS Specialist and PMTCT Advisor	UNICEF TACRO
Leila Pakkala	Regional Director	UNICEF ESARO
Deepa Pokharel	Communication for Development Specialist	UNICEF ESARO
Bettina Schunter	Child Protection Regional Advisor	UNICEF ESARO
Pablo A Stansberry	ECD Regional Advisor	UNICEF ESARO
Landry Dongmo Tsague	Regional PMTCT Advisor	UNICEF WCARO
Partner		
Asa Andersson	Regional Programme Coordinator of the SRHR-HIV Linkages project	UNFPA East and Southern Africa
Biziwick Mwale	Strategic information	UNAIDS East and Southern Africa
Morkor Newman	WHO/AFRO regional PMTCT/ART coordinator	WHO
Brian Pazvakanambwa	WHO/AFRO regional HIV	WHO
Sheila Tlou	Regional Director	UNAIDS East and Southern Africa

Country case study key informants

Name	Title	Organisation
Cambodia		
UNICEF		
Etienne Poirot	Chief of Child Survival and Development, Integrated Early Childhood Development	UNICEF
Penelope Campbell	Health Section Chief (2012–13) HIV/AIDS Section Chief/ Advisor (2009–12)	UNICEF
Sedtha Chin	HIV/AIDS specialist (2005–15)	UNICEF
Government		
Mean Chhi Vun	Director (2005–14)	NCHADS

Partners and other organisations		
Tony Lisle	Regional Programme Advisor, UNAIDS Regional Support Team, Asia and the Pacific (2012 to date) Country Coordinator, UNAIDS Cambodia (2006–12)	UNAIDS
Marie-Odile Emond	Country Coordinator, UNAIDS Cambodia (2012 to date)	UNAIDS
Kunthea Soch	HIV Specialist (2007 to date)	USAID/ PEPFAR
Nicole Seguy	Country Office HIV Advisor (2005–10)	WHO
Kolab Chhim	Deputy Chief of Party and Manager: HIV/ AIDS Care and treatment	Khmer HIV/AIDS NGO Alliance
Cameroon		
UNICEF		
Christophe Awono	Programme Assistant Programme Support & Partnerships	UNICEF
Ange Geneviève EPEE	Human Resources Assistant	UNICEF
Daniela Luciani	Chief, Child Protection	UNICEF
Brigitte Matchinda	Education Specialist and Gender Focal Point	UNICEF
Ibrahim Mugnol	PMTCT officer	UNICEF
Thérèse Nduwimana	Chief HIV/AIDS	UNICEF
Belyse Halmata Nguum	Chief, Health	UNICEF
Felicité Tchibindat	CCO Representative	UNICEF
Government		
Tjek Biyaga	Head (“chef de service”) of PMTCT	DFH
Jean Bosco Elat	Permanent Secretary	CNLS
Zeh Kakanou	Responsible for HIV Response	DDC
Alain Charlie Mbo’o	Former Head (“chef de service”) of HIV	DDC
Seidou Moluh	Director of the Department of Reproductive Health	DFH
Anne Esther Njom Nlend	Paediatrician	CNPS
Marie Louise Ngono	Former Head (“chef de service”) of PMTCT	DLMEP and then DSF
Partners and other organisations		
Michel Irogo	President	RECAP
Etienne Kembou	HIV/AIDS, Nutrition and Food Safety, Programme Officer	WHO
Ebogo Mbezele Mesmey	Country Director	ICAP

Claire Mulanga	Country Director	UNAIDS
Ida Penda	Paediatrician	Laquintinie Hospital
Patrice Tchenjou	M&E Supervisor (consultant)	EGPAF
Gabriel Tchokomakwa	Programme Analyst, Reproductive Health/Youth and Humanitarian National Programme Officer	UNFPA
Haiti		
UNICEF		
Marie Sonia Jean	HIV/AIDS Specialist	UNICEF (HCO)
Francine Kimanuka	Health Manager	UNICEF (HCO)
Marc Vincent	Country Office Representative	UNICEF (HCO)
Government		
Reynold Grand Pierre	Director	Direction de la Santé de la Famille (DSF) du MoH
Partners and other organisations		
Evelyne Degraff	MNCH Advisor	WHO/PAHO
Marie Marcelle Deschamps	Programme Manager, Director	GHESKIO
Altagrace Michèle Maignan	Technical Director	Fondation Esther B. Stanislas
Anthony Monfiston	National consultant HIV/Reproductive Health	WHO/PAHO
India		
UNICEF		
Henriette Ahrens	Deputy Representative	UNICEF – Delhi
Dr Sudha Balakrishnan	Health Specialist	UNICEF – Delhi
Dr Khanindra Bhuyan	Health Specialist	UNICEF – Mumbai
Dr Dick Chamla	Paediatric HIV Lead	UNICEF – HQ
Shweta Dahiya	Resource Mobilisation Section	UNICEF – Delhi
Mr Sonykutty George	Child Protection Specialist	UNICEF – Hyderabad
Dr Gagan Gupta	Newborn Lead, Health Section	UNICEF – Delhi
Dr Prakash Gurnani	Chief of Field Office (retired)	UNICEF – Gujarat
Dr Lalitha Hande	PPTCT Consultant (UNICEF supported)	Karnataka
Dr Madhulika Jonathan	Chief of Field Office	UNICEF – Ranchi
Swati Mohapatra	Communication Specialist	UNICEF – Delhi
Dr Mario Mosquera	Chief C4D	UNICEF – Delhi

Bernadette Rai	M&E Officer, m4D	UNICEF – Delhi
Dr Tushar Rane	Chief of Field Office	UNICEF–Guwahati
Dr Karanveer Singh	Nutrition Specialist	UNICEF – Delhi
Dr Meena Som	Health Specialist	UNICEF – Hyderabad
Michiru Tamanai	Chief HR	UNICEF – Delhi
Dr Sanjeev Upadhyaya	Health Specialist	UNICEF – Hyderabad
Vijayalakshmi Vasudevan	Budget Officer, m4D	UNICEF – Delhi
Dr Yaron Wolman	Chief of Health	UNICEF – Delhi
Government and health facility staff		
Ms Narmada Anand	Programme Director ICPS	Ministry of Women & Child Development
Dr Ashok	Ex-DAPCU Officer, Udupi, and Deputy Director Maternal Health (current)	MoHFW, Karnataka
Dr Damodar Bachani	Deputy Director General for Basic Services Department and Care Support and Treatment	MoHFW
Dr Dinesh Baswal	Deputy Commissioner, Maternal Health	MoHFW
Dr Asha Benakappa	Director	Indira Ghandi Paediatric Centre of Excellence, Karnataka
Dr Anita Desai	Professor and Head of Neurovirology Department	NIMHANS, Karnataka
Dr Dhanyakumar	Ex-Director, Health Services, Health Directorate	MoHFW, Karnataka
Dr Jagdish	I/C District AIDS Prevention and Control Unit (DAPCU) Officer	MoHFW, Karnataka
Dr Karur	Additional Project Director and Consultant for Mental Health (Current)	KSAPS, Karnataka
Dr Sunil Khaparde	Deputy Director General for Basic Services Department	MoHFW
Dr Ravi Kumar	Medical Officer	ART centre, Karnataka
Dr Mamta Manglani	Professor & Head of Paediatrics, Chief of the Division of Hematology and Oncology, Programme Director for the Paediatric Centre of Excellence for HIV Care	Lokmanya Tilak Municipal Medical College & General Hospital, Mumbai
Dr Suresh Mohammed	National Programme Officer for PPTCT	NACO and MoHFW
Mr Chakravarthy Mohan	Ex-Project Director and Commissioner for Collegiate Education	KSAPS, Karnataka
Dr Mohan Raj	Programme Director, Reproductive and Child Health, Health Directorate (retired)	MoHFW, Karnataka
Dr Rajkumar	Ex-DAPCU Officer, Kolar, and Deputy Director ASHA programme (current)	MoHFW, Karnataka
Dr H.C. Ramesh	Programme Director, Reproductive and Child Health, Health Directorate (retired)	MoHFW, Karnataka
Dr Raghuram Rao	National Programme Officer–ICTC/PPTCT and Assistant Director General, NACO	NACO and MoHFW
Mr Raveendra	Ex-Project Director	KSAPS, Karnataka

Dr Ravi	Professor, Department of Neurovirology	NIMHANS, Karnataka
Dr Renuka	Programme Director, Reproductive and Child Health, Health Directorate	MoHFW, Karnataka
Dr G.N. Sanjeeva	Assistant Professor	Indira Ghandi Paediatric Centre of Excellence, Karnataka
Dr Satish	Senior Medical Officer	ART centre, Karnataka
Partners and other organisations		
Dr Balasubramanya	CEO	Swami Vivekananda Youth Movement
Dr Rehana Begum	PPTCT Consultant	Centre for Global Health Research
Mr Ajey Bhardwaj	CEO	Avni Health Foundation, Maharashtra
Dr Po-Lin Chan	Medical Officer for HIV and Senior Advisor Hepatitis/HIV/STI	WHO- China (ex-WHO-India)
Dr Paul Francis	National Professional Officer, MCH	WHO-India
Nandini Dhingra Kapoor	Senior Programme Advisor	UNAIDS
Ms P. Kousalya	President	Positive Women Network
Amith Nagaraj	Operations Officer	World Bank
Mr Manoj Pardesi	General Secretary	National Coalition Of People Living With HIV in India
Dr D.C.S. Reddy	Surveillance expert (retired)	WHO-India
Ms Saroja	Director	Karnataka Network of Positive People
Dr Nicole Seguy	Team Leader Communicable Diseases Cluster	WHO-India
Dr K. Sudhakar	Senior Advisor (retired)	CDC – India
Oussamma Tawil	Country Director	UNAIDS
South Africa		
UNICEF		
Dr Sanjana Bhardwaj	Chief of Health and Nutrition section	UNICEF
Dr Yulia Privalova Krieger	Deputy Representative	UNICEF
Ms Sebenzile Mabena	HR Specialist	UNICEF
Ms Zodwa Mthethwa	M&E Specialist	UNICEF
Dr Kondwani N'goma	HIV/AIDS Specialist	UNICEF
Ms Nokuthula Prusent	Adolescent and Youth Specialist	UNICEF
Mr Rory Williams	Budget Officer	UNICEF
Government		
Dr Lesley Bamford	Technical Advisor, Child health cluster	NDoH Child Health Cluster
Dr Peter Barron	Technical Advisor PMTCT	NDoH
Dr Pearl Holele	Chief Director: Maternal, Neonatal and Women's Health	NDoH

Ms Lebo Madisha	Deputy Director, and programme manager for paediatric HIV	NDoH Child Health Cluster
Ms Mazibuko	Director, Child health cluster	NDoH Child Health Cluster
Yogan Pillay	Deputy DG/HIV, TB and MCH/South Africa, and global policy advisor	NDoH
Partners and other organisations		
Dr Sandra Barber	WHO Representative	WHO
Prof. Jerry Coovadia		MATCH
Dr Ameena Goga	Senior Specialist Scientist: Health Systems Research Unit	South African Medical Research Council
Dr Shungu Gwarinda	Country Director	mothers2mothers
Mr Mark Heywood	Executive Director	Section 27
Dr Gulprit Kindra	Public Health Specialist Care and Treatment Branch	CDC
Dr Nancy Knight	Coordinator	CDC
Dr Mary Mogaswa	Chief, Care and Treatment Branch	CDC
Dr Erasmus Morah	Country Director	UNAIDS
Precious Robinson	MNCWH and PMTCT Programme Lead	Right to Care
Dr Gayle Sherman	Associate Professor Department of Paediatrics and Child Health	University of the Witwatersrand Centre for HIV & STI
Dr Margot Uys	Head: Integrated Health Systems Strengthening, Technical Assistance Department	Foundation for Professional Development
Ukraine		
UNICEF		
Tetyana Tarasova	HIV/AIDS Officer	UNICEF Country Officer
Government		
Nadiya Zhylka	Professor of obstetrics, gynaecology and perinatal care; Former Head of Obstetrics Department	National Medical Association of Post graduate education 2009–16, MCH Department, Ministry of Health
Partners and other organisations		
Iryna Ageeva	Director, Programme and Projects	All Ukrainian Network, PLWHA
Violetta Martsinovska	Epidemiologist	Ukraine Centre for Disease Control
Olena Sherstyuk	Global Outreach Officer	UNAIDS
Zimbabwe		
UNICEF		
Geoffrey Larry Acaye	Health Manager	UNICEF
Vandana Agarwai	Nutrition Manager – YCSD	UNICEF

Shelly E Chitsungo	Health Specialist (MNH)	UNICEF
Rumbi Iza	Social Economic Analyst	UNICEF
Angeline Katsalde	Finance Team	UNICEF
Susanne Kinyua	Donor Relations Specialist	UNICEF
Deborah Maleni	Social Economic Analyst	UNICEF
Yamikanu Masharira	Finance Team	UNICEF
Joyce Mphaya	Chief – HIV/AIDS	UNICEF
Emely Muchochomi	HR Officer and Acting HR Manager	UNICEF
Leon Muwoni	Child Protection Specialist	UNICEF
Florence Naluyinda-Kitabire	HIV/AIDS Manager Zimbabwe 2010–13	UNICEF
Milicent Nyagata	Finance Team	UNICEF
Prudence Samakande	HR Officer	UNICEF
Beula Senzanje	HIV/AIDS Specialist	UNICEF
Judith Sherman	Chief, HIV, UNICEF Malawi	UNICEF
Vikas Singh	Chief – Planning and Monitoring	UNICEF
Lloyd	Child Projection	UNICEF
Munya	M&E Specialist, PMU	UNICEF
Therese	Consultant, PMU	UNICEF
Government		
Ancikaira Chigumira	Deputy Director Nutrition Services	MoHCC
Dr Madzima	Director, Family Health	MoHCC
Tendaye Mbengeranuka Mhaka	Key Populations Coordinator	NAC
Mutsa Mhangara	SI Coordinator, AIDS and TB	MoHCC
Owen Mugurungi	Director of HIV/AIDS and TB Unit	MoHCC

Joseph Murungu	Director Care and Treatment, AIDS and TB Programme	MoHCC
Angela Mushavi	PMTCT and Paediatric HIV Coordinator	MoHCC
Richard Sabumba	Logistics Manager, Directorate of Pharmacy	MoHCC
Raymond Yekeye	Operations Director	NAC
Partners and other organisations		
Shirish Balachandra	Branch Chief, HIV Services	CDC
Michael Bartos	Country Director	UNAIDS
Emmanuel Boadi	Project Manager/Coordinator	UNDP
Farai Charasika	Program Director	World Education Inc.
Barbara Engelsmann	Country Director	OPHID
Lena Forsgren	First Secretary Development Cooperation	Embassy of Sweden
Dagmar Hanisch	Technical Specialist HIV Prevention and SRH	UNFPA
Margaret Jambere	District Officer Support and Quality Improvement Officer	KAPNECK
Alexio Mangwiro	Country Director	CHAI
Fundai H. Mudzengerere	Research & Program Audit Manager	World Education Inc.
Oscar Mundida	CCM Coordinator	CCM
Tichaona Nyamundaya		EGPAF
Diana Patel	Deputy Country Director	OPHID
Lia Tavadze	Human Rights and Gender Equality Advisor	UNAIDS
Gregory Thorne	Partner Management Branch Chief	CDC
Nicola Willis	Director	AFRICAID

ANNEX H: UNICEF'S CONTRIBUTION TO THE GLOBAL AND NATIONAL POLICY SHIFTS TOWARDS OPTION B+: A CASE STUDY

Introduction

This case study considers UNICEF's contribution to the widespread adoption of the Option B+ for PMTCT, as an example of its role in supporting evidence-based policy shifts. It describes a unique set of problems, policy alternatives and political contexts, which all converged in 2011–2013, opening a window of opportunity for major changes to policies related to HIV prevention, care and treatment for mothers and children.[126]

The emergence of Option B+ on the policy agenda

Initial PMTCT scale-up was slow in many high burden countries (see Section 5 of this report). Many countries struggled to implement the complex 2010 recommendations for PMTCT.[127] The ARV regimens recommended (Options A or B[128]) required the identification of pregnant and breastfeeding women who were eligible for ART, which proved challenging in primary care facilities in most low- and middle-income settings. As early as 2010, Malawi considered and discarded Options A and B, proposing instead Option B+ in which all pregnant women who tested HIV-positive would be offered lifelong treatment regardless of CD4 count or clinical status. Country stakeholders were concerned that Option A was complex to implement and yet of limited effectiveness. In addition, they felt that Option B (which required starting ART but stopping at the end of breastfeeding) would not be practical among women who had short intervals between pregnancies, a significant concern in a country with high fertility rates. They also felt that the messaging around Option B was at odds with instructions on ART as lifelong treatment and would create confusion.[129] UNICEF CO staff participated in and supported Malawi's decision-making around policy options for PMTCT, along with other members of the MOH's technical working group on PMTCT.[130]

Option B+ did not immediately gain traction as a policy alternative. The Malawi policy decision was initially criticised.[131] Several international scientific experts were strongly opposed to the policy, being concerned about lack of evidence for the approach, the risk of poor treatment adherence and retention of healthy pregnant women, and safety and cost issues.[132,133] Malawi initially experienced difficulties in securing Global Fund support for its Option B+ scale-up plan as it was not at that time aligned with WHO recommendations. WHO faced a dilemma in how to respond to this controversy, as the evidence for Option B+ was not yet sufficient for revisiting the 2010 recommendations.[134]

---

[126] The Kingdon multiple-streams theory is applied to examine how a policy agenda was set, and includes consideration of the problem, policy and political 'streams'. Kingdon, J., 1984. Agendas, Alternatives and Public Policies. Boston: Little Brown. Walt, G., Shiffman, J., Schneider, H. et al.: 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy and Planning* 2008, 23(5):308-317.

[127] World Health Organization 2010. Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. Recommendations for a public health approach. 2010 version.

[128] Option A involved the use of three ARV drugs used in different combinations and for different durations in both mother and infant, while Option B involved the use of a triple ARV regimen from the third month of pregnancy until one week after the cessation of breastfeeding together with the provision of a short course of a single ARV to the infant.

[129] Interview with a national stakeholder.

[130] Interview with UNICEF staff member.

[131] Schouten, E. J., Jahn, A., Midiani, D. et al.: Prevention of mother-to-child transmission of HIV and the health-related Millennium Development Goals: time for a public health approach. *Lancet* 2011, 378(9787):282-284.

[132] Coutsoudis, A., Goga, A., Desmond, C. et al.: Is Option B+ the best choice? Authors' reply. *Lancet* 2013, 381(9874):1273-1274. Ahmed, S., Kim, M. H., Abrams, E. J.: Risks and benefits of lifelong antiretroviral treatment for pregnant and breastfeeding women: a review of the evidence for the Option B+ approach. *Current opinion in HIV and AIDS* 2013, 8:474–489. Coutsoudis, A., Goga, A., Desmond, C., Barron, P., Black, V., Coovadia, H.: Is Option B+ the best choice? *Lancet* 2013, 381(9863):269-27113, 8(5):474-489.

[133] Coutsoudis, A., Goga, A., Desmond, C. et al., Is Option B+ the best choice? *Lancet* 2013, 381(9863):269-27113, 8(5):474-489.

[134] WHO 2010 PMTCT guidelines did include Option B+ as a priority for implementation research

The rapid adoption and implementation of Option B+

Concerted UNICEF lobbying was central to the rapid adoption and implementation of Option B+. After a period of initial hesitation, HIV staff in UNICEF headquarters rapidly recognised the potential of Option B+ to overcome the operational limitations of Options A and B and became active proponents of a transition to Option B+. UNICEF, together with a handful of organisations, served as 'policy entrepreneurs',[135] actively championing Option B+ among IATT partners; at ministerial level; at key international meetings, such as the 2012 AIDS conference and in events around the 2012 World Health Assembly; and through different forms of documentation detailing the advantages and cost implications of Option B+.[136] Other international and national actors gradually came to support the proposal, and built a critical mass and momentum that helped to counter the initial resistance of some organisations, influential international experts and ministries of health.[137] Through the success of their lobbying and leadership around the adoption of Option B+, UNICEF was able to reposition itself within a contested global policy space occupied by a multitude of international actors. With Option B+, UNICEF "*rediscovered its niche that had been lost in the preceding year or two*" (UN partner, global)."*It [Option B+] kind of positioned us again and gave people a lot of motivation*" (UNICEF staff member).

Once the Option B+ policy had reached the policy agenda, a growing momentum rapidly secured its adoption within global guidelines. On the back of a series of meetings and documents in 2012, the Option B+ policy was formally adopted by WHO in 2013[138] – "for operational programmatic reasons, particularly in generalized epidemics" – in recognition that, by then, 13 of 22 Global Plan priority countries had already adopted Option B+.[139] WHO's traditional strengths re-emerged with the rapid accrual of evidence on Option B+, allowing the organisation to reassert its normative roles, and its complementarity to UNICEF. Of note, civil society and activist interest groups, the usual HIV advocacy leaders, appear to have played little role in formulating the B+ policy, or its framing. Finally, WHO's formal endorsement of Option B+,[140] and the concomitant alignment of ART for pregnant women and for adults also facilitated the consolidation of global,[141] and increasingly national,[142] PMTCT and adult ART guidelines. Once the shift to Option B+ was accepted globally, Global Fund and other financing quickly became available, thereby incentivising the policy's adoption of B+ in individual countries.

UNICEF country teams "led the charge"[143] in securing adoption of Option B+ at country level, and the effective transfer of the policy from one country to another. UNICEF's activities at country level were set within long-standing trust relations with health ministries, making it an "*ideal organisation for Option B+, with countries poised for change*" (UNICEF staff member). UNICEF often mobilised heads of other organisations to assist with advocacy for Option B+, or formed joint leadership roles with them. For example, a UN partner in Cambodia reflected that: "*Option B and B+ probably wouldn't have been adopted without UNICEF and their partnership with WHO*".[144]

While UNICEF clearly advocated vigorously for adoption of B+, it also supported countries to consider the operational and cost implications of the policy before its implementation at scale. In Mozambique, for example, the Ministry of Health was advised to "*make sure that if you go ahead in moving to B+, you know what you are doing and*

[135] Policy entrepreneurs, also referred to as policy communities, promote particular ideas through journals, conferences, and different forms of media, and are crucial to the success of an idea.

[136] For example, in 2012, Options B and B+: Key Considerations for Countries to Implement an Equity-Focused Approach. UNICEF, CHAI, BLC Business case for Option B

[137] Nkomo, P., Davies, N., Sherman, G. et al., *SA Journal HIV Medicine*. 2016. How ready are our health systems to implement prevention of mother to child transmission Option B+?

[138] World Health Organization 2013. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.

[139] Nelson, L. J.(1), Beusenberg, M., Habiyambere, V. et al., Adoption of national recommendations related to use of antiretroviral therapy before and shortly following the launch of the 2013 WHO consolidated guidelines. *AIDS*. 2014 Mar;28 Suppl 2:S217-24.

[140] World Health Organization 2013. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.

[141] Ibid

[142] For example: South Africa Department of Health 2015. Consolidated PMTCT, adult and child HIV treatment guide.

[143] HIV staff member terminology.

[144] Cambodia country report Page 5

you can manage the additional amount [of patients receiving ART]" (UNICEF staff member). Finally, UNICEF's strategy of sharing a country's experiences of Option B+ with other countries in the region helped reassure 'late adopters' that Option B+ was a viable alternative.[145] Similarly, later on, UNICEF facilitated cross-country sharing of implementation experiences, around both the programmatic implications and the monitoring and evaluation implications of Option B+.[146]

At country level, a massive shift to Option B+ took place within a few years. Country-level policy adoption was rapid – "*In terms of the normal pace for countries of uptake of new WHO guidelines, it was phenomenal*" (UNICEF senior staff member). By the end of 2015, all Global Plan priority countries except Nigeria had commenced roll-out of Option B+ and 12 countries had achieved – or were close to achieving – full national coverage.[147] Implementation shifts were rapid in many countries – Zimbabwe, for example, devised a one-year transition plan to Option B+.[148] In Cameroon, however, this transition to Option B+ was not completed until the end of 2015, although the policy was adopted in principle in 2012.

UNICEF's role in securing the transformation of PMTCT policy: strategic advocacy, innovation and pragmatism

The case for Option B+ was framed around programmatic simplicity, values and goals, as well as an investment case,[149] rather than strictly around biomedical evidence, and heralded a substantive transformation in policy development. By contrast, previous policy shifts around PMTCT regimens (including single-dose nevirapine and Options A and B) had been highly responsive to evidence from clinical trials and represented more rational, incremental policy developments. UNICEF is credited with being among the first to argue: "*[It] doesn't make any sense that we have this complicated regimen of treatments of the moms and the kids. Why don't we just put moms on ARVs for their entire pregnancy or for their entire lives?*" (Partner). It was also making the case for "*urgently getting things done*" (UNICEF staff member). The e-MTCT targets and Global Plan provided a platform for claims of urgency to be made, and for pressing countries to do things differently. In promoting Option B+, UNICEF decided to "*Put the health of women at the centre of the response to HIV among children*".[150] This notion was listed first among the strategies to accelerate PMTCT in the 2012 Stocktaking report.[151] Placing "*women first, not the child,*"[152] demarcated a major shift from previous approaches to PMTCT, in which, "*it was all about children at the beginning*".[153]

Option B+ marked an evolution in UNICEF's work on PMTCT. Within the organisation, in mid-to-late 2011, UNICEF staff rapidly shifted their allegiance to Option B+, from Option A. UNICEF and its IATT partners also moved rapidly to develop a full body of knowledge products to support policy costing, adoption and implementation,[154] and to align its monitoring and evaluation indicators and processes with Option B+ (for example around monitoring retention of women in ART). UNICEF's country-level activities also shifted. The period prior to Option B+ had centred around operationalising policies, supporting pilot demonstrations, and assisting countries to decentralise and scale-up services. The UNICEF 2010 Stocktaking report sums this up as 'doing better what we already know how to do'.[155] In those years, the organisation did work on maternal health, PMTCT and paediatric ART with poor or no linkages between these areas, and the generation of strategic information was also fragmented by topic. The Option B+ era marked a

[145] For example, UNICEF facilitated the visit of Cambodian officials to learn from Thailand's experience with Option B+.

[146] For example, UNICEF 2015. Promising practices: Building on experience from Nigeria, Zambia and Zimbabwe. IATT 2016, Technical Synthesis from the M&E Country Consultation Meeting on Dissemination of the B+ M&E Framework. Uganda.

[147] UNAIDS 2016. On the fast-track to an AIDS-free generation.

[148] Ministry of Health and Child Care. 2013. An Operational Plan for the Nationwide Transition to Option B+ in Zimbabwe.

[149] BLC, UNICEF, CHAI, 2012. A business case for Options B and B+ to eliminate MTCT of HIV by 2015: Key Considerations for Countries to Implement an Equity-Focused Approach.

[150] UNICEF staff member quote.

[151] UNICEF, 2013: Children and AIDS. 6th Stocktaking Report

[152] UNICEF staff member quote

[153] Ibid

[154] IATT Toolkit 2013: Expanding and simplifying treatment for pregnant women living with HIV: managing the transition to Option B/B+.

[155] UNICEF 2010: Children and AIDS: 5th Stocktaking Report

shift to a more innovative role for UNICEF, with a greater focus on supporting integration of service delivery platforms and optimising synergies with HIV care and treatment.[156] The 'Double Dividend' concept of integrating paediatric HIV and child health platforms epitomises this approach.[157] Importantly, the strategically packaged advocacy around Option B+, the detailed cost analyses[158] and the active high-level lobbying, contrasted strongly with the Mother-Baby Pack initiative in 2010 which had implicitly promoted Option A. Quite possibly, the methods used by UNICEF to promote Option B+ drew on the lessons from that experience, namely the need to involve partners and to conduct an in-depth analysis of key issues. Nevertheless, through backing Option B+, which carried substantial risks of failure, the UNICEF staff demonstrated intrepidity in challenging conventional wisdom.

The principles underlying Option B+ resonate with UNICEF's core values and practical approach at country level. Even though substantial changes occurred in UNICEF's roles and views on PMTCT policy, as discussed above, it was evident that the organisation maintained its core focal areas throughout. These were described as equity, gender equality, advocacy for action around issues for children and the importance of generating data for advocacy, all features stated as "*within the DNA of the organisation*" (UNICEF staff member). Importantly, Option B+ managed to attract strong support from all levels of UNICEF, suggesting that the policy was compatible with the organisation's core values. Moreover, UNICEF is traditionally adept at championing and supporting interventions that are: technically feasible, operationally simplified; coherent with existing supply chains; easy to explain and translate at country level; and amenable to being framed around the dominant societal values and as part of a bigger picture. All these features characterise Option B+, and perhaps even trumped the need for definitive data from a randomised trial. In fact, at the time of its formal adoption by WHO in 2013, B+ was given a GRADE review rating of 'low-quality evidence'.[159] Finally, a desire or sense of urgency to get the job done is part of UNICEF's culture, even though "*sometimes UNICEF runs too quickly with ideas*" (UNICEF staff member). In essence, this case study suggests that UNICEF can run quickly with ideas, and if the ideas are coherent with its strengths, responsive to countries' needs and sufficient partners are on board, the ideas can hold.

Conclusion

Option B+ has been described as a 'game changer'[160] for PMTCT. UNICEF served as one of the leading agenda-setting agencies for B+ and as a key actor in securing its widespread implementation. The preceding period of incremental policy change was disrupted or punctuated by a burst of rapid policy transformation, stemming from a new understanding of the problem and a policy alternative that overcame previous conceptualisations of the problem and possible solutions. PMTCT shifted from a narrow prevention focus to increasingly fall under the adult ART umbrella. UNICEF and other actors had successfully created a compelling frame around Option B+, thereby setting in motion a series of international and national processes that culminated in Option B+ being implemented at scale in virtually all LMICs.

---

[156] UNICEF 2015 Community-Facility Linkages to Support the Scale Up of Lifelong Treatment for Pregnant and Breastfeeding Women Living with HIV.

[157] UNICEF/WHO/EGPAF, 2013. Double Dividend

[158] Business Leadership Council, UNICEF, Clinton Health Access Initiative 2012. A business case for Options B and B+ to eliminate MTCT of HIV by 2015.

[159] World Health Organization 2013. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.

[160] UNAIDS 2016. On the fast track to an AIDS free generation.

Figure H.1 Timelines for key global guideline development

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Key recommendations on the use of ARVs for the prevention or treatment of HIV in children		ART for eligible pregnant women plus prophylaxis for the infant or else ARV prophylaxis for pregnant women and child (different ARV drug combinations for different durations) Age-specific approaches for diagnosis and treatment of children with HIV				2 options for ARV prophylaxis for PMTCT (Option A and B) using 2 or 3 ARVs		Third option (Option B+) providing the lifelong triple ARV drugs to all HIV-infected pregnant women regardless of clinical or immunological status	WHO guidelines on Option B/B+, within consolidated ART guidelines, together with revised guidelines for the Management of HIV in Children recommending that all HIV-infected children under the age of one should receive ART, irrespective of immunological status		Initiation of ART in all adults and children with HIV regardless of clinical or immunological status (Test and Treat)
Other relevant information						Malawi adopts Option B+	Malawi introduces Option B+ Launch of the Global Plan towards Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive.				
Technical guidance for programme and policy implementation								BLC, UNICEF, CHAI: Business Case for Option B+. UNICEF: Case for Options B and B+ to Eliminate MTCT of HIV by 2015. UNICEF: Options B and B+: Key Considerations for Countries to Implement an Equity-Focused Approach	IATT Toolkit: Expanding and Simplifying Treatment for Pregnant Women Living with HIV: Managing the Transition to Option B/B+		

ANNEX I: SURVEY DATA

Background information

TABLE I.1: NUMBER AND % RESPONDENTS BY REGION

Region	Total
CEE-CIS	22 10%
EAP	48 23%
ESA	45 21%
LAC	20 9%
MENA	15 7%
not specified	1 0.5%
ROSA	26 12%
WCA	34 16%
Grand Total	211 100%

TABLE I.2: NUMBER AND % RESPONDENTS BY ORGANISATION

Organisation	Total
a. UNICEF	74 35%
b. Government	64 30%
c. WHO	7 3%
d. UNAIDS	13 6%
e. Academic institution	8 4%
f. Other UN agency, development partner or non-governmental organisation (please specify)	45 21%
Grand Total	211 100%

TABLE I.3: NUMBER OF YEARS WORKING IN PMTCT/PAEDIATRIC HIV IN THE COUNTRY

	less than 1	1–3 years	4–6 years	7–9 years	10 or more years	Grand Total
a. UNICEF	10 14%	17 23%	22 30%	11 15%	14 19%	74 100%
b. Government	1 2%	6 9%	17 27%	5 8%	35 55%	64 100%
c. WHO	1 14%	2 29%	0 0%	1 14%	3 43%	7 100%
d. UNAIDS	1 8%	4 31%	2 15%	3 23%	3 23%	13 100%
e. Academic institution	0 0%	0 0%	0 0%	0 0%	8 100%	8 100%
f. Other	0 0%	9 20%	11 24%	9 20%	16 36%	45 100%
Grand Total	13 6%	38 18%	52 25%	29 14%	79 37%	211 100%

TABLE I.4: SELF-ASSESSED DEGREE OF FAMILIARITY WITH UNICEF'S WORK IN PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT IN THE COUNTRY

	a. Very familiar	b. Somewhat familiar	c. Not familiar	Grand Total
a. UNICEF	60	13	1	74
	81%	18%	1%	100%
b. Government	48	15	1	64
	75%	23%	2%	100%
c. WHO	5	1	1	7
	71%	14%	14%	100%
d. UNAIDS	8	5	0	13
	62%	38%	0%	100%
e. Academic institution	5	2	1	8
	63%	25%	13%	100%
f. Other	30	14	1	45
	67%	31%	2%	100%
Grand Total	156	50	5	211
	74%	24%	2%	100%

Focus areas for UNICEF

To what extent have each of the activity areas listed below been key areas of focus for UNICEF in your country, during the period of 2005–2015, in relation to PMTCT and paediatric HIV care and treatment? Please provide your best estimate for each area, based on your knowledge and the time period in which you have been working in the area:

TABLE I.5: MOBILISING FINANCIAL RESOURCES FOR PROGRAMME IMPLEMENTATION FROM DEVELOPMENT PARTNERS

Type of organisation	a. None	b. Minimal	c. Significant	d. Critical	e. Don't know	Grand Total
a. UNICEF	1	12	39	19	3	74
	1%	16%	53%	26%	4%	100%
b. Government	3	8	33	19	1	64
	5%	13%	52%	30%	2%	100%
c. WHO	2	1	2	0	2	7
	29%	14%	29%	0%	29%	100%
d. UNAIDS	0	4	7	2	0	13
	0%	31%	54%	15%	0%	100%
e. Academic institution	1	0	5	2	0	8
	13%	0%	63%	25%	0%	100%
f. Other	1	7	21	10	6	45
	2%	16%	47%	22%	13%	100%
Grand Total	8	32	107	52	12	211
	4%	15%	51%	25%	6%	100%

TABLE I.6: SUPPORT IN MOBILISING FINANCIAL RESOURCES FOR PROGRAMME IMPLEMENTATION FROM DOMESTIC SOURCES

Type of organisation	a. None	b. Minimal	c. Significant	d. Critical	e. Don't know	Grand Total
a. UNICEF	9 12%	26 35%	31 42%	6 8%	2 3%	74 100%
b. Government	6 9%	18 28%	24 38%	9 14%	7 11%	64 100%
c. WHO	2 29%	2 29%	1 14%	0 0%	2 29%	7 100%
d. UNAIDS	0 0%	5 38%	4 31%	3 23%	1 8%	13 100%
e. Academic institution	1 13%	1 13%	2 25%	1 13%	3 38%	8 100%
f. Other	2 4%	22 49%	9 20%	3 7%	9 20%	45 100%
Grand Total	20 9%	74 35%	71 34%	22 10%	24 11%	211 100%

TABLE I.7: ADVOCACY FOR INCREASED ACCESS FOR WOMEN AND CHILDREN TO CARE AND TREATMENT

Type of organisation	a. None	b. Minimal	c. Significant	d. Critical	e. Don't know	Grand Total
a. UNICEF	2 3%	6 8%	25 34%	39 53%	2 3%	74 100%
b. Government	2 3%	1 2%	43 67%	18 28%	0 0%	64 100%
c. WHO	1 14%	2 29%	1 14%	2 29%	1 14%	7 100%
d. UNAIDS	0 0%	1 8%	11 85%	1 8%	0 0%	13 100%
e. Academic institution	0 0%	1 13%	4 50%	2 25%	1 13%	8 100%
f. Other	0 0%	6 13%	19 42%	17 38%	3 7%	45 100%
Grand Total	5 2%	17 8%	103 49%	79 37%	7 3%	211 100%

TABLE I.8: SUPPORT FOR DEVELOPMENT OF EVIDENCE-INFORMED POLICIES, STRATEGIES AND PLANS

Type of organisation		a. None	b. Minimal	c. Significant	d. Critical	e. Don't know	Grand Total
a. UNICEF		1	6	25	40	2	74
		1%	8%	34%	54%	3%	100%
b. Government		2	5	35	21	1	64
		3%	8%	55%	33%	2%	100%
c. WHO		2	1	2	1	1	7
		29%	14%	29%	14%	14%	100%
d. UNAIDS		0	1	8	4	0	13
		0%	8%	62%	31%	0%	100%
e. Academic institution		0	0	6	1	1	8
		0%	0%	75%	13%	13%	100%
f. Other		0	4	31	8	2	45
		0%	9%	69%	18%	4%	100%
Grand Total		5	17	107	75	7	211
		2%	8%	51%	36%	3%	100%

TABLE I.9: SUPPORT FOR PROGRAMME IMPLEMENTATION OF PMTCT AND/OR PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation		a. None	b. Minimal	c. Significant	d. Critical	e. Don't know	Grand Total
a. UNICEF		2	7	25	38	2	74
		3%	9%	34%	51%	3%	100%
b. Government		1	5	34	23	1	64
		2%	8%	53%	36%	2%	100%
c. WHO		1	2	2	1	1	7
		14%	29%	29%	14%	14%	100%
d. UNAIDS		0	1	7	5	0	13
		0%	8%	54%	38%	0%	100%
e. Academic institution		0	0	6	1	1	8
		0%	0%	75%	13%	13%	100%
f. Other		0	6	19	19	1	45
		0%	13%	42%	42%	2%	100%
Grand Total		4	21	93	87	6	211
		2%	10%	44%	41%	3%	100%

TABLE I.10: CAPACITY DEVELOPMENT IN RELATION TO PMTCT AND/OR PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation	a. None	b. Minimal	c. Significant	d. Critical	e. Don't know	Grand Total
a. UNICEF	1 1%	9 12%	22 30%	40 54%	2 3%	74 100%
b. Government	2 3%	8 13%	29 45%	23 36%	2 3%	64 100%
c. WHO	3 43%	0 0%	1 14%	2 29%	1 14%	7 100%
d. UNAIDS	0 0%	0 0%	9 69%	4 31%	0 0%	13 100%
e. Academic institution	0 0%	1 13%	3 38%	3 38%	1 13%	8 100%
f. Other	0 0%	13 29%	17 38%	12 27%	3 7%	45 100%
Grand Total	6 3%	31 15%	81 38%	84 40%	9 4%	211 100%

TABLE I.11: PRODUCTION AND DISSEMINATION OF STRATEGIC INFORMATION OR TECHNICAL GUIDANCE

Type of organisation	a. None	b. Minimal	c. Significant	d. Critical	e. Don't know	Grand Total
a. UNICEF	2 3%	11 15%	33 45%	26 35%	2 3%	74 100%
b. Government	3 5%	9 14%	34 53%	18 28%	0 0%	64 100%
c. WHO	1 14%	2 29%	3 43%	0 0%	1 14%	7 100%
d. UNAIDS	0 0%	0 0%	10 77%	3 23%	0 0%	13 100%
e. Academic institution	0 0%	1 13%	6 75%	0 0%	1 13%	8 100%
f. Other	0 0%	9 20%	22 49%	10 22%	4 9%	45 100%
Grand Total	6 3%	32 15%	108 51%	57 27%	8 4%	211 100%

TABLE I.12: PRODUCTION AND DISSEMINATION OF NEW KNOWLEDGE DERIVED FROM RESEARCH, EVALUATIONS OR REVIEWS

Type of organisation	a. None	b. Minimal	c. Significant	d. Critical	e. Don't know	Grand Total
a. UNICEF	4 5%	13 18%	37 50%	18 24%	2 3%	74 100%
b. Government	3 5%	12 19%	35 55%	12 19%	2 3%	64 100%
c. WHO	1 14%	4 57%	1 14%	0 0%	1 14%	7 100%
d. UNAIDS	0 0%	3 23%	8 62%	2 15%	0 0%	13 100%
e. Academic institution	0 0%	0 0%	7 88%	0 0%	1 13%	8 100%
f. Other	0 0%	18 40%	17 38%	5 11%	5 11%	45 100%
Grand Total	8 4%	50 24%	105 50%	37 18%	11 5%	211 100%

TABLE I.13: PROCUREMENT OF HIV COMMODITIES - INCLUDING PAEDIATRIC ARVS AND DIAGNOSTICS

Type of organisation	a. None	b. Minimal	c. Significant	d. Critical	e. Don't know	Grand Total
a. UNICEF	15 20%	20 27%	20 27%	17 23%	2 3%	74 100%
b. Government	8 13%	17 27%	26 41%	12 19%	1 2%	64 100%
c. WHO	3 43%	1 14%	1 14%	0 0%	2 29%	7 100%
d. UNAIDS	1 8%	2 15%	7 54%	2 15%	1 8%	13 100%
e. Academic institution	1 13%	1 13%	2 25%	1 13%	3 38%	8 100%
f. Other	8 18%	10 22%	8 18%	13 29%	6 13%	45 100%
Grand Total	36 17%	51 24%	64 30%	45 21%	15 7%	211 100%

Thematic leadership, advocacy and partnerships

Please indicate whether you strongly agree, agree, disagree or strongly disagree with each of the following statements in your country currently:

TABLE I.14: THERE IS POLITICAL COMMITMENT TO PLAN FOR AND SUPPORT THE SCALE-UP OF PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT SERVICES

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	32	28	6	3	3	2	74
	43%	38%	8%	4%	4%	3%	100%
b. Government	37	19	4	1	2	1	64
	58%	30%	6%	2%	3%	2%	100%
c. WHO	2	3	2	0	0	0	7
	29%	43%	29%	0%	0%	0%	100%
d. UNAIDS	5	8	0	0	0	0	13
	38%	62%	0%	0%	0%	0%	100%
e. Academic institution	4	3	0	0	1	0	8
	50%	38%	0%	0%	13%	0%	100%
f. Other	18	19	5	1	0	2	45
	40%	42%	11%	2%	0%	4%	100%
Grand Total	98	80	17	5	6	5	211
	46%	38%	8%	2%	3%	2%	100%

TABLE I.15: STRATEGIES, POLICIES AND IMPLEMENTATION PLANS FOR PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT ARE ALIGNED AND COHERENT ACROSS PARTNERS

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	26	29	11	3	3	2	74
	35%	39%	15%	4%	4%	3%	100%
b. Government	28	28	4	2	1	1	64
	44%	44%	6%	3%	2%	2%	100%
c. WHO	2	3	2	0	0	0	7
	29%	43%	29%	0%	0%	0%	100%
d. UNAIDS	6	3	2	1	1	0	13
	46%	23%	15%	8%	8%	0%	100%
e. Academic institution	1	6	0	0	1	0	8
	13%	75%	0%	0%	13%	0%	100%
f. Other	12	23	5	0	3	2	45
	27%	51%	11%	0%	7%	4%	100%
Grand Total	75	92	24	6	9	5	211
	36%	44%	11%	3%	4%	2%	100%

TABLE I.16: THERE IS ADEQUATE CAPACITY AMONG NATIONAL STAKEHOLDERS TO PLAN FOR AND SUPPORT THE SCALE-UP OF PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT SERVICES

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	14 19%	35 47%	15 20%	4 5%	4 5%	2 3%	74 100%
b. Government	25 39%	28 44%	7 11%	0 0%	3 5%	1 2%	64 100%
c. WHO	0 0%	5 71%	1 14%	1 14%	0 0%	0 0%	7 100%
d. UNAIDS	0 0%	7 54%	4 31%	1 8%	1 8%	0 0%	13 100%
e. Academic institution	1 13%	3 38%	1 13%	2 25%	1 13%	0 0%	8 100%
f. Other	10 22%	20 44%	10 22%	3 7%	0 0%	2 4%	45 100%
Grand Total	50 24%	98 46%	38 18%	11 5%	9 4%	5 2%	211 100%

TABLE I.17: UNICEF HAS CONTRIBUTED TO SHIFTS IN PRIORITIES AND INCREASING COMMITMENTS IN RELATION TO PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	35 47%	28 38%	6 8%	1 1%	2 3%	2 3%	74 100%
b. Government	32 50%	27 42%	2 3%	1 2%	1 2%	1 2%	64 100%
c. WHO	4 57%	2 29%	0 0%	0 0%	1 14%	0 0%	7 100%
d. UNAIDS	5 38%	6 46%	1 8%	0 0%	1 8%	0 0%	13 100%
e. Academic institution	3 38%	4 50%	0 0%	0 0%	1 13%	0 0%	8 100%
f. Other	19 42%	24 53%	0 0%	0 0%	0 0%	2 4%	45 100%
Grand Total	98 46%	91 43%	9 4%	2 1%	6 3%	5 2%	211 100%

TABLE I.18: UNICEF HAS BUILT EFFECTIVE PARTNERSHIPS AROUND PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	33 45%	30 41%	7 9%	0 0%	2 3%	2 3%	74 100%
b. Government	27 42%	28 44%	5 8%	1 2%	2 3%	1 2%	64 100%
c. WHO	3 43%	1 14%	2 29%	0 0%	1 14%	0 0%	7 100%
d. UNAIDS	4 31%	8 62%	1 8%	0 0%	0 0%	0 0%	13 100%
e. Academic institution	3 38%	3 38%	0 0%	0 0%	2 25%	0 0%	8 100%
f. Other	12 27%	28 62%	3 7%	0 0%	0 0%	2 4%	45 100%
Grand Total	82 39%	98 46%	18 9%	1 0%	7 3%	5 2%	211 100%

TABLE I.19: UNICEF HAS PLAYED AN IMPORTANT ROLE IN COORDINATING PROGRAM DESIGN, PLANNING AND IMPLEMENTATION AMONG PARTNERS

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	34 46%	29 39%	7 9%	0 0%	2 3%	2 3%	74 100%
b. Government	25 39%	29 45%	6 9%	1 2%	2 3%	1 2%	64 100%
c. WHO	2 29%	3 43%	1 14%	0 0%	1 14%	0 0%	7 100%
d. UNAIDS	5 38%	6 46%	2 15%	0 0%	0 0%	0 0%	13 100%
e. Academic institution	3 38%	4 50%	0 0%	0 0%	1 13%	0 0%	8 100%
f. Other	15 33%	25 56%	3 7%	0 0%	0 0%	2 4%	45 100%
Grand Total	84 40%	96 45%	19 9%	1 0%	6 3%	5 2%	211 100%

TABLE I.20: UNICEF HAS BUILT CAPACITY OF COUNTRY LEVEL STAKEHOLDERS FOR PLANNING, RESOURCING AND IMPLEMENTING PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT SERVICES

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	28	33	8	1	2	2	74
	38%	45%	11%	1%	3%	3%	100%
b. Government	22	29	7	2	3	1	64
	34%	45%	11%	3%	5%	2%	100%
c. WHO	3	2	1	0	1	0	7
	43%	29%	14%	0%	14%	0%	100%
d. UNAIDS	3	7	3	0	0	0	13
	23%	54%	23%	0%	0%	0%	100%
e. Academic institution	2	4	0	0	2	0	8
	25%	50%	0%	0%	25%	0%	100%
f. Other	11	24	7	0	1	2	45
	24%	53%	16%	0%	2%	4%	100%
Grand Total	69	99	26	3	9	5	211
	33%	47%	12%	1%	4%	2%	100%

TABLE I.21: UNICEF HAS PLAYED AN IMPORTANT ROLE IN SUPPORTING THE SCALE-UP OF PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT SERVICES

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	34	25	8	2	3	2	74
	46%	34%	11%	3%	4%	3%	100%
b. Government	30	26	3	1	3	1	64
	47%	41%	5%	2%	5%	2%	100%
c. WHO	3	2	1	0	1	0	7
	43%	29%	14%	0%	14%	0%	100%
d. UNAIDS	3	10	0	0	0	0	13
	23%	77%	0%	0%	0%	0%	100%
e. Academic institution	3	3	0	0	2	0	8
	38%	38%	0%	0%	25%	0%	100%
f. Other	19	18	5	0	1	2	45
	42%	40%	11%	0%	2%	4%	100%
Grand Total	92	84	17	3	10	5	211
	44%	40%	8%	1%	5%	2%	100%

Resource mobilisation

Please indicate whether you strongly agree, agree, disagree or strongly disagree with each of the following statements in your country currently:

TABLE I.22: THE RESOURCES FOR PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT ARE PROVIDED IN A PREDICTABLE MANNER

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	9 12%	31 42%	26 35%	2 3%	4 5%	2 3%	74 100%
b. Government	11 17%	36 56%	9 14%	2 3%	5 8%	1 2%	64 100%
c. WHO	0 0%	2 29%	2 29%	1 14%	1 14%	1 14%	7 100%
d. UNAIDS	1 8%	5 38%	6 46%	0 0%	1 8%	0 0%	13 100%
e. Academic institution	1 13%	4 50%	2 25%	0 0%	1 13%	0 0%	8 100%
f. Other	8 18%	23 51%	9 20%	0 0%	0 0%	5 11%	45 100%
Grand Total	30 14%	101 48%	54 26%	5 2%	12 6%	9 4%	211 100%

TABLE I.23: THE RESOURCES FOR PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT ARE PROVIDED IN A SUSTAINABLE MANNER

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	4 5%	25 34%	32 43%	4 5%	7 9%	2 3%	74 100%
b. Government	12 19%	30 47%	13 20%	2 3%	6 9%	1 2%	64 100%
c. WHO	1 14%	1 14%	2 29%	1 14%	1 14%	1 14%	7 100%
d. UNAIDS	0 0%	5 38%	7 54%	0 0%	1 8%	0 0%	13 100%
e. Academic institution	1 13%	3 38%	3 38%	0 0%	1 13%	0 0%	8 100%
f. Other	5 11%	19 42%	14 31%	1 2%	1 2%	5 11%	45 100%
Grand Total	23 11%	83 39%	71 34%	8 4%	17 8%	9 4%	211 100%

TABLE I.24: UNICEF HAS MADE AN IMPORTANT CONTRIBUTION TO INCREASING DOMESTIC SPENDING ON PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	9	35	16	3	9	2	74
	12%	47%	22%	4%	12%	3%	100%
b. Government	11	35	8	1	8	1	64
	17%	55%	13%	2%	13%	2%	100%
c. WHO	1	1	2	0	2	1	7
	14%	14%	29%	0%	29%	14%	100%
d. UNAIDS	3	4	3	0	3	0	13
	23%	31%	23%	0%	23%	0%	100%
e. Academic institution	1	3	2	0	2	0	8
	13%	38%	25%	0%	25%	0%	100%
f. Other	7	11	7	1	14	5	45
	16%	24%	16%	2%	31%	11%	100%
Grand Total	32	89	38	5	38	9	211
	15%	42%	18%	2%	18%	4%	100%

TABLE I.25: UNICEF HAS MADE AN IMPORTANT CONTRIBUTION TO INCREASING THE AMOUNT OF EXTERNAL RESOURCES FOR PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	12	42	14	1	3	2	74
	16%	57%	19%	1%	4%	3%	100%
b. Government	13	33	7	1	9	1	64
	20%	52%	11%	2%	14%	2%	100%
c. WHO	2	1	1	0	2	1	7
	29%	14%	14%	0%	29%	14%	100%
d. UNAIDS	3	5	2	0	3	0	13
	23%	38%	15%	0%	23%	0%	100%
e. Academic institution	2	2	1	0	3	0	8
	25%	25%	13%	0%	38%	0%	100%
f. Other	8	22	4	0	6	5	45
	18%	49%	9%	0%	13%	11%	100%
Grand Total	40	105	29	2	26	9	211
	19%	50%	14%	1%	12%	4%	100%

TABLE I.26: UNICEF HAS INITIATED, SUPPORTED AND COORDINATED MOVEMENTS, CAMPAIGNS OR INVESTMENT PLANS TO MOBILISE FINANCIAL RESOURCES FOR PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	12	39	15	2	4	2	74
	16%	53%	20%	3%	5%	3%	100%
b. Government	17	34	4	1	7	1	64
	27%	53%	6%	2%	11%	2%	100%
c. WHO	1	1	1	0	3	1	7
	14%	14%	14%	0%	43%	14%	100%
d. UNAIDS	2	5	3	0	3	0	13
	15%	38%	23%	0%	23%	0%	100%
e. Academic institution	3	3	1	0	1	0	8
	38%	38%	13%	0%	13%	0%	100%
f. Other	9	22	4	0	5	5	45
	20%	49%	9%	0%	11%	11%	100%
Grand Total	44	104	28	3	23	9	211
	21%	49%	13%	1%	11%	4%	100%

TABLE I.27: UNICEF HAS HAD AN IMPORTANT CONTRIBUTION TO ESTABLISHING AND BUILDING A SUSTAINABLE PROGRAMME FOR PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	20	38	8	2	4	2	74
	27%	51%	11%	3%	5%	3%	100%
b. Government	16	39	6	1	1	1	64
	25%	61%	9%	2%	2%	2%	100%
c. WHO	1	2	1	0	2	1	7
	14%	29%	14%	0%	29%	14%	100%
d. UNAIDS	3	7	2	0	1	0	13
	23%	54%	15%	0%	8%	0%	100%
e. Academic institution	4	3	0	0	1	0	8
	50%	38%	0%	0%	13%	0%	100%
f. Other	5	22	10	1	2	5	45
	11%	49%	22%	2%	4%	11%	100%
Grand Total	49	111	27	4	11	9	211
	23%	53%	13%	2%	5%	4%	100%

Strategic information, knowledge generation and dissemination

Please indicate whether you strongly agree, agree, disagree or strongly disagree with each of the following statements in your country currently:

TABLE I.28: THERE ARE MECHANISMS TO ENSURE ACCOUNTABILITY FOR PROVISION AND SCALE-UP OF PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT AT COUNTRY LEVEL

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	14 19%	41 55%	13 18%	1 1%	3 4%	2 3%	74 100%
b. Government	23 36%	28 44%	4 6%	0 0%	7 11%	2 3%	64 100%
c. WHO	3 43%	1 14%	1 14%	0 0%	1 14%	1 14%	7 100%
d. UNAIDS	1 8%	7 54%	3 23%	1 8%	1 8%	0 0%	13 100%
e. Academic institution	2 25%	3 38%	1 13%	1 13%	1 13%	0 0%	8 100%
f. Other	9 20%	24 53%	5 11%	1 2%	0 0%	6 13%	45 100%
Grand Total	52 25%	104 49%	27 13%	4 2%	13 6%	11 5%	211 100%

TABLE I.29: STRATEGIES, POLICIES AND APPROACHES TO IMPLEMENTATION ARE INFORMED BY EVIDENCE ON WHAT DOES AND DOES NOT WORK, AND WHY, IN RELATION TO PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	15 20%	46 62%	7 9%	1 1%	3 4%	2 3%	74 100%
b. Government	18 28%	36 56%	2 3%	2 3%	4 6%	2 3%	64 100%
c. WHO	2 29%	2 29%	1 14%	0 0%	1 14%	1 14%	7 100%
d. UNAIDS	2 15%	7 54%	3 23%	1 8%	0 0%	0 0%	13 100%
e. Academic institution	1 13%	4 50%	1 13%	1 13%	1 13%	0 0%	8 100%
f. Other	10 22%	22 49%	4 9%	0 0%	3 7%	6 13%	45 100%
Grand Total	48 23%	117 55%	18 9%	5 2%	12 6%	11 5%	211 100%

TABLE I.30: UNICEF HAS HAD AN IMPORTANT ROLE IN THE GENERATION OF DATA AND KNOWLEDGE RELATED TO PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	25 34%	34 46%	8 11%	1 1%	4 5%	2 3%	74 100%
b. Government	17 27%	38 59%	4 6%	1 2%	2 3%	2 3%	64 100%
c. WHO	2 29%	1 14%	2 29%	0 0%	1 14%	1 14%	7 100%
d. UNAIDS	4 31%	8 62%	1 8%	0 0%	0 0%	0 0%	13 100%
e. Academic institution	4 50%	2 25%	1 13%	0 0%	1 13%	0 0%	8 100%
f. Other	14 31%	24 53%	0 0%	0 0%	1 2%	6 13%	45 100%
Grand Total	66 31%	107 51%	16 8%	2 1%	9 4%	11 5%	211 100%

TABLE I.31: UNICEF HAS HAD AN IMPORTANT ROLE IN THE DISSEMINATION OF DATA AND KNOWLEDGE RELATED TO PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	20 27%	40 54%	6 8%	2 3%	4 5%	2 3%	74 100%
b. Government	17 27%	39 61%	1 2%	1 2%	4 6%	2 3%	64 100%
c. WHO	2 29%	1 14%	2 29%	0 0%	1 14%	1 14%	7 100%
d. UNAIDS	4 31%	6 46%	2 15%	0 0%	1 8%	0 0%	13 100%
e. Academic institution	2 25%	5 63%	1 13%	0 0%	0 0%	0 0%	8 100%
f. Other	8 18%	28 62%	1 2%	0 0%	2 4%	6 13%	45 100%
Grand Total	53 25%	119 56%	13 6%	3 1%	12 6%	11 5%	211 100%

TABLE I.32: UNICEF'S WORK ON DATA AND KNOWLEDGE HAS CONTRIBUTED TO PROGRESS IN SCALING UP PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT SERVICES

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	21 28%	35 47%	10 14%	2 3%	4 5%	2 3%	74 100%
b. Government	17 27%	34 53%	5 8%	1 2%	5 8%	2 3%	64 100%
c. WHO	1 14%	2 29%	1 14%	0 0%	2 29%	1 14%	7 100%
d. UNAIDS	3 23%	6 46%	2 15%	0 0%	2 15%	0 0%	13 100%
e. Academic institution	3 38%	4 50%	0 0%	1 13%	0 0%	0 0%	8 100%
f. Other	11 24%	23 51%	1 2%	0 0%	4 9%	6 13%	45 100%
Grand Total	56 27%	104 49%	19 9%	4 2%	17 8%	11 5%	211 100%

TABLE I.33: UNICEF HAS STRENGTHENED COUNTRY-LEVEL ABILITY TO GENERATE AND COLLATE DATA FOR ACCOUNTABILITY AND LEARNING AROUND PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	18 24%	37 50%	9 12%	2 3%	6 8%	2 3%	74 100%
b. Government	15 23%	35 55%	5 8%	1 2%	6 9%	2 3%	64 100%
c. WHO	1 14%	2 29%	1 14%	0 0%	2 29%	1 14%	7 100%
d. UNAIDS	4 31%	4 31%	4 31%	0 0%	1 8%	0 0%	13 100%
e. Academic institution	3 38%	3 38%	1 13%	0 0%	1 13%	0 0%	8 100%
f. Other	9 20%	22 49%	3 7%	0 0%	5 11%	6 13%	45 100%
Grand Total	50 24%	103 49%	23 11%	3 1%	21 10%	11 5%	211 100%

Cross-cutting issues

Please state whether you strongly agree, agree, disagree or strongly disagree with the following statements: In your country currently:

TABLE I.34: PMTCT AND PAEDIATRIC HIV POLICIES AND PROGRAMMES ARE RESOURCED AND IMPLEMENTED IN A GENDER-SENSITIVE MANNER

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	f. Not applicable	no response given	Grand Total
a. UNICEF	6 8%	41 55%	15 20%	1 1%	4 5%	4 5%	3 4%	74 100%
b. Government	14 22%	35 55%	7 11%	1 2%	0 0%	1 2%	6 9%	64 100%
c. WHO	3 43%	0 0%	0 0%	0 0%	1 14%	1 14%	2 29%	7 100%
d. UNAIDS	1 8%	9 69%	0 0%	0 0%	1 8%	2 15%	0 0%	13 100%
e. Academic institution	3 38%	3 38%	1 13%	0 0%	0 0%	1 13%	0 0%	8 100%
f. Other	2 4%	28 62%	4 9%	0 0%	4 9%	1 2%	6 13%	45 100%
Grand Total	29 14%	116 55%	27 13%	2 1%	10 5%	10 5%	17 8%	211 100%

TABLE I.35: PMTCT AND PAEDIATRIC HIV POLICIES AND PROGRAMMES ARE RESOURCED AND IMPLEMENTED IN A GEOGRAPHICALLY EQUITABLE MANNER

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	f. Not applicable	no response given	Grand Total
a. UNICEF	10 14%	35 47%	19 26%	4 5%	0 0%	3 4%	3 4%	74 100%
b. Government	17 27%	28 44%	11 17%	2 3%	0 0%	0 0%	6 9%	64 100%
c. WHO	3 43%	0 0%	2 29%	0 0%	0 0%	0 0%	2 29%	7 100%
d. UNAIDS	0 0%	5 38%	4 31%	1 8%	3 23%	0 0%	0 0%	13 100%
e. Academic institution	2 25%	4 50%	2 25%	0 0%	0 0%	0 0%	0 0%	8 100%
f. Other	4 9%	16 36%	13 29%	1 2%	4 9%	1 2%	6 13%	45 100%
Grand Total	36 17%	88 42%	51 24%	8 4%	7 3%	4 2%	17 8%	211 100%

TABLE I.36: PMTCT AND PAEDIATRIC HIV POLICIES AND PROGRAMMES ARE RESOURCED AND IMPLEMENTED IN A MANNER THAT PRIORITISES THE MOST DISADVANTAGED POPULATIONS

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	f. Not applicable	no response given	Grand Total
a. UNICEF	10 14%	31 42%	22 30%	3 4%	2 3%	3 4%	3 4%	74 100%
b. Government	17 27%	30 47%	7 11%	2 3%	0 0%	2 3%	6 9%	64 100%
c. WHO	3 43%	1 14%	1 14%	0 0%	0 0%	0 0%	2 29%	7 100%
d. UNAIDS	1 8%	4 31%	1 8%	1 8%	5 38%	1 8%	0 0%	13 100%
e. Academic institution	2 25%	2 25%	2 25%	0 0%	2 25%	0 0%	0 0%	8 100%
f. Other	6 13%	19 42%	9 20%	0 0%	3 7%	2 4%	6 13%	45 100%
Grand Total	39 18%	87 41%	42 20%	6 3%	12 6%	8 4%	17 8%	211 100%

TABLE I.37: PMTCT AND PAEDIATRIC HIV POLICIES AND PROGRAMMES ARE RESOURCED AND IMPLEMENTED IN A HUMAN RIGHTS BASED MANNER

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	f. Not applicable	no response given	Grand Total
a. UNICEF	9 12%	44 59%	10 14%	2 3%	2 3%	4 5%	3 4%	74 100%
b. Government	20 31%	35 55%	2 3%	0 0%	0 0%	1 2%	6 9%	64 100%
c. WHO	4 57%	1 14%	0 0%	0 0%	0 0%	0 0%	2 29%	7 100%
d. UNAIDS	4 31%	5 38%	1 8%	1 8%	2 15%	0 0%	0 0%	13 100%
e. Academic institution	2 25%	3 38%	0 0%	0 0%	2 25%	1 13%	0 0%	8 100%
f. Other	4 9%	25 56%	5 11%	0 0%	3 7%	2 4%	6 13%	45 100%
Grand Total	43 20%	113 54%	18 9%	3 1%	9 4%	8 4%	17 8%	211 100%

TABLE I.38: PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT ARE INTEGRATED INTO ANY HUMANITARIAN RESPONSES.

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	f. Not applicable	no response given	Grand Total
a. UNICEF	3 4%	24 32%	23 31%	4 5%	4 5%	13 18%	3 4%	74 100%
b. Government	16 25%	25 39%	8 13%	0 0%	6 9%	3 5%	6 9%	64 100%
c. WHO	3 43%	2 29%	0 0%	0 0%	0 0%	0 0%	2 29%	7 100%
d. UNAIDS	0 0%	4 31%	1 8%	1 8%	7 54%	0 0%	0 0%	13 100%
e. Academic institution	2 25%	2 25%	2 25%	0 0%	1 13%	1 13%	0 0%	8 100%
f. Other	3 7%	18 40%	10 22%	0 0%	6 13%	2 4%	6 13%	45 100%
Grand Total	27 13%	75 36%	44 21%	5 2%	24 11%	19 9%	17 8%	211 100%

In the period 2005–15, to what extent have gender, human rights, equity and delivery of services in humanitarian situations been a focus of UNICEF's approach to PMTCT and paediatric HIV care and treatment programming in your country?

TABLE I.39: GENDER - SCORE

Type of organisation	1 (not a focus)	2 (limited focus)	3 (moderate focus)	4 (strong focus)	Don't know	no response given	Not applicable (N/A)	Grand Total
a. UNICEF	8 11%	11 15%	18 24%	28 38%	3 4%	3 4%	3 4%	74 100%
b. Government	5 8%	2 3%	18 28%	29 45%	4 6%	6 9%	0 0%	64 100%
c. WHO	0 0%	1 14%	2 29%	1 14%	1 14%	2 29%	0 0%	7 100%
d. UNAIDS	0 0%	1 8%	3 23%	7 54%	0 0%	0 0%	2 15%	13 100%
e. Academic institution	0 0%	0 0%	5 63%	2 25%	1 13%	0 0%	0 0%	8 100%
f. Other	0 0%	6 13%	14 31%	13 29%	6 13%	6 13%	0 0%	45 100%
Grand Total	13 6%	21 10%	60 28%	80 38%	15 7%	17 8%	5 2%	211 100%

TABLE I.40: HUMAN RIGHTS - SCORE

Type of organisation	1 (not a focus)	2 (limited focus)	3 (moderate focus)	4 (strong focus)	Don't know	no response given	Not applicable (N/A)	Grand Total
a. UNICEF	6 8%	5 7%	19 26%	33 45%	4 5%	3 4%	4 5%	74 100%
b. Government	2 3%	4 6%	19 30%	30 47%	3 5%	6 9%	0 0%	64 100%
c. WHO	1 14%	0 0%	1 14%	2 29%	1 14%	2 29%	0 0%	7 100%
d. UNAIDS	0 0%	1 8%	5 38%	7 54%	0 0%	0 0%	0 0%	13 100%
e. Academic institution	1 13%	1 13%	3 38%	2 25%	1 13%	0 0%	0 0%	8 100%
f. Other	1 2%	7 16%	10 22%	13 29%	8 18%	6 13%	0 0%	45 100%
Grand Total	11 5%	18 9%	57 27%	87 41%	17 8%	17 8%	4 2%	211 100%

TABLE I.41: EQUITY - SCORE

Type of organisation	1 (not a focus)	2 (limited focus)	3 (moderate focus)	4 (strong focus)	Don't know	no response given	Not applicable (N/A)	Grand Total
a. UNICEF	3 4%	8 11%	21 28%	34 46%	2 3%	3 4%	3 4%	74 100%
b. Government	0 0%	7 11%	25 39%	24 38%	2 3%	6 9%	0 0%	64 100%
c. WHO	0 0%	0 0%	2 29%	1 14%	2 29%	2 29%	0 0%	7 100%
d. UNAIDS	0 0%	4 31%	4 31%	4 31%	1 8%	0 0%	0 0%	13 100%
e. Academic institution	0 0%	0 0%	3 38%	4 50%	1 13%	0 0%	0 0%	8 100%
f. Other	0 0%	5 11%	14 31%	15 33%	4 9%	6 13%	1 2%	45 100%
Grand Total	3 1%	24 11%	69 33%	82 39%	12 6%	17 8%	4 2%	211 100%

TABLE I.42: PMTCT AND PAEDIATRIC HIV CARE AND TREATMENT IN HUMANITARIAN SITUATIONS - SCORE

Type of organisation	1 (not a focus)	2 (limited focus)	3 (moderate focus)	4 (strong focus)	Don't know	no response given	Not applicable (N/A)	Grand Total
a. UNICEF	11	19	17	9	3	3	12	74
	15%	26%	23%	12%	4%	4%	16%	100%
b. Government	3	8	11	26	6	6	4	64
	5%	13%	17%	41%	9%	9%	6%	100%
c. WHO	0	1	3	0	1	2	0	7
	0%	14%	43%	0%	14%	29%	0%	100%
d. UNAIDS	1	2	1	2	6	0	1	13
	8%	15%	8%	15%	46%	0%	8%	100%
e. Academic institution	0	0	1	4	3	0	0	8
	0%	0%	13%	50%	38%	0%	0%	100%
f. Other	2	6	7	16	8	6	0	45
	4%	13%	16%	36%	18%	13%	0%	100%
Grand Total	17	36	40	57	27	17	17	211
	8%	17%	19%	27%	13%	8%	8%	100%

Organisational structure

Please state whether you strongly agree, agree, disagree or strongly disagree with the following statements:

TABLE I.43: UNICEF COUNTRY OFFICE HAS A CLEAR STRATEGY IN RELATION TO ITS WORK IN PMTCT AND PAEDIATRIC HIV

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	e. Don't know	no response given	d. Strongly disagree	Grand Total
a. UNICEF	37	22	6	3	5	1	74
	50%	30%	8%	4%	7%	1%	100%
b. Government	22	26	2	7	7	0	64
	34%	41%	3%	11%	11%	0%	100%
c. WHO	3	1	0	1	2	0	7
	43%	14%	0%	14%	29%	0%	100%
d. UNAIDS	5	8	0	0	0	0	13
	38%	62%	0%	0%	0%	0%	100%
e. Academic institution	3	3	2	0	0	0	8
	38%	38%	25%	0%	0%	0%	100%
f. Other	15	20	1	3	6	0	45
	33%	44%	2%	7%	13%	0%	100%
Grand Total	85	80	11	14	20	1	211
	40%	38%	5%	7%	9%	0%	100%

TABLE I.44: PMTCT AND PAEDIATRIC HIV ARE GIVEN ADEQUATE PRIORITY BY THE LEADERSHIP OF THE COUNTRY OFFICE

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Not asked (UNICEF only question)	Grand Total
a. UNICEF	22	27	12	3	5	5	0	74
	30%	36%	16%	4%	7%	7%	0%	100%
b. Government	0	0	0	0	0	0	64	64
	0%	0%	0%	0%	0%	0%	97%	100%
c. WHO	0	0	0	0	0	0	7	7
	0%	0%	0%	0%	0%	0%	100%	100%
d. UNAIDS	0	0	0	0	0	0	13	13
	0%	0%	0%	0%	0%	0%	100%	100%
e. Academic institution	0	0	0	0	0	0	8	8
	0%	0%	0%	0%	0%	0%	100%	100%
f. Other	0	0	0	0	0	0	45	45
	0%	0%	0%	0%	0%	0%	100%	100%
Grand Total	22	27	12	3	5	5	137	211
	10%	13%	6%	1%	2%	2%	67%	100%

TABLE I.45: UNICEF FOCUSES ITS ACTIVITIES IN PMTCT AND PAEDIATRIC HIV WHERE IT ADDS MOST VALUE

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	25	31	7	1	5	5	74
	34%	42%	9%	1%	7%	7%	100%
b. Government	19	32	2	1	3	7	64
	30%	50%	3%	2%	5%	11%	100%
c. WHO	2	2	0	0	1	2	7
	29%	29%	0%	0%	14%	29%	100%
d. UNAIDS	4	5	0	0	4	0	13
	31%	38%	0%	0%	31%	0%	100%
e. Academic institution	2	4	2	0	0	0	8
	25%	50%	25%	0%	0%	0%	100%
f. Other	13	18	4	0	4	6	45
	29%	40%	9%	0%	9%	13%	100%
Grand Total	65	92	15	2	17	20	211
	31%	44%	7%	1%	8%	9%	100%

TABLE I.46: THE NUMBER OF PEOPLE WORKING ON PMTCT AND PAEDIATRIC HIV IN THE COUNTRY OFFICE IS APPROPRIATE FOR THE AREAS IN WHICH IT IS WORKING

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	4 5%	30 41%	22 30%	8 11%	5 7%	5 7%	74 100%
b. Government	8 13%	22 34%	16 25%	2 3%	9 14%	7 11%	64 100%
c. WHO	1 14%	1 14%	2 29%	1 14%	0 0%	2 29%	7 100%
d. UNAIDS	2 15%	4 31%	2 15%	2 15%	3 23%	0 0%	13 100%
e. Academic institution	0 0%	1 13%	3 38%	1 13%	3 38%	0 0%	8 100%
f. Other	3 7%	16 36%	10 22%	3 7%	7 16%	6 13%	45 100%
Grand Total	18 9%	74 35%	55 26%	17 8%	27 13%	20 9%	211 100%

TABLE I.47: THE STRUCTURE OF THE TEAM THAT IS WORKING ON PMTCT AND PAEDIATRIC HIV IN THE COUNTRY OFFICE IS APPROPRIATE

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Not asked (UNICEF only question)	Grand Total
a. UNICEF	6 8%	34 46%	16 22%	8 11%	5 7%	5 7%	0 0%	74 100%
b. Government	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	64 100%	64 100%
c. WHO	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	7 100%	7 100%
d. UNAIDS	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	13 100%	13 100%
e. Academic institution	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	8 100%	8 100%
f. Other	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	45 100%	45 100%
Grand Total	6 3%	34 16%	16 8%	8 4%	5 2%	5 2%	137 65%	211 100%

TABLE I.48: UNICEF STAFF HAVE THE RIGHT SKILLS AND COMPETENCIES FOR THE AREAS IN WHICH THEY ARE WORKING

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	19 26%	35 47%	10 14%	3 4%	2 3%	5 7%	74 100%
b. Government	18 28%	30 47%	2 3%	0 0%	7 11%	7 11%	64 100%
c. WHO	3 43%	1 14%	1 14%	0 0%	0 0%	2 29%	7 100%
d. UNAIDS	4 31%	5 38%	0 0%	1 8%	3 23%	0 0%	13 100%
e. Academic institution	2 25%	3 38%	1 13%	1 13%	1 13%	0 0%	8 100%
f. Other	10 22%	22 49%	3 7%	1 2%	3 7%	6 13%	45 100%
Grand Total	56 27%	96 45%	17 8%	6 3%	16 8%	20 9%	211 100%

TABLE I.49: UNICEF HAS BEEN EFFECTIVE IN SECURING SUFFICIENT FINANCIAL RESOURCES FOR ITS ACTIVITIES

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Not asked (UNICEF only question)	Grand Total
a. UNICEF	8 11%	31 42%	20 27%	6 8%	4 5%	5 7%	0 0%	74 100%
b. Government	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	64 100%	64 100%
c. WHO	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	7 100%	7 100%
d. UNAIDS	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	13 100%	13 100%
e. Academic institution	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	8 100%	8 100%
f. Other	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	45 100%	45 100%
Grand Total	8 4%	31 15%	20 9%	6 3%	4 2%	5 2%	137 65%	211 100%

TABLE I.50: UNICEF HAS RESPONDED TO DEVELOPMENTS IN PMTCT AND PAEDIATRIC HIV OVER TIME, MAKING NECESSARY INTERNAL ADJUSTMENTS

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Not asked (UNICEF only question)	Grand Total
a. UNICEF	16 22%	37 50%	10 14%	2 3%	4 5%	5 7%	0 0%	74 100%
b. Government	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	64 100%	64 100%
c. WHO	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	7 100%	7 100%
d. UNAIDS	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	13 100%	13 100%
e. Academic institution	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	8 100%	8 100%
f. Other	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	45 100%	45 100%
Grand Total	16 8%	37 18%	10 5%	2 1%	4 2%	5 2%	137 65%	211 100%

TABLE I.51: UNICEF HAS RESPONDED TO DEVELOPMENTS IN PMTCT AND PAEDIATRIC HIV OVER TIME, MAKING ADJUSTMENTS TO ITS WAYS OF WORKING

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Not asked (external question only)	Grand Total
a. UNICEF	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%	74 100%	74 100%
b. Government	21 33%	29 45%	3 5%	1 2%	3 5%	7 11%	0 0%	64 100%
c. WHO	2 29%	1 14%	1 14%	0 0%	1 14%	2 29%	0 0%	7 100%
d. UNAIDS	2 15%	9 69%	0 0%	0 0%	2 15%	0 0%	0 0%	13 100%
e. Academic institution	4 50%	4 50%	0 0%	0 0%	0 0%	0 0%	0 0%	8 100%
f. Other	8 18%	23 51%	3 7%	1 2%	4 9%	6 13%	0 0%	45 100%
Grand Total	37 18%	66 31%	7 3%	2 1%	10 5%	15 7%	74 35%	211 100%

TABLE I.52: THERE IS EFFECTIVE COORDINATION BETWEEN THE UNICEF COUNTRY OFFICE, REGIONAL OFFICE, AND HEADQUARTERS

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	e. Don't know	no response given	Not asked (UNICEF only question)	Grand Total
a. UNICEF	12 16%	47 64%	5 7%	5 7%	5 7%	0 0%	74 100%
b. Government	0 0%	0 0%	0 0%	0 0%	0 0%	64 100%	64 100%
c. WHO	0 0%	0 0%	0 0%	0 0%	0 0%	7 100%	7 100%
d. UNAIDS	0 0%	0 0%	0 0%	0 0%	0 0%	13 100%	13 100%
e. Academic institution	0 0%	0 0%	0 0%	0 0%	0 0%	8 100%	8 100%
f. Other	0 0%	0 0%	0 0%	0 0%	0 0%	45 100%	45 100%
Grand Total	12 6%	47 22%	5 2%	5 2%	5 2%	137 65%	211 100%

TABLE I.53: THERE ARE STRONG AND EFFECTIVE LINKAGES BETWEEN UNICEF'S WORK IN PMTCT AND PAEDIATRIC HIV AND ITS WORK IN OTHER SECTORS

Type of organisation	a. Strongly agree	b. Agree	c. Disagree	d. Strongly disagree	e. Don't know	no response given	Grand Total
a. UNICEF	9 12%	39 53%	14 19%	2 3%	5 7%	5 7%	74 100%
b. Government	11 17%	37 58%	5 8%	2 3%	2 3%	7 11%	64 100%
c. WHO	2 29%	0 0%	1 14%	0 0%	2 29%	2 29%	7 100%
d. UNAIDS	3 23%	4 31%	1 8%	0 0%	5 38%	0 0%	13 100%
e. Academic institution	0 0%	4 50%	0 0%	1 13%	3 38%	0 0%	8 100%
f. Other	7 16%	22 49%	2 4%	0 0%	8 18%	6 13%	45 100%
Grand Total	32 15%	106 50%	23 11%	5 2%	25 12%	20 9%	211 100%

ANNEX J: OVERVIEW OF UNICEF BUDGETING, RESOURCE MOBILIZATION AND ALLOCATION PROCESSES

Budgeting process

In broad terms, UNICEF's resource mobilisation targets are based on the organisation's multi-year strategic plans. These are then translated into multi-year, and then annual, work plans and budgets at the country, regional and global level. This is designed to ensure that within UNICEF's decentralised structure, there is a tangible link between the organisation's strategic priorities and the resources required to achieve them.[161]

Resource mobilisation

UNICEF has two departments that deal directly with resource mobilisation:[162]

- The Public Sector Alliances and Resource Mobilisation Office (PARMO) deals with governments, intergovernmental organisations, inter-organisational arrangements and international financial institutions.
- The Private Fundraising and Partnerships (PFP) Division deals with national committees, foundations and non-governmental organisations.

Programme departments from headquarters, regional and country offices also undertake fundraising efforts, dealing with both public and private sector donors, with support from PARMO and PFP. UNICEF's approach to fundraising involves developing partnerships with potential donors around shared commitments. Fundraising is the responsibility of all UNICEF staff involved in the delivery of results, not just individuals working in resource mobilisation teams.[163]

We understand that while Regular Resources are predominantly raised at the HQ level, the majority of Other Resources raised is by regional and country offices.

Allocation of resources

The financial resources mobilised are then allocated by headquarters, regional and country offices to budgeted activities. However, this depends on the type of resources raised:

- *Regular Resources:* The allocation of UNICEF's Regular Resources is determined by a formula based on under-five mortality rates, Gross National Income per capita, and child population estimates. The allocation is also defined by some parameters, where all country offices receive a minimum annual allocation ($850,000 in 2015), least developed countries receive a minimum proportion of total Regular Resources (60% in 2015), and countries in sub-Saharan Africa receive a minimum proportion of total Regular Resources (50% in 2015).[164] Country offices have flexibility to allocate these funds between programme areas and cost components (e.g. implementation; staff and personnel; supplies and commodities). A small proportion of Regular Resources (7% in 2014 and previous years) are, however, allocated by the UNICEF Executive Director across a range of programmes to "meet the needs of the most marginalised children".[165]
- *Other Resources:* The allocation of Other Resources to programme activities is dependent on the nature of the funds raised. For example, highly earmarked funds are likely to be restricted to a specific activity or purpose, while more loosely earmarked funds (e.g. by sector/programme) are allocated at the country office's discretion.

---

[161] Achamkulangare, G. 2014. An Analysis of the Resource Mobilisation Function within the United Nations System. UN Joint Inspection Unit. https://www.unjiu.org/en/reports-notes/JIU%20Products/JIU_REP_2014_1_English.pdf

[162] Ibid

[163] Ibid

[164] UNICEF. 2016. Report on Regular Resources 2015.

[165] Ibid

ANNEX K: RESOURCE MOBILIZATION: DATA ANALYSIS

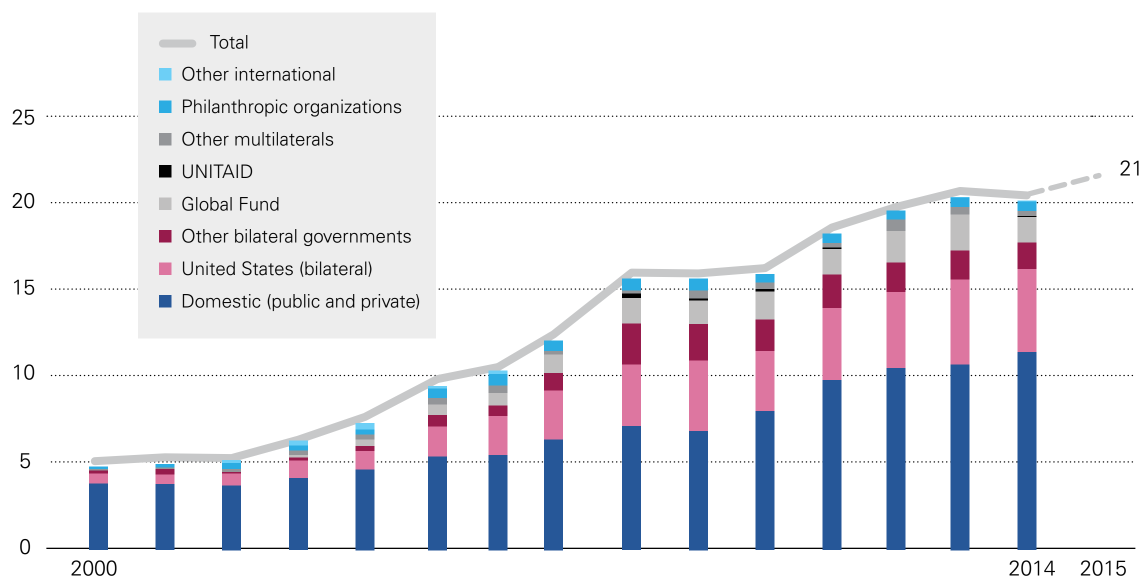
Global HIV financing landscape

As shown in Figure K.1, global resources for HIV/AIDS in low- and middle-income countries have more than doubled over the evaluation period, from under US$10bn in 2005 to just over US$20bn in 2014, and it is estimated that resources reached US$21.7bn in 2015. We do, however, note that a more recent Kaiser Family Foundation and UNAIDS study found that donor government funding for HIV actually fell in 2015, although the actual estimates are yet to be confirmed.[166] These resources are broadly in line with the financing goals set out in the 2001 United Nations Political Declaration on HIV/AIDS that called for US$9.2bn to be available for HIV/AIDS prevention and treatment by 2005, and the 2011 United Nations Political Declaration on HIV/AIDS that set a resource goal to reach US$22–24bn by 2015 for the global AIDS response in low- and middle-income countries.

The proportion of resources from domestic sources (public and private) has grown steadily over time, from approximately 50% between 2005 and 2010, to around 57% between 2011 and 2014. This increase in domestic resources is driven by a consistent increase in domestic public resources, and in spite of a fall in domestic private (mainly out-of-pocket) expenditures over the period. The trend in countries increasing domestic expenditure on HIV/AIDS is relatively widespread, with 84 of 121 low- and middle-income countries increasing their domestic spending on AIDS between 2009 and 2014 – 46 of these reported an increase of more than 50%, and 35 reported an increase of more than 100%.

As shown below, international financing for HIV/AIDS increased dramatically between 2005 and 2015, alongside domestic financing. However, Figure K.2 shows that while Official Development Assistance (ODA) for HIV/AIDS initially grew as a proportion of total ODA (from 2% in 2005 to 5% in 2007) and ODA for health (from 10% in 2005 to 32% in 2007), it then fell consistently each year to 2% for total ODA and 11% for ODA for health.

Figure K.1: Global resources for HIV/AIDS in low- and middle-income countries, 2005–15 (US$ bn)

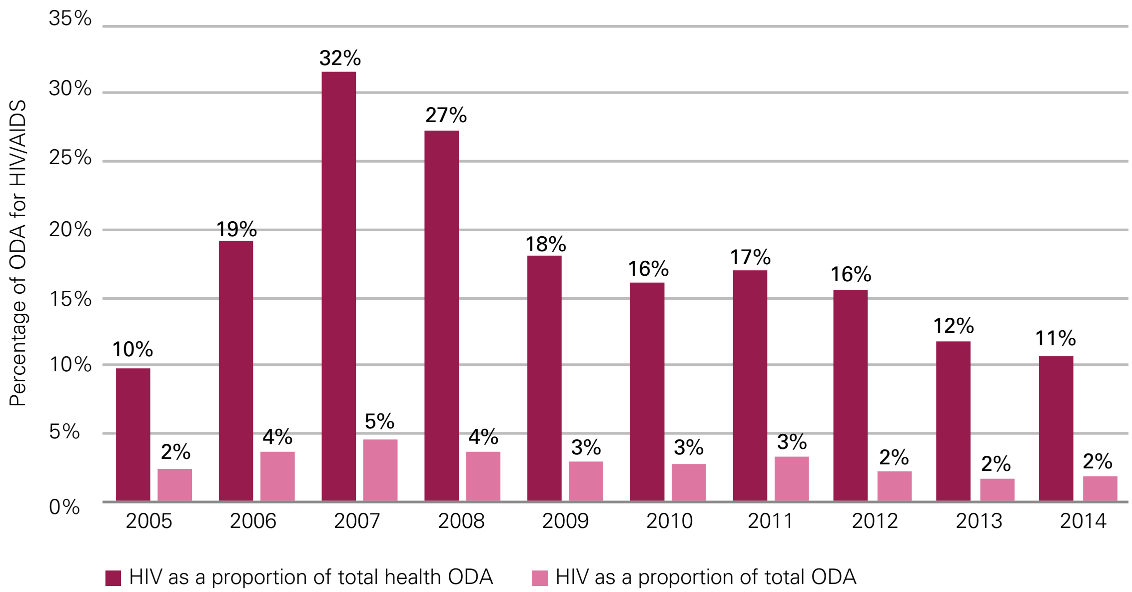


Source: UNAIDS (2015): "How AIDS Changed Everything"[167]

[166] http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/july/20150815_kaiser

[167] The level of global resources reflected in this figure is significantly higher than data available in publicly available databases (i.e. the AIDSinfo and OECD CRS databases). The evaluation team has not had access to the data used to generate this figure, and as such the figure presented is copied from the UNAIDS (2015): "How AIDS Changed Everything" report. The figures presented below, generated using data from the AIDSinfo and OECD CRS databases should be considered in this context.

Figure K.2: ODA for HIV/AIDS as a proportion of total ODA and ODA for health, 2005–14[168]

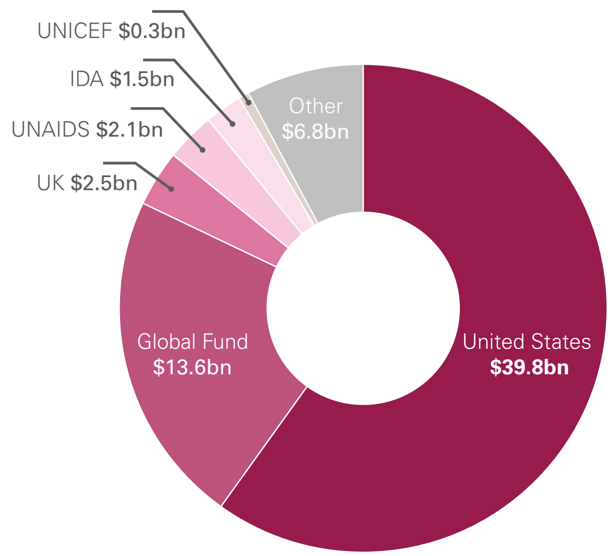


Source: OECD CRS database

As shown in Figure K.3, the United States has been by far the largest donor, providing US$39.8bn between 2005 and 2014, accounting for 60% of total ODA for HIV/AIDS. The Global Fund is the second largest donor, disbursing US$13.6bn since its inception to 2014, followed by the United Kingdom (4% of total), UNAIDS (3% of total), and International Development Association (IDA, 2% of total). The category 'Other' in Figure K.3 includes contributions from a range of donors, but most significantly Australia, Canada, EU Institutions, Germany, Ireland, Netherlands, Norway and Sweden, all of whom disbursed around 1% of total ODA for HIV/AIDS between 2005 and 2014. UNICEF disbursed US$0.3bn (0.5% of total) for HIV/AIDS over the period.

As shown in Figure K.4, the majority (62%) of ODA for HIV/AIDS between 2005 and 2014 has been disbursed to the Eastern and Southern Africa (ESA) region, with the remainder being disbursed to West and Central Africa (WCA, 16%), East Asia and the Pacific (EAP, 8%), Latin America and the Caribbean (LAC, 5%), South Asia (SA, 5%), Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS; 3%), and Middle East and North Africa (MENA, 1%).

Figure K.3: Gross ODA disbursements for HIV/AIDS by donor, 2005–14 (US$ bn)[169]

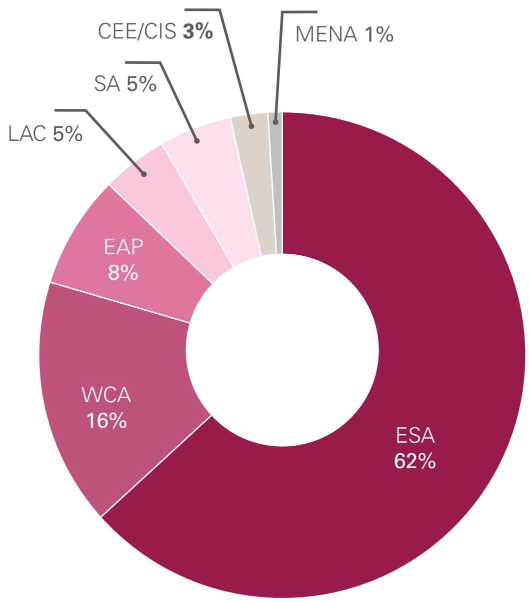


Source: OECD CRS database

[168] Figures calculated using the OECD CRS sector codes 13040 (STD control, including HIV/AIDS) and 16064 (Social mitigation of HIV/AIDS).

[169] Figures calculated using the OECD CRS sector codes 13040 (STD control, including HIV/AIDS) and 16064 (Social mitigation of HIV/AIDS).

Figure K.4: Gross ODA disbursements for HIV/AIDS by UNICEF region, 2005–14 (US$ bn)[170]

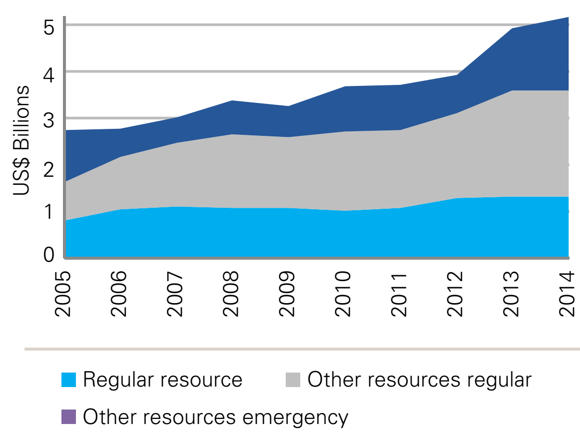


Source: OECD CRS database

As shown in Figure K.5, UNICEF's total revenue has increased from under US$3bn in 2005 to over US$5bn in 2014 and 2015, at a compound annual growth rate (CAGR) of 0.09. Regular Resources grew at the slowest rate, at a CAGR of 0.04, and, as such, have comprised a decreasing proportion of total revenues over time.[173] Other Resources Regular grew at a CAGR of 0.10, and Other Resources Emergencies grew fastest at a CAGR of 0.14.

As shown in Figure K.6, revenue from public and private sectors grew at the same pace, at a CAGR of 0.10 over the period, although the majority of resources (approx. 70%) came from the public sector. UNICEF notes that while it continues to broaden its donor base, this is still relatively concentrated, with over 76% of total revenue in 2014 received from the top 20 donors – in order of size of contribution, these are the United States, United Kingdom, European Commission, Norway and Germany.

Figure K.5: UNICEF revenue by category (2005–15)



Source: UNICEF (2014) Annual Report 2014; and UNICEF. 2015. HIV/AIDS Annual Results Report 2015

UNICEF financing

This section considers the trend and structure of UNICEF's total revenue streams; revenue for HIV/AIDS; expenditure on HIV/AIDS; and expenditure on PMTCT and care and treatment of children affected by HIV/AIDS.

UNICEF TOTAL REVENUE

UNICEF classifies revenue into two categories:[171]

- Regular Resources are those with no restrictions on their use.
- Other Resources are funds earmarked by donors for a specific purpose, such as a country, theme, project, sector, emergency or any other category.[172]

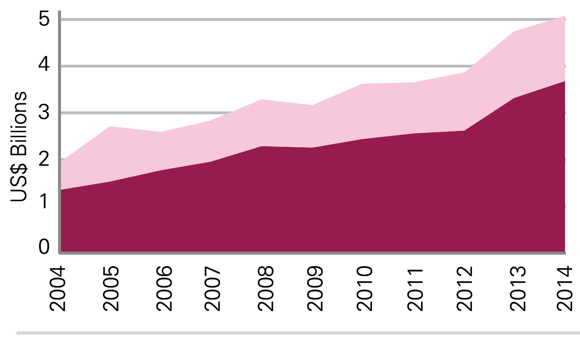
[170] Figures calculated using the OECD CRS sector codes 13040 (STD control, including HIV/AIDS) and 16064 (Social mitigation of HIV/AIDS).

[171] UNICEF (2011): "Funding Modalities (Quick References)".

[172] Other Resources are further classified as: Other Resources Regular (funds for specified non-emergency programmes and strategic priorities); Other Resources Thematic (contributions that donors earmark to support strategic and pre-defined objectives for countries, regions, UNICEF's Strategic Plan focus areas or humanitarian response); and Other Resources Emergency (funds specifically provided by donors for UNICEF's humanitarian actions and post crisis recovery activities).

[173] http://www.unicef.org/about/execboard/files/2013-4-End-of-cycle_review-MTSP-ODS-English.pdf.

Figure K.6: UNICEF revenue by source (2005–14)



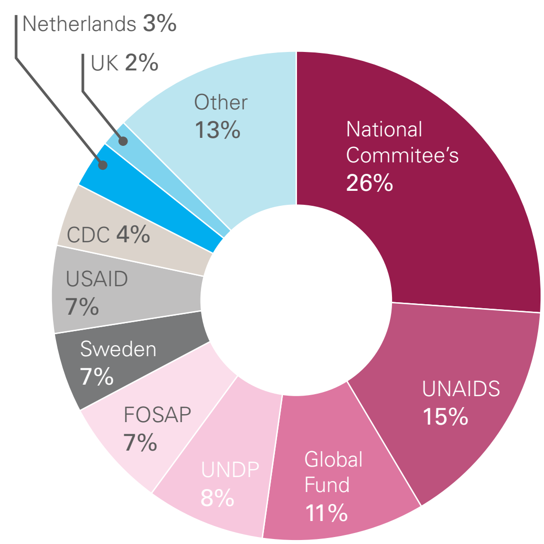
Source: UNICEF (2014) Annual Report 2014

UNICEF REVENUE FOR HIV/AIDS

As shown in Figure K.7, UNICEF's resources for HIV/AIDS have also been relatively concentrated among a few donors, with more than 50% of revenue being sourced from national committees, UNAIDS and the Global Fund. Key points to note are as follows:

- National committees provided 26% of UNICEF's total revenue for HIV/AIDS between 2010 and 2015 – this has been provided by the Korean National Committee (23% of total national committee revenues over the period), Netherlands National Committee (12%), French National Committee (10%), US and German National Committees (7% each), Hong Kong, Norwegian and UK National Committees (6% each), and a series of others.[174]
- The UNAIDS UBRAF provided US$72m (15% of total revenue) for HIV/AIDS between 2010 and 2015.
- This analysis is somewhat distorted by the inclusion of some funds where UNICEF has acted as an intermediary for financial flows. This is thought to affect funds from:
  - The Global Fund, where UNICEF has acted as a Principal/Sub Recipient.
  - FOSAP, as the Principle Recipient of a Global Fund grant in Chad, for which UNICEF was the Sub Recipient.
  - UNDP, where resources largely relate to H4+ activities.
- The 'Other' category includes contributions from 47 other donors.

Figure K.7: Sources of Other Resources for HIV/AIDS (2010–15)



Source: Analysis of internal UNICEF data, adjusted for data in UNICEF. 2015. HIV/AIDS Annual Results Report 2015

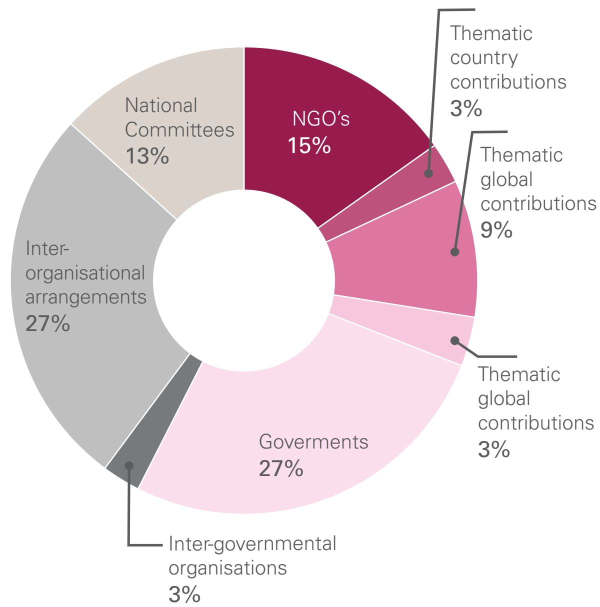
[174] The other national committees providing funds for HIV/AIDS are as follows: Japan, Denmark, Spain, Sweden, Finland, Canada, Italy, Australia, Andorra, Switzerland, Turkey, Luxembourg, New Zealand, Austria, Ireland, Portugal.

As shown in Figure K.8, thematic contributions in 2015 comprised 13% of total Other Resources for HIV/AIDS, with the majority of other funding being sourced from governments (27%), inter-organisational arrangements, such as UBRAF (27%), NGOs (15%) and national committees (13%).

As shown in Figure K.9, funding from some of UNICEF's key donors for HIV/AIDS has been highly variable, and generally in decline. In particular:

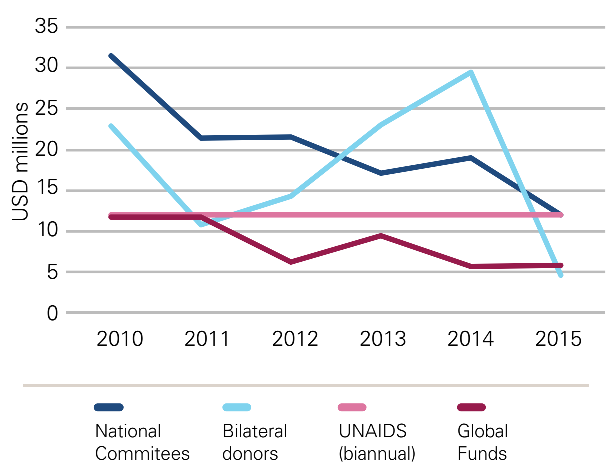
- Funding from National Committees declined by 60% from US$32m in 2010 to US$12m in 2015. This has been driven by reduced contributions from the national committees traditionally providing the most support – in particular, funding from the Korean, Netherlands, French and US National Committees reduced from 2014 to 2015 by 54%, 50%, 35% and 62%, respectively.
- Funding from bilateral donors has been highly variable, initially declining by 80% from US$23m in 2010 to US$11m in 2011, before increasing annually to peak at US$30m in 2014, and then declining to US$5m in 2015. This has been driven by volatile (and seemingly unpredictable) contributions by all of UNICEF's major bilateral donors, and is thought to relate to the political landscape in donor countries, non-uniform programme agreement cycles that lead to peaks and troughs of funding; and/or a number of donors reducing support for HIV/AIDS, including Australia, the UK, Netherlands and the EU.
- UNAIDS UBRAF funding has been maintained at US$12m p.a. between 2010 and 2015.
- Global Fund resources have declined by 50% from US$12m in 2010/2011 to US$6m to 2015.

Figure K.8: Sources of Other Resources for HIV/AIDS (2015)



Source: UNICEF. 2015. HIV/AIDS Annual Results Report 2015

Figure K.9: Trends in sources of Other Resources for HIV/AIDS (2010–15)



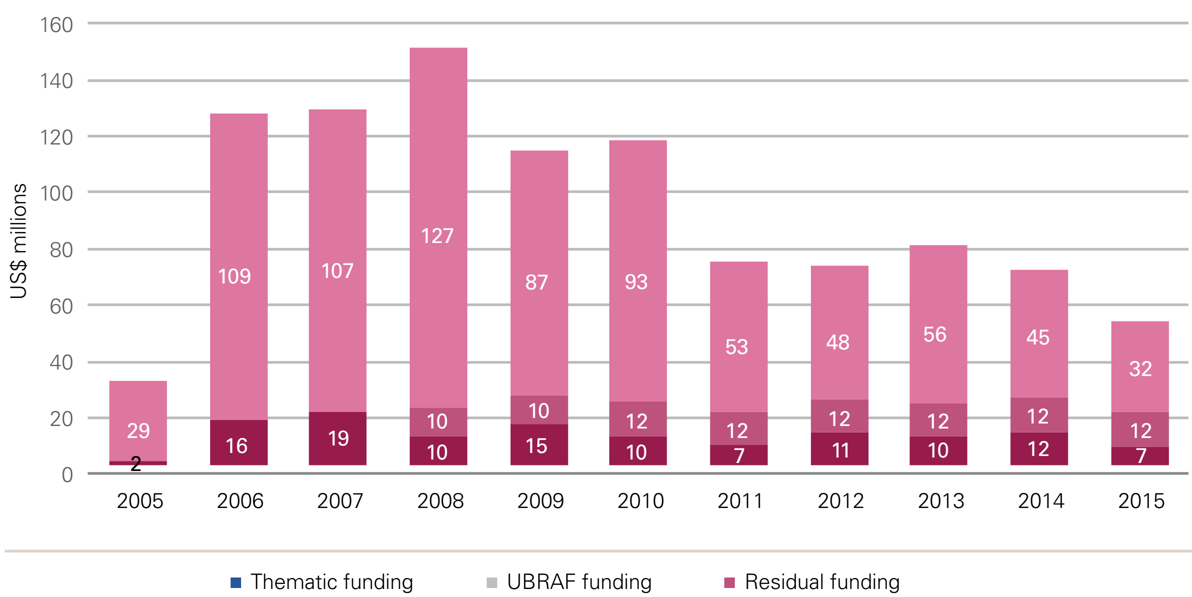
Source: Analysis of internal UNICEF data

THEMATIC FUNDING FOR HIV/AIDS AND THE UBRAF

Thematic resources (i.e. contributions that donors earmark to support strategic and pre-defined objectives for countries, regions, UNICEF's Strategic Plan focus areas or humanitarian response) are considered to be the second most flexible form of funding for UNICEF, after Regular Resources. They are allocated on a needs basis at the global, regional or country level, and allow for long-term planning and sustainability of programmes.[175] As shown in Figure K.10, thematic resources for HIV/AIDS have varied year by year, at an average of US$12m, but peaking at US$19m in 2007 before falling to US$7m in 2015. As a proportion of total Other Resources for HIV/AIDS, thematic resources for HIV/AIDS have varied from 17% in 2005 to 7% in 2008, before gradually increasing to 13% in 2015.

Funding through the UNAIDS UBRAF, earlier called the Unified Budget and Workplan (UBW), is designed to combine the efforts of UN Cosponsors and the UNAIDS Secretariat to improve the coherence, coordination and impact of UN's response to HIV/AIDS.[176,177] The UBRAF is focused on supporting the achievement of the targets of the Political Declaration on HIV/AIDS adopted by the General Assembly on 10 June 2011, and includes a core budget, which is allocated to each of the Cosponsors and the UNAIDS Secretariat. This source of funding is considered to be the next most flexible source of funding for HIV/AIDS within UNICEF. UNICEF resources through the UBRAF core budget have remained constant at US$12m p.a., since growing from US$10.4m p.a. in 2008 and 2009. This has represented a slight decrease in the proportion of the total UBRAF core budget, from over 15% in 2008–09 to below 14% in 2014–15 and 2016–17. However, given the overall decline in Other Resources for HIV/AIDS, UBRAF funds have represented an increasing proportion of UNICEF's Other Resources for HIV/AIDS, growing from 7% in 2008 to 24% in 2015.

Figure K.10: UNICEF thematic and non-thematic Other Resources for HIV/AIDS



Source: UNICEF 2013 & 2014 Annual Reports; 2015 Annual Results Report for HIV/AIDS; UNAIDS (2015) '2016–2021 UBRAF'; and analysis of internal UNICEF data

175 http://www.unicef.org/publicpartnerships/66662_66851.html

176 Cosponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank.

177 http://www.unaids.org/sites/default/files/sub_landing/files/JC2353%20UBRAF_en.pdf

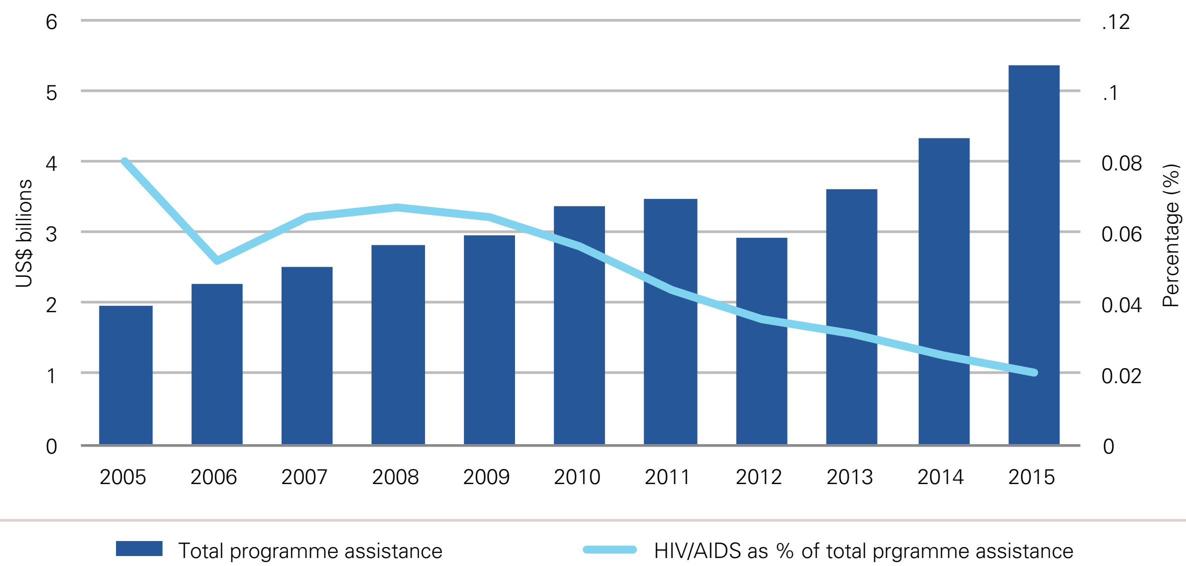
UNICEF EXPENDITURE ON HIV/AIDS

UNICEF's total programme assistance increased from US$1.8bn in 2005 to US$5.2bn in 2015, at a CAGR of 0.11. However, as shown in Figure K.11, the proportion of programme assistance that was allocated to HIV/AIDS decreased gradually (with the exception of 2006) from 8% in 2005 to just 2% in 2015.

As shown in Figure K.12, UNICEF's expenditure on HIV/AIDS initially grew from US$157m in 2005 to US$188m between 2008 and 2010, although then fell significantly to US$103m in 2012 and subsequently plateaued. Total HIV expenditure was US$107m in 2014 and 2015.

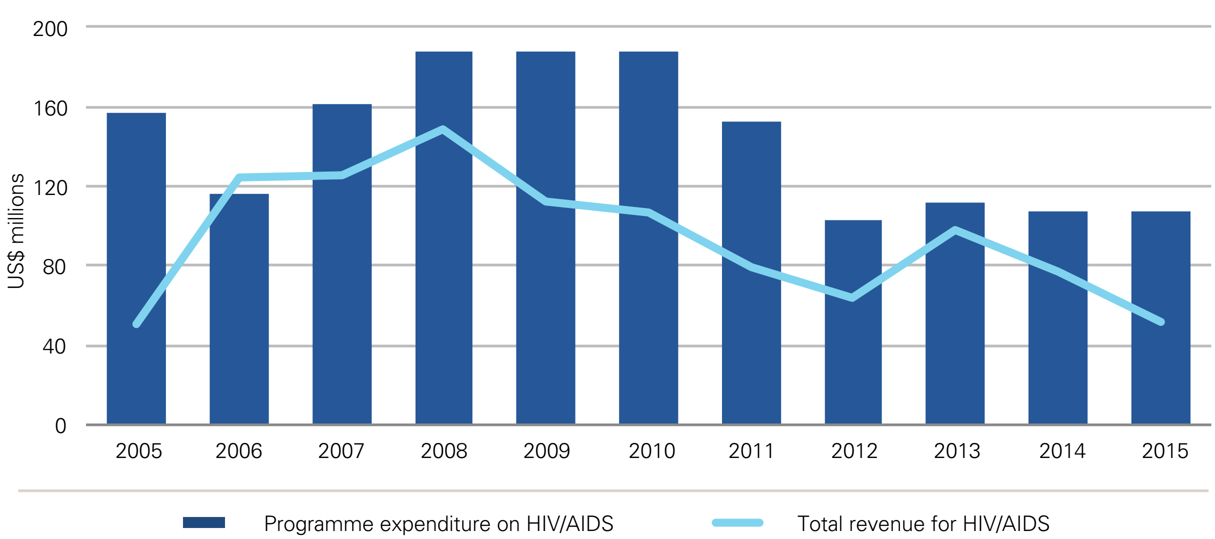
UNICEF's expenditure on HIV/AIDS is considerably higher than revenues received – this is because revenue only reflects Other Resources (i.e. earmarked donor contributions) for HIV/AIDS, while expenditure is UNICEF's total allocation for HIV/AIDS, including Regular and Other Resources.

Figure K.11: UNICEF total programme assistance (2005–2015)



Source: Successive UNICEF Annual Reports from 2005 to 2014; and analysis of internal UNICEF data

Figure K.12: Comparison of UNICEF revenues and expenditures for HIV/AIDS (2005–2015)



Source: Successive UNICEF Annual Reports from 2005 to 2014; and analysis of internal UNICEF data

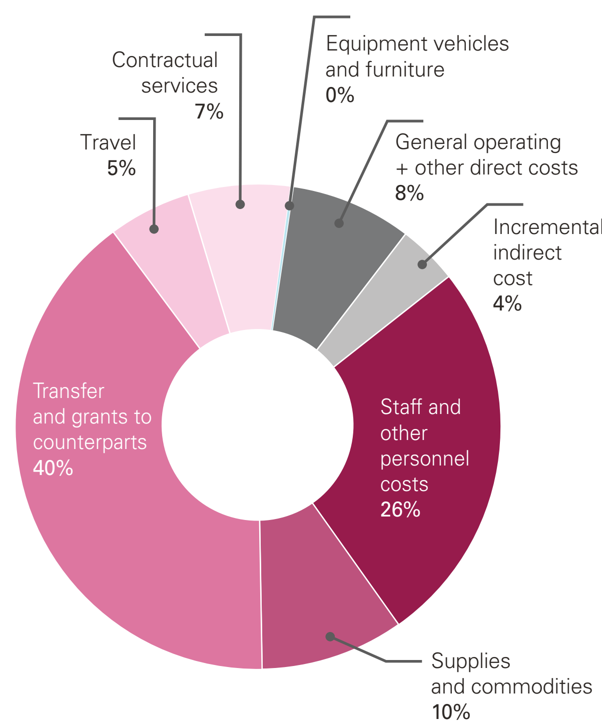
Figure K.13: UNICEF programme expenditure on HIV/AIDS by funding type (2012–15)

Source: Successive UNICEF Annual Reports from 2005 to 2014; and analysis of internal UNICEF data

As shown in Figure K.13, Regular Resources have varied by year. This has accounted for a relatively high proportion of total programme expenditure for HIV/AIDS (33% in 2015) as compared with other programme areas. For example, in 2015 Regular Resources accounted for 13% of total programme expenditure for Water, Sanitation and Hygiene; 16% for Education; 18% for Health; 22% for Nutrition; 24% for Child Protection; and 45% for Social Inclusion.[178]

As shown in Figures K.14 and K.15, UNICEF's global expenditure on HIV/AIDS for 2014 and 2015 was similar each year in terms of breakdown by cost category, with the majority of UNICEF's total expenditure on HIV/AIDS being used for transfers and grants to counterparts (between 39–40% in 2014 and 2015); staff and personnel costs (between 25–26% in 2014 and 2015); and supplies and commodities (between 10–14% in 2014 and 2015). Other cost categories include travel (5% in 2014 and 2015); contractual services (between 6%-7% in 2014 and 2015); general operating and other direct costs (between 7–8% in 2014 and 2015); and incremental indirect costs (4% in 2014 and 2015).

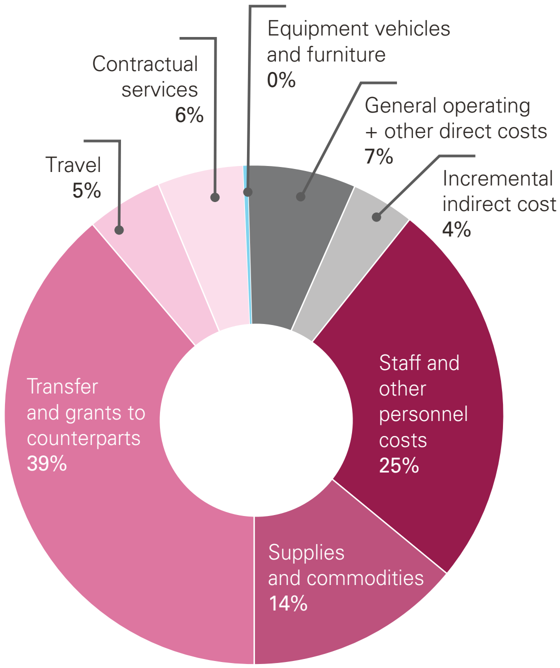
Figure K.14: UNICEF expenditure on HIV/AIDS (2014)



Source: Analysis of internal UNICEF data

[178] UNICEF. 2016. Report on Regular Resources 2015

Figure K.15: UNICEF expenditure on HIV/AIDS (2015)



Source: Analysis of internal UNICEF data

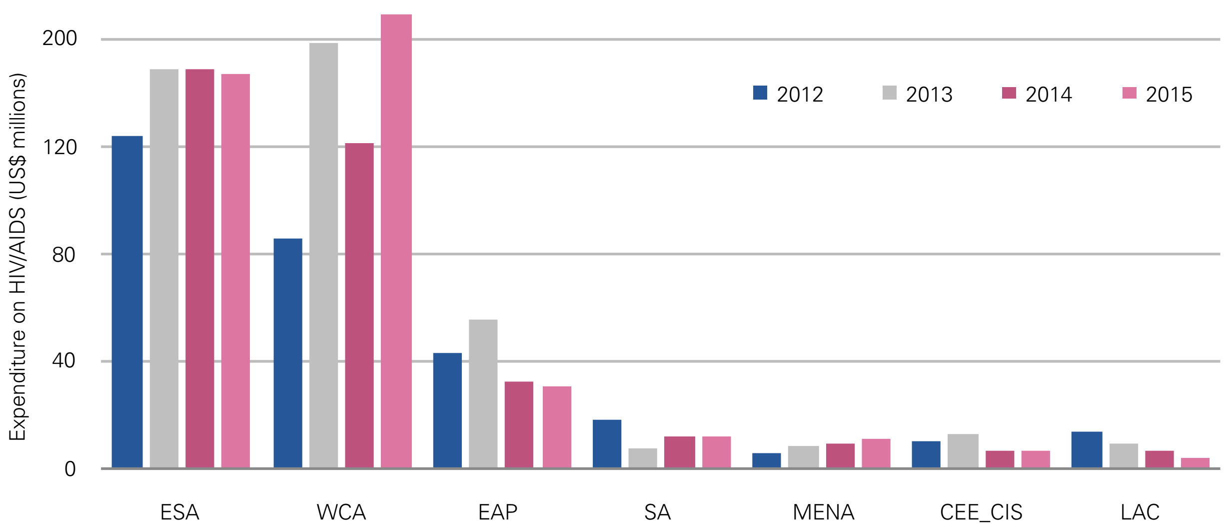
UNICEF EXPENDITURE ON PMTCT AND CARE AND TREATMENT OF CHILDREN AFFECTED BY HIV/AIDS

As shown in Figure K.16, expenditure on PMTCT and care and treatment of children affected by HIV/AIDS between 2012 and 2015 was largely directed towards sub-Saharan Africa through the ESA and WCA regions, which received 40% and 38% of the total allocation over the period, respectively. The allocation for other regions was as follows: EAP – 11%; SA – 3%; CEE-CIS – 3%; MENA – 2%; and LAC – 2%.

As shown in Figure K.17:

- UNICEF's resources have been targeted at a mix of countries with both very low numbers of pregnant women living with HIV (between 100–200 women in 2014; such as Bangladesh, Egypt, Panama, Nicaragua, Sri Lanka) and high numbers of pregnant women, such as the 22 Global Plan priority countries denoted by red markers, including Nigeria (210,000) and South Africa (240,000).

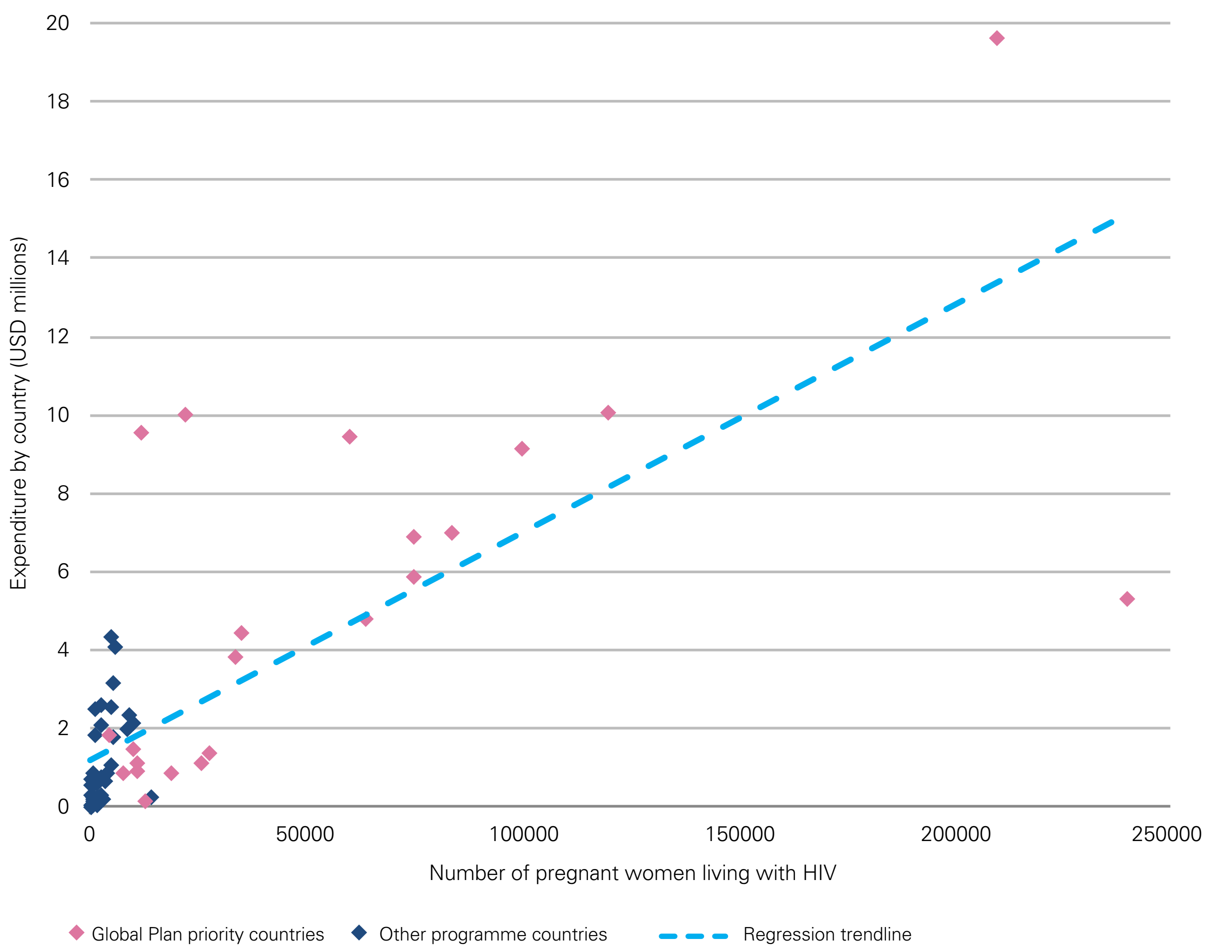
Figure K.16: UNICEF expenditure on PMTCT and care and treatment of children affected by HIV/AIDS by region (2012–15)



Source: Analysis of internal UNICEF data

- The upward slope of the trendline demonstrates a positive correlation between the number of pregnant women living with HIV and UNICEF's expenditure on PMTCT and care and treatment of children affected by HIV/AIDS. There has, however, been significant variance from the trendline, as shown by the number of outliers (and reflected by a low R^2 value of 0.55) – in particular, expenditure in Nigeria (denoted by the red marker in the top right of Figure K.17) was significantly higher than the trendline, while expenditure in South Africa (denoted by the red marker in the bottom right of Figure K.17) was significantly below the trendline.

Figure K.17: UNICEF expenditure on PMTCT and care and treatment of children affected by HIV/AIDS (2012–15) and the WHO estimated number of pregnant women living with HIV (2014)[179]



Source: Analysis of internal UNICEF data; WHO Statistical Information System

[179] The data points contained in the figure relate to all countries where UNICEF has expended funds on PMTCT and care and treatment of children affected by HIV/AIDS between 2012 and 2015, where data has been available. Data for India on the estimated number of pregnant women living with HIV was not available through WHOSIS and was supplemented by estimates gathered from the country visit.

ANNEX L: UNICEF'S WORK ON HIV IN HUMANITARIAN SITUATIONS: SUPPLEMENTARY EVIDENCE

UNICEF is an active member of the inter-agency coordination mechanisms related to humanitarian crises. At global level, UNICEF leads the Nutrition and the WASH clusters, co-leads the Education cluster with Save the Children,[180] as well as being the focal point agency for the Child Protection area of responsibility (AOR) and co-focal point (with UNFPA) for the GBV AOR.[181] UNICEF is the organisation with the most clusters and AORs under its remit.[182] In 2015 alone, UNICEF and partners responded to 310 humanitarian situations of varying scales in 102 countries.[183]

An evaluation of UNICEF's Cluster Lead Agency (CLA) role in Humanitarian Action found that UNICEF has invested significantly in implementing its CLA role since the Inter-Agency Standing Committee (IASC) cluster system was set up and is increasingly effective in its role, despite at times being hampered by the fact that it is undertaking its activities in an increasing number of situations and over prolonged periods.[184]

HIV/AIDS is a shared responsibility in the humanitarian response architecture. HIV/AIDS does not have its own cluster at global level and is considered to be a cross-cutting issue requiring multi-sectoral responses beyond health.[185] In some emergency settings, an HIV/AIDS sub-cluster is created on an ad hoc basis, under the health cluster lead by WHO, in which UNICEF participates.

UNICEF, together with partners, has contributed to the development of a number of normative documents aiming to draw attention to the need to provide HIV services, including PMTCT/paediatric HIV care and treatment, in emergency settings and providing guidance on operationalisation. UNICEF staff identified a number of key documents that they have produced on this topic alone or in collaboration with other partners, such as Save the Children and UNHCR:

- **In 2010, UNICEF published the Core Commitments for Children (CCCs) in Humanitarian Action**, a global framework for humanitarian action for children undertaken by UNICEF and its partners.[186] The commitments cover HIV/AIDS, among other areas. UNICEF has sought to build an alliance with partners around the CCCs and has endeavoured to contribute to the achievement of the CCCs through resource mobilisation, direct support to partners and advocacy. ECHO, the Humanitarian Aid and Civil Protection Directorate General of the European Commission, as well as some major INGOs active in the humanitarian arena, uphold these commitments.
- **In 2010, IASC, of which UNICEF is a member, published programmatic guidelines on addressing HIV in humanitarian settings.**[187] This included advocating for continuing treatment for pregnant women already on ART, which had not been part of the previous version of these guidelines, published in 2004. This revision took into account a growing understanding that ART can be provided in low-resource settings, including during emergencies.

180 UN. 2013. United Nations Disaster Assessment and Coordination (UNDAC) Field Hand book.

181 The Inter-Agency Standing Committee (IASC) coordinates the humanitarian response of all partners, from United Nations agencies, funds and programmes, to the Red Cross movement and non-governmental organisations (NGOs). In 2005, to further enhance humanitarian coordination, IASC endorsed the cluster approach, which organizes the response into sectors.

182 UNICEF. 2013. Evaluation of UNICEF's Cluster Lead Agency role in Humanitarian Action.

183 UNICEF. 2015. Annual Results Report – Humanitarian Action.

184 UNICEF. 2013. Evaluation of UNICEF's Cluster Lead Agency role in Humanitarian Action.

185 UN. 2013. United Nations Disaster Assessment and Coordination (UNDAC) Field Hand book.

186 UNICEF. 2010. Core Commitments for Children in Humanitarian Action.

187 IASC. 2010. Guidelines for addressing HIV in humanitarian settings.

- **Together with UNHCR and Save the Children, UNICEF took the initiative for and steered the work that led to the Inter-agency Task Team for HIV in Humanitarian Emergencies' publication of PMTCT guidelines in humanitarian settings in 2015.**[188] The recommendations include: (i) incorporate preparedness and contingency planning into PMTCT/ART programming and include PMTCT/ART in general national disaster preparedness plans; (ii) pre-position buffer stocks, re-distribute supplies in areas with greater need, provide support for transport and emergency procurement to ensure drug and commodities supply in humanitarian settings; (iii) in generalised HIV epidemics, provide leadership and support to ensure PMTCT/ART is included in the emergency response from the outset; (iv) mobilise HIV development actors to redirect activities, get humanitarian actors involved in PMTCT implementation, and apply context-adapted, alternative modes of service delivery.
- **UNICEF recently co-led the development of the overarching framework for the "Basic Package for Risk-Informed Programming"** and is leading the development of a chapter on HIV that will include useful tools as part of the "how to" guide.[189] The chapter, still to be finalised and published, will contain a step-by-step guide encompassing: (i) risk analysis for HIV; (ii) programme diagnosis (using bottleneck analysis); (iii) planning and implementation for risk-informed HIV programs; (iv) partnership and coordination.[190]

In the context of El Niño and its effects – including water shortages, drought, hunger and disease in Southern Africa, where many countries have high HIV burdens – ESARO has recently published a HIV-specific brief to highlight possible programmatic interventions to integrate HIV in the response to the situation.[191] However, more broadly, as part of the "preparedness agenda", some UNICEF respondents highlighted the need to ensure that COs are maintaining a certain level of preparedness and are clear on what predictable support they would be able to provide to countries from the first few hours following an emergency.

UNICEF has supported the inclusion of HIV services for women and children in various humanitarian settings, with some success stories. An analysis of UNICEF's reports, as well as interviews conducted as part of this evaluation, revealed that on a number of occasions UNICEF included PMTCT/paediatric HIV care and treatment as part of its humanitarian response.

- According to the 2015 Annual Results Report for humanitarian action, 16,000 HIV-positive pregnant women – that is 59% of women targeted by UNICEF in emergency settings – continued ART in the previous year.[192]
- In **Burundi** in 2008, a total of 51 additional PMTCT centres were established in health centres with UNICEF support.[193]
- In **Cameroon**, UNICEF has successfully advocated for an integrated emergency response package that includes HIV/AIDS. No parallel structures have been created in UNICEF intervention zones, but the refugees from Central African Republic, Chad and Nigeria have access to PMTCT services in local health structures and Option B+ and paediatric HIV treatment are free for all. These measures were facilitated by UNICEF establishing two sub-national offices in the emergencies areas of Bertoua in the East region and Maroua in the Far North region.
- In conflict-affected **CAR**, in 2015 UNICEF provided technical support to reactivate 76 percent of the PMTCT sites and to provide HIV testing services in severe-acute malnutrition (SAM) and tuberculosis units.[194]

---

[188] Interagency Task Team HIV in Humanitarian Emergencies. 2015. PMTCT in humanitarian settings. Part I: Lessons Learned and Recommendations.

[189] UNICEF. 2015. UNICEF follow-up to recommendations and decisions of the UNAIDS Programme Coordinating Board meetings.

[190] UNICEF. Forthcoming. Risk-informed programming. HIV chapter (unpublished).

[191] UNICEF. 2016. UNICEF and HIV in the context of El Niño in Southern Africa.

[192] UNICEF. 2015. Annual Results Report for Humanitarian Action.

[193] UNICEF. 2009. Humanitarian Action Report.

[194] UNICEF. 2015. Annual Results Report for Humanitarian Action.

- After the 2010 earthquake in Haiti, in line with its Core Commitments for Children and with its partners and cluster structures, UNICEF delivered emergency assistance to Haitian children in the WASH, nutrition, and health sectors.[195] In support of the Health Cluster and the MoH, UNICEF assisted the expansion of a decentralised public health system for MNCH services. UNICEF also developed the health section of the Haiti Post-Disaster Need Assessment that raised awareness of the HIV component in the humanitarian response and led its subsequent operationalisation.
- During the 2014–2015 conflict in Ukraine, UNICEF played a critical role in the humanitarian response in non-government controlled areas in Eastern Ukraine, in providing HIV treatment to women, children and adults. From 2015, UNICEF with Global Fund emergency resources has: provided antiretroviral medications and diagnostic supplies; enabled continuity of services and uninterrupted access to ARV treatment for 8,000 people living with HIV (including 300 HIV-positive children and 600 pregnant women) at risk of treatment interruption; and provided HIV testing for over 31,000 pregnant women and their children.

[195] UNICEF. 2010. Mid-Year Review of 2010 Humanitarian Action Report.

REFERENCE LIST

Achamkulangare, G. 2014. An Analysis of the Resource Mobilisation Function within the United Nations System. UN Joint Inspection Unit.

Ahmed S. et al. 2013. Risks and benefits of lifelong antiretroviral treatment for pregnant and breastfeeding women: a review of the evidence for the Option B+ approach. *Current opinion in HIV and AIDS*, 8:474–489.

Bhardwaj S. et al. 2014. Elimination of mother-to-child transmission of HIV in South Africa: Rapid scale-up using quality improvement. *South African Medical Journal*. 104(Suppl1):239–243.

BLC, UNICEF, CHAI. 2012. A business case for Options B and B+ to eliminate MTCT of HIV by 2015: Key Considerations for Countries to Implement an Equity-Focused Approach.

Chamla D. et al. 2013. Evidence from the field: missed opportunities for identifying and linking HIV-infected children for early initiation of ART. AIDS, 27 (Suppl 2): S139-S146.

Chamla D. et al. 2015. Integration of HIV in child survival platforms: a novel programmatic pathway towards the 90-90-90 targets. *Journal of the International AIDS Society*, 18(Suppl 6):20250.

Coutsoudis A. et al. 2013. Is Option B+ the best choice? Authors' reply. *Lancet*, 381(9874):1273–1274.

Coutsoudis A. et al. 2013. Is Option B+ the best choice? *Lancet*, 381(9863):269–27113, 8(5):474–489.

Department of Health, South Africa, and South African National AIDS Council. 2016. South African HIV and TB Investment Case.

DFID. 2013. Multilateral Aid Review.

Fozzard, A. et al. 2000. Aid Transaction Costs in Vietnam, Final Report.

Government of Haiti. 2010. Haiti Earthquake PDNA: Assessment of damages, losses, general and sectoral needs.

IASC. 2010. Guidelines for addressing HIV in humanitarian settings.

IATT. 2013. IATT Toolkit: Expanding and simplifying treatment for pregnant women living with HIV: managing the transition to Option B/B+.

IATT. 2016. Technical Synthesis from the M&E Country Consultation Meeting on Dissemination of the B+ M&E Framework. Uganda.

Idele P.A. et al. Prevention of mother-to-child transmission of HIV and paediatric HIV treatment monitoring: From measuring process to impact and elimination of mother-to-child transmission of HIV. *AIDS and Behavior*, submitted.

Interagency Task Team HIV in Humanitarian Emergencies. 2015. PMTCT in humanitarian settings. Part I: Lessons Learned and Recommendations.

Jashi M. et al. 2013. Informing policy and programme decisions for scaling up the PMTCT and paediatric HIV response through joint technical missions. Health Policy and Planning 28: 367–374.

Kingdon J. 1984. *Agendas, Alternatives and Public Policies*. Boston: Little Brown.

Ministry of Health and Child Care. 2013. An Operational Plan for the Nationwide Transition to Option B+ in Zimbabwe.

Nelson L.J. et al. 2014. Adoption of national recommendations related to use of antiretroviral therapy before and shortly following the launch of the 2013 WHO consolidated guidelines. *AIDS*. Mar; 28 Suppl 2:S217–24.

Nkomo P. et al. 2016. How ready are our health systems to implement prevention of mother-to-child transmission Option B+? *SA Journal HIV Medicine*.

OECD-DAC. 2010. DAC Report on Multilateral Aid.

Schouten E.J. et al. 2011. Prevention of mother-to-child transmission of HIV and the health-related Millennium Development Goals: time for a public health approach. *Lancet*, 378(9787):282–284.

Schwartländer, B. et al. 2011. Towards an improved investment approach for an effective response to HIV/AIDS, *Lancet*, DOI:10.1016/S0140- 6736(11)60702-2.

South Africa Department of Health. 2015. Consolidated PMTCT, adult and child HIV treatment guide.

Strode, A. and Grant, K. 2011. Children and HIV: Using an evidence-based approach to identifying legal strategies that protect and promote the right of children infected and affected by HIV and AIDS. Working Paper prepared for the Third Meeting of the Technical Advisory Group of the Global Commission on HIV and the Law, 7–9 July.

UN Committee on the Rights of the Child. 2003. General Comment No. 3, HIV/AIDS and the rights of the child.

UN Secretariat. 2009. Strengthening the system-wide funding architecture of operational activities of the UN for development.

UN. 2013. United Nations Disaster Assessment and Coordination (UNDAC) Field Hand book.

UNAIDS. 2011. Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive 2011–2015.

UNAIDS. 2013. UNAIDS 2012–2015 Unified Budget, Results and Accountability Framework: Budget for 2014–2015. Programme Coordinating Board Thirty Second Meeting. 25–27 June.

UNAIDS. 2015. How AIDS Changed Everything.

UNAIDS. 2016. Global AIDS Update.

UNAIDS. 2016. On the fast track to an AIDS-free generation.

UNGA. 2016. Political Declaration on Ending AIDS: on the Fast Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030.

UNICEF Evaluation Office. 2008. Evaluation of Gender Policy Implementation in UNICEF.

UNICEF Zimbabwe. 2014. Gender Review Report.

UNICEF, WHO, EGPAF. 2013. Double Dividend.

UNICEF. 2010. Unite for Children, Unite against AIDS Campaign Evaluation. Evaluation Report.

UNICEF. 2009. Humanitarian Action Report.

UNICEF. 2009. Thematic Report 2008 - Policy Advocacy and Partnerships for Children's Rights.

UNICEF. 2010. Blame and Banishment - the underground HIV epidemic affecting children in Eastern Europe and Central Asia.

UNICEF. 2010. Children and AIDS: 5th Stocktaking Report.

UNICEF. 2010. Core Commitments for Children in Humanitarian Action.

UNICEF. 2010. Humanitarian Action Report.

UNICEF. 2010. Mid-Year Review of 2010 Humanitarian Action Report.

UNICEF. 2010. Narrowing the Gaps to Meet the Goals.

UNICEF. 2010. UNICEF Strategic Priority Action Plan for Gender Equality: 2010–2012.

UNICEF. 2010. Unite for Children, Unite Against AIDS Campaign Evaluation.

UNICEF. 2010. Working for an Equal Future - UNICEF Policy on Gender Equality and the Empowerment of Girls and Women.

UNICEF. 2011. Funding Modalities (Quick References).

UNICEF. 2011. Training Manual on the Equity Focus in Programmes.

UNICEF. 2012. Accelerating Results for Deprived Children through Level Three Monitoring - Workstream One Country Report.

UNICEF. 2013. Children and AIDS. 6th Stocktaking Report.

UNICEF. 2013. Costing the HIV Response, presented at the UNICEF National Committee Meeting, Nov. 2013 Paris, France.

UNICEF. 2013. Evaluation of UNICEF's Cluster Lead Agency Role in Humanitarian Action.

UNICEF. 2013. Medium-term Strategic Plan 2006–2013. A data and results companion to the end of cycle review.

UNICEF. 2013. The UNICEF Strategic Plan, 2014–2017. Realizing the rights of every child, especially the most disadvantaged.

UNICEF. 2013. Thematic Report 2013, HIV/AIDS and Children.

UNICEF. 2014. Annual Results Report: HIV/AIDS.

UNICEF. 2014. UNICEF Gender Action Plan 2014–2017.

UNICEF. 2014. UNICEF's lessons learned for HIV programming: 2013 floods in Gaza province, Mozambique.

UNICEF. 2015. Annual Report on the Implementation of the UNICEF Gender Action Plan, 2014–2017 UNICEF Executive Board June 17, 2015 *[slides]*.

UNICEF. 2015. Annual report on the implementation of UNICEF Gender Action Plan.

UNICEF. 2015. Annual Results Report: Humanitarian Action.

UNICEF. 2015. Community-Facility Linkages to Support the Scale-Up of Lifelong Treatment for Pregnant and Breastfeeding Women Living with HIV.

UNICEF. 2015. Promising practices: Building on experience from Nigeria, Zambia and Zimbabwe.

UNICEF. 2015. UNICEF follow-up to recommendations and decisions of the UNAIDS Programme Coordinating Board meetings.

UNICEF. 2015. UNICEF's Strategy for Health (2016–2030), UNICEF Programme Division, Annex E.

UNICEF. 2016. Annual Results Report: HIV and AIDS.

UNICEF. 2016. Report on Regular Resources 2015.

UNICEF. 2016. UNICEF and HIV in the context of El Niño in Southern Africa.

UNICEF. 2016. UNICEF HIV Strategic Reflection Survey Results.

UNICEF. Forthcoming. Risk-informed programming. HIV chapter (unpublished).

UNICEF. 2010. HIV and AIDS Office Management Plan, 2010–2011.

Walt G. et al. 2008. 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy and Planning*, 23(5):308–317.

WHO. 2010. Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. Recommendations for a public health approach.

WHO. 2013. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.

Yenzingane Network and UNICEF. 2010. Questions and Answers: Infant feeding in the context of HIV in South Africa.

Zeng, W. et al. 2016. Resource needs and gap analysis in achieving universal access to HIV/AIDS services: a data envelopment analysis of 45 countries. *Health Policy Plan*. 31 (5): 624–633.

OTHER DATA SOURCES

https://www.ictedge.org/tools/frontlineSMS.html

http://promotinghealthinwomen.ca/online-course/unit-3-approaches-to-integrating-gender-in-health-promotion/gender-sensitive/

https://www.theglobalfund.org/en/news/2015-08-17-life-saving-hiv-treatment-for-adults-and-children-arrives-in-ukraine/

http://www.who.int/healthsystems/publications/abuja_declaration/en/

http://www.unaids.org/sites/default/files/sub_landing/files/JC2353%20UBRAF_en.pdf.

http://www.unaids.org/sites/default/files/sub_landing/files/JC2034_UNAIDS_Strategy_en.pdf.

http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf.

http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

http://www.unicef.org/about/execboard/files/2013-4-End-of-cycle_review-MTSP-ODS-English.pdf.

http://www.unicef.org/policyanalysis/rights/index_60319.html.

http://www.unicef.org/publicpartnerships/66662_66851.html.

https://www.unocha.org/about-us/who-we-are

http://www.who.int/hiv/mtct/GPF_01_05CalltoAction.pdf

COUNTRY STUDIES

Cambodia

AIDS info Online Database. Available at http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx (accessed May 2016).

Bigdeli, M. and Annear, P.L. 2008. Barriers to access and the purchasing function of health equity funds: Lessons from Cambodia. WHO.

Chhea, C. and Seguy, N. 2010. HIV prevalence among drug users in Cambodia 2007. NCHADS & NACD; 2010. Phnom Penh, Cambodia.

Chhea C. 2012. HIV sentinel survey 2010: Female entertainment workers (FEW), antenatal care clinic (ANC) attendees. Ministry of Health: NCHADS. Phnom Penh, Cambodia.

GOC. 2010. Third National Strategic Plan (NSP III) for the response to HIV/AIDS (2011–15).

GOC. 2014. Demographic and Health Survey 2014.

GOC. 2015. Cambodia Country Progress Report, UNGASS.

GOC National AIDS Authority. 2014. Cambodia Country Progress Report: Monitoring Progress towards the Targets of the 2011 UN Political Declaration on HIV and AIDS.

GOC and UNICEF. 2013. MTR of Country Programme Action Plan 2011–15.

NCHADS. 2007. Standard Operating Procedures (SOP) to Initiate a Linked Response for Prevention, Care, and Treatment of HIV/AIDS and Sexual and Reproductive Health Issues.

NCHADS. 2010. HIV/AIDS annual report for 2009. Ministry of Health: NCHADS, Phnom Penh, Cambodia.

NCHADS. 2013. Conceptual Framework on Virtual Elimination of New HIV Infections in Cambodia by 2020: Cambodia 3.0.

NCHADS. 2014. HIV/AIDS annual report for 2013. Ministry of Health: NCHADS, Phnom Penh, Cambodia.

OECD Creditor Reporting System database. Available at https://stats.oecd.org/Index.aspx?DataSetCode=CRS1 (accessed April and May 2016).

UNAIDS. 2012. 31st Meeting of the Programme Coordinating Board – Case Study: The Royal Government of Cambodia at the forefront in applying new investment approach.

UNICEF. 2005. Cambodia Annual Report 2005.

UNICEF. 2006. Cambodia Annual Report 2006.

UNICEF. 2007. Cambodia Annual Report 2007.

UNICEF. 2008. Cambodia Annual Report 2008.

UNICEF. 2009. Cambodia Annual Report 2009.

UNICEF. 2010. Cambodia Annual Report 2010.

UNICEF. 2011. Cambodia Annual Report 2011.

UNICEF. 2012. Cambodia Annual Report 2012.

UNICEF. 2013. Cambodia Annual Report 2013.

UNICEF. 2014. Cambodia Annual Report 2014.

UNICEF. 2015. Cambodia Annual Report 2015.

UNICEF. 2005. Country Programme Action Plan 2006–10.

UNICEF. 2010. Executive Board Annual Session 2010: Cambodia.

UNICEF. 2010. Country Programme Action Plan 2011–15.

WHO, UNICEF, UNAIDS, UNFPA. 2015. Elimination of PTCT and syphilis in Asia and the Pacific in 2015 and beyond: Progress Review and Road Map.

Cameroon

DROS. 2015. Revue du plan d'élimination de la transmission mère-enfant du VIH (TME 2011–2015).

EGPAF. The Cameroon Programme.

Institut National de la Statistique. 2015. Enquête par grappes à indicateurs multiples (MICS5). Résultats clés.

MJEC. 2014. Revue Annuelle Sectorielle du Programme VIH et SIDA.

MOPH. 2016. Plan opérationnel d'élimination de la transmission du VIH de la mère à l'enfant au Cameroun.

MOPH. 2016. Plan opérationnel national d'accélération de la prise en charge du VIH chez l'enfant et l'adolescent Cameroun (2016–2018).

MOPH. 2013. Vers l'élimination de la transmission du VIH de la mère à l'enfant à l'horizon 2015 au Cameroun. Draft Progress Report n. 7. Année 2012.

MOPH. 2014. Estimations et projections sur le VIH et le SIDA au Cameroun. Période 2010–2020.

MOPH. 2014. Vers l'élimination de la transmission du VIH de la mère à l'enfant à l'horizon 2015 au Cameroun. Draft Progress Report n. 8. Année 2013.

MOPH. 2015. Analyse de la situation de la prise en charge du VIH pédiatrique au Cameroun.

MOPH. 2015. Appui technique à la collecte, l'harmonisation des données et au monitorage du microplan d'élimination de la transmission mère-enfant du VIH-sida (e-tme) dans le district de santé de la Cité Verte. Rapport de consultation.

MOPH. 2015. Evaluation du plan d'élimination de la transmission mère-enfant (2011–2015).

MOPH. 2015. Vers l'élimination de la transmission du VIH de la mère à l'enfant à l'horizon 2015 au Cameroun. Draft Progress Report n. 9. Année 2014.

MOPH. 2014. Rapport annuel 2014 des activités de lutte contre le VIH/SIDA et les IST au Cameroun. Ppt presentation by Serge Billong.

MOPH.2014. Rapport national de suivi de la déclaration politique sur le VIH/SIDA Cameroun. Global AIDS Response Progress (GARP).

MOPH. 2014. Standards de performance pour l'offre des services de PTME de qualité.

MOPH. 2014. Standards de performance sur l'offre des services de PECP de qualité.

MOPH. 2015. Global Fund Concept Note 2016–2107. Investir pour obtenir un impact contre la tuberculose et le VIH.

MOPH. 2015. Note technique harmonisée sur la stratégie communautaire dans la mise en œuvre du NFM au Cameroun 2016–2017.

MOPH. 2015. Note technique harmonisée sur la stratégie communautaire dans la mise en œuvre du NFM au Cameroun.

MOPH. 2015. Rapport annuel 2014 des activités de lutte contre le VIH/SIDA et les IST au Cameroun.

MOPH. 2015. Rapport national de suivi de la déclaration politique sur le VIH/SIDA Cameroun. Global AIDS Response Progress (GARP).

MOPH. 2016. Plan opérationnel d'élimination de la transmission du VIH de la mère a l'enfant (2016–2017).

MOPH. Plan opérationnel de la mise en œuvre de l'option B+ pour la PMTE au Cameroun (draft).

National AIDS Control Committee. The Impact of HIV and AIDS in Cameroon through 2020.

PEPFAR. 2013. Cameroon Operational Plan Report FY 2012.

PEPFAR. 2015. PEPFAR district prioritization in COP15 (ppt presentation).

Republic of Cameroon. 1998. Décision n° 0209/ID/MSP/CAB du 2 décembre portant réorganisation de la lutte contre le SIDA au Cameroun.

Republic of Cameroon. 2005. Décision n° 009/MSP/CAB du 14 janvier complétant les dispositions de la décision n° 468 bis/MSP/CAB du 24 septembre 2004 fixant la nouvelle tarification des protocoles de première ligne de prise en charge des personnes vivant avec le VIH/SIDA (PVVS).

Republic of Cameroon. 2006. Prévention de la transmission du VIH de la mère à l'enfant. Guide de poche.

Republic of Cameroon. 2010. Plan de suivi et d'évaluation du plan stratégique national de lutte contre le SIDA 2011–2015. Draft prefinal.

Republic of Cameroon. 2010. Plan stratégique national de lutte contre le VIH, le SIDA et les IST. 2011–2015.

Republic of Cameroon. 2012. Guide pour la prise en charge des enfants exposés et infectés par le VIH/SIDA. Version simplifiée.

Republic of Cameroon. 2012. Plan national d'élimination de la transmission mère-enfant du VIH à l'horizon 2015 au Cameroun.

Republic of Cameroon. 2013. Plan stratégique national de lutte contre le VIH, le SIDA et les IST. 2014–2017.

Republic of Cameroon. 2014. Lettre circulaire n. D36-97 / LC / MINSANTE / CAB / SG / SP / CNLS du 13 novembre.

Republic of Cameroon. 2014. Rapport national de suivi de la déclaration politique sur le VIH/SIDA Cameroun. Global AIDS Response Progress (GARP).

Republic of Cameroon. 2015. Programme de Cooperation Cameroun-Unicef 2013–2017.

Republic of Cameroon. 2015. Programme de coopération Cameroun-UNICEF 2013–2017. Revue à mi-parcours. Revue sectorielle VIH. Rapport synthèse.

The Global Fund. 2016. Audit des subventions du Fonds Mondial accordées à la République du Cameroun (DRAFT).

UNICEF Cameroon. 2007. Draft Country Programme Document 2008–2012

UNICEF Cameroon. 2007. Plan d'Action du Programme de Pays 2008–2012 (CPAP)

UNICEF Cameroon. 2012. Annexe 1. Plan d'Action du Programme de Pays (CPAP)

UNICEF Cameroon. 2012. Plan de Gestion du Programme Pays/ Budget Intégré 2013–2017 (CPMP)

UNICEF Cameroon. 2013. Plan Annuel de Gestion (AMP).

UNICEF Cameroon. 2014. Plan Annuel de Gestion (AMP).

UNICEF Cameroon. 2015. Plan Annuel de Gestion (AMP).

UNICEF Cameroon. 2015. Plan de Gestion du Programme Pays - Révisé 2016–2017. Revue à mi-parcours.

UNICEF Cameroon. 2016. Plan Annuel de Gestion (AMP).

UNICEF. 2010. Core Commitments for Children in Humanitarian Action.

UNICEF. 2015. Programme de coopération Cameroun-UNICEF. Plan de Travail Annuel 2015.

UNICEF. 2016. Cameroon Humanitarian Situation Report.

UNICEF. 2016. Programme de coopération Cameroun-UNICEF. Plan de Travail biannuel 2016–2017. Santé, Nutrition, VIH&SIDA.

UNICEF. Allocation budgétaires par sous-composante programme de 2008 à 2012. Programme Enfant VIH/SIDA.

UNICEF. Analysis of programme and institutional budget 2014–2017.

Haiti

Government of Haiti. 2010. Haiti Earthquake PDNA: Assessment of damages, losses, general and sectoral needs.

Government of Haiti. 2013. Premier et second rapports périodiques de l'état haïtien sur l'application de la convention relative aux droits de l'enfant.

Haggerty, R. 1989. Haiti: A country study. Washington: GPO for the Library of Congress.

IHE. 2006. Enquête Morbidité, Mortalité, Utilisation des Services (EMMUS IV).

IHE. 2012. Enquête Morbidité, Mortalité, Utilisation des Services (EMMUS V).

MOH. 2011. Plan Stratégique National d'élimination de la transmission mère-enfant du VIH et de la syphilis.

MOH. 2014. Déclaration d'engagement sur le VIH/Sida. GARPR. Rapport de situation nationale Haïti.

MOH/DSF. 2015. Evaluation du programme de prévention de la transmission mère-enfant dans le cadre de l'Initiative de l'élimination du VIH et de la syphilis congénitale.

PAHO/WHO. 2013. Progress Report 2012. Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis in the Americas.

PNLS. 2015. Plan Stratégique National Multisectoriel 2012–15 révisé avec extension à 2018.

PSI-Haiti. 2012. Behavioural and biological study cited in the Global Fund Concept Note for 2015–17.

Schwartländer, B., Stover, J. Hallett, T., Atun, R. et al. 2011: Towards an improved investment approach for an effective response to HIV/AIDS, *Lancet* 377(9782): 2031–41.

The Global Fund. 2014. Concept note 2015–17.

UN. 2001. UNDAF Haiti 2002–06.

UN. 2008. UNDAF Haiti. 2009–11.

UN. 2013. UNICEF Strategic Plan 2014–17. Realizing the rights of every child, especially the most disadvantaged.

UNICEF. 2006. Haiti Annual Report.

UNICEF. 2007. Revue Annuelle du Programme de Cooperation. Programme Santé / Nutrition (ppt presentation).

UNICEF. 2007. Revue Annuelle Programme Santé (ppt presentation).

UNICEF. 2007. Annual Working Plan – HCO.

UNICEF. 2007. Haiti Annual Report.

UNICEF. 2007. Revue Annuelle du Programme de Coopération. Programme Santé / Nutrition (ppt)

UNICEF. 2008. Annual Working Plan – HCO.

UNICEF. 2008. Country Programme Management Plan. 2009–11.

UNICEF. 2008. Draft Country Programme Document – Haiti 2009–11.

UNICEF. 2008. Plan d'Action de Programme de Pays entre Le Gouvernement d'Haïti et Le Fonds des Nations Unies pour l'Enfance 2009–11.

UNICEF. 2008. Revue Annuelle Sectorielle VIH (ppt).

UNICEF. 2009. Annual Working Plan – HCO.

UNICEF. 2009. Country Programme Action Plan – Haiti 2009–11 + results framework.

UNICEF. 2009. Country Programme Action Plan – Haiti 2013–16.

UNICEF. 2011. Amendment to UNICEF Haiti Country Programme Management Plan 2010–12.

UNICEF. 2011. Country Office Annual Report: Haiti, TACRO.

UNICEF. 2011. Haiti Annual Report.

UNICEF. 2012. Country Office Annual Report: Haiti, TACRO.

UNICEF. 2012. Country Programme Management Plan. 2013–16.

UNICEF. 2012. Draft Lessons Learned, Country Programme Document 2013–16.

UNICEF. 2012. Haiti Annual Report.

UNICEF. 2012. Country Programme Document 2013–16.

UNICEF. 2013. Haiti Rolling Management Plan 2013–14.

UNICEF. 2013. Rolling Working Plan – Haiti – Health 2013–14.

UNICEF. 2014. Annual Work Plan 2014–15 Haiti – Health.

UNICEF. 2014. Haiti Rolling Management Plan 2014–15.

UNICEF. 2014. JPMS 2014 Report.

UNICEF. 2015. JPMS 2015 Report.

United States Department of State. 2015. Haiti Country Operational Plan (COP).

WHO. 2014. Global Guidance on Criteria and Processes for Validation: Elimination of Mother-to-Child Transmission of HIV and syphilis.

India

AIDS info Online Database. Available at http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx (accessed May 2016).

CBGA. 2014. Major Dimensions of Inequalities in India: Health Care. Available at http://www.cbgaindia.org/policy-brief/major-dimensions-of-inequalities-in-india-healthcare/ (accessed May 2016).

CBHI, MoHFW. 2015. National Health Profile.

GOI. 1998. NACP II (1999–2006) Strategy Document, Government of India.

GOI. 2006. NACP II (2007–11) Strategy Document, Government of India.

GOI. 2007. Policy Framework for Children and AIDS, Government of India.

GOI. 2009. NFHS-3 National Fact Sheet India, Registrar General India, Vital Statistics Division, Government of India.

GOI. 2009. Special Bulletin on Maternal Mortality in India 2004–06: Sample Registration System. New Delhi: Registrar General, Government of India. Available at http://censusindia.gov.in/Vital_Statistics/SRS_Bulletins/MMR-Bulletin-April-2009.pdf (accessed May 2016).

GOI. 2011. NACP IV (2012–17) Strategy Document, Government of India.

GOI. 2011–13. MoHFW MMR Bulletin, Government of India.

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

GOI. 2015. Rural Health Statistics 2015, Government of India. Available at http://www.indiaenvironmentportal.org.in/files/file/Rural%20Health%20Statistics%202014-15.pdf (accessed May 2016).

GOI. 2016–17. Budget Brief, National Health Mission (NHM), Accountability Initiative CPR, Government of India.

HIV-Sensitive Social Protection. 2012. A situational analysis across different stakeholders in the district of Khurda and Koraput, Odisha, Mar.

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

MoHFW. 2013. MMR Bulletin, 2011–13.

Muthu, M., Bachani, D. and Sogarwal, R. 2010. Is there any gender inequity in accessing care for children living with HIV? Evidence from India. Abstract on gender equity, Vienna International AIDS Conference.

MWCD and UNICEF. 2013–14. Rapid Survey on children India. Available at http://indianexpress.com/article/opinion/columns/indias-malnutrition-shame/#sthash.NrvAJA3N.dpuf (accessed in May 2016).

NACO. 2015. Annual Report 2014–15.

NACO & NIMS. 2015. Technical Report – India HIV Estimates.

OECD Creditor Reporting System database. Available at https://stats.oecd.org/Index.aspx?DataSetCode=CRS1 (accessed April and May 2016).

Social Protection for children affected by HIV in India, A Mapping Study, 2011.

UNAIDS. 2015. How AIDS Changed Everything.

UNGASS. 2010. India Progress Report 2010.

World Bank. 2015. India Country Snapshot.

World Bank. 2015. India Country Overview. Available at http://www.worldbank.org/en/country/india/overview (accessed May 2016).

World Bank. 2015. Databank. Available at http://data.worldbank.org/ (accessed May 2016).

South Africa

"Accelerate Progress, Envision the Future" – 3rd Partners' Forum for Maternal Newborn and Child Health, 7 February 2014. Available at: http://southafrica.unfpa.org/news/accelerate-progress-envision-future-3rd-partners-forum-maternal-newborn-and-child-health#sthash.7YopV64p.dpuf

Agu, V.U. 2010. *The Development of Harmonized Minimum Standards for Guidance on HIV Testing and Counselling and Prevention of Mother-to-Child Transmission of HIV in the SADC Region: PMTCT Country Report South Africa*, 24 March 2010. Available at: http://www.hsrc.ac.za/en/research-outputs/view/4964

Barron, P., Pillay, Y., Doherty, T. Sherman, G. et al. 2013. Eliminating mother-to-child HIV transmission in South Africa. *Bulletin of the World Health Organization* 91: 70–4.

Bateman, C. 2009. Time to 'stop pedalling backwards' – Motsoaledi, *South African Medical Journal* 99(11). http://www.samj.org.za/index.php/samj/article/view/3817/2563

Bhardwaj, S. 2013. Connecting the dots for EMTCT. *UNICEF: South Africa*. Available at: http://www.unicef.org/southafrica/resources_16175.html

Bhardwaj, S. 2014. Getting to the last mile – diagonal approach and pathways for improving maternal and child health outcomes in South Africa. *Public Health Association of South Africa*. https://www.phasa.org.za/getting-last-mile-diagonal-approach-pathways-improving-maternal-child-health-outcomes-south-africa/

Bradshaw, D., Dorrington, R.E. and Laubscher, R. 2012. *Rapid Mortality Surveillance Report, 2011*. Cape Town: South African Medical Research Council. ISBN: 978-1-920618-00-1. http://www.mrc.ac.za/bod/RapidMortality2011.pdf

Day, C. 2013. *Focus on Maternal Mortality District Health Barometer 2012/13*: Supplement Series 1. Health Systems Trust. http://www.hst.org.za/publications/focus-maternal-mortality-dhb–1213-supplement-series-1

Department of Health, South Africa. (n.d.) Blue Print for Action: Keeping Children Alive and Healthy in South Africa. http://megaslides.com/doc/129973/keeping-mothers-and-children-alive-and-healthy-in-south-a...

Department of Health, South Africa. 2005. Millennium Development Goals 2005 Country Report. Pretoria. http://www.statssa.gov.za/MDG/MDGR_2005.pdf

Department of Health, South Africa. 2006. *The National HIV and syphilis antenatal sero-prevalence survey in South Africa, 2005*. Pretoria. http://www.hst.org.za/sites/default/files/antenatal_2005.pdf

Department of Health, South Africa. 2007. *The National HIV and syphilis antenatal sero-prevalence survey in South Africa, 2006*. Pretoria. http://www.hst.org.za/sites/default/files/antenatal_2006.pdf

Department of Health, South Africa. 2007. *HIV & AIDS and STI Strategic Plan for South Africa 2007–11*. http://www.tac.org.za/documents/NSP-Draft10-2007-2011.pdf

Department of Health, South Africa. 2008. *The National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2007*. Pretoria. http://www.hst.org.za/sites/default/files/antenatal_2007.pdf

Department of Health, South Africa. 2009. *The National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2008*. Pretoria. http://www.hst.org.za/sites/default/files/antenatal_2008.pdf

Department of Health, South Africa. 2010. *The National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2009*. Pretoria. http://www.uj.ac.za/corporateservices/hiv-aids-office/Documents/2009%20HIV%20Antenatal%20Survey.pdf

Department of Health, South Africa. 2010. *Clinical guidelines: PMTCT (prevention of mother-to-child transmission)*. Pretoria. Available from: http://www.sahivsoc.org/FileUpload/NDOH_PMTCT.pdf

Department of Health, South Africa. 2010. *Republic of South Africa Country Progress Report on the Declaration of Commitment on HIV/AIDS, 2010 Final Report, Reporting Period: January 2008 – December 2009*. Available from: http://data.unaids.org/pub/Report/2010/southafrica_2010_country_progress_report_en.pdf

Department of Health, South Africa. 2011. *The HRH Strategy for the Health Sector: Human Resources for Health South Africa: Abridged version of the HRH SA Strategy for the launch of the HRH SA Strategy at University of the Witwatersrand, 11* October 2011. http://www.gov.za/sites/www.gov.za/files/hrh_strategy_0.pdf

Department of Health, South Africa. 2011. *The National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa*, 2010. http://www.hst.org.za/sites/default/files/hiv_aids_survey.pdf

Department of Health, South Africa. 2012. *The National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2011*. Pretoria. https://www.health-e.org.za/wp-content/uploads/2013/05/f0980fb5107a7ce543a8bd5730e52333.pdf

Department of Health, South Africa. 2012. *Saving mothers 2008–2010: Fifth report on confidential enquiries into maternal deaths in South Africa*. Pretoria. Available from: http://sanac.org.za/wp-content/uploads/2015/12/Report_on_Confidential_Enquiries_into_Maternal_Deaths_in_South_Africa.pdf

Department of Health, South Africa. 2012. *Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa, 2012–16*. https://extranet.who.int/nutrition/gina/sites/default/files/ZAF%202012%20MNCWHstratplan.pdf

Department of Health, South Africa. 2013. 2013 *National Antenatal Sentinel HIV Prevalence Survey South Africa*. https://www.health-e.org.za/wp-content/uploads/2016/03/Dept-Health-HIV-High-Res-7102015.pdf

Department of Health, South Africa. 2013. *Joint Review of HIV, TB and PMTCT Programmes in South Africa: Main Report (October).* Under the supervision of the Joint HIV, TB and PMTCT Review Steering Committee. https://www.health-e.org.za/wp-content/uploads/2014/04/who-final-report-of-joint-hiv-tb-pmtct-main-report.pdf

Department of Health, South Africa. 2013. *The South African Antiretroviral Treatment Guidelines 2013: PMTCT Guidelines: Revised March 2013*. http://www.sahivsoc.org/Files/2013%20ART%20Treatment%20Guidelines%20Final%2025%20March%202013%20corrected.pdf

Department of Health, South Africa. 2014. *The National Antenatal Sentinel HIV & Herpes Simplex Type-2 Prevalence Survey in South Africa, 2012*. https://www.health-e.org.za/wp-content/uploads/2014/05/ASHIVHerp_Report2014_22May2014.pdf

Department of Health, South Africa. 2014. *National consolidated guidelines for the prevention of mother-to-child transmission HIV (PMTCT) and the management of HIV in children, adolescents and adults*. Pretoria.

Department of Health, South Africa. 2015. *National consolidated guidelines for the prevention of mother-to-child transmission HIV (PMTCT) and the management of HIV in children, adolescents and adults*. Pretoria. https://aidsfree.usaid.gov/sites/default/files/tx_south-africa_pmtct_2015.pdf

Department of Health, South Africa. 2015. *The National Antenatal Sentinel HIV Prevalence Survey in South Africa, 2013*. Pretoria. https://www.health-e.org.za/wp-content/uploads/2016/03/Dept-Health-HIV-High-Res-7102015.pdf

Department of Health, South Africa and South African National AIDS Council: South African HIV and TB Investment Case – Summary Report Phase 1. March 2016. http://sanac.org.za/wp-content/uploads/2016/03/1603-Summary-Report-LowRes-18-Mar.pdf

Doherty, T., Chopra, M., Nsibande, D. and Mngoma, D. 2009. Improving the coverage of the PMTCT programme through a participatory quality improvement intervention in South Africa, *BMC Public Health* 9: 406 doi: 10.1186/1471-2458-9-406 pmid: 19891775.

Doherty, T., Sanders, D., Goga, A. and Jackson, D. 2011 Implications of the new WHO guidelines on HIV and infant feeding for child survival in South Africa, *Bulletin of the World Health Organization* 89: 62–7. doi: 10.2471/BLT.10.079798

Dorrington, R.E., Bradshaw, D. and Laubscher, R. 2014 *Rapid Mortality Surveillance Report, 2012*. Cape Town: South African Medical Research Council. ISBN: 978-1-920618-19-3. http://www.mrc.ac.za/bod/RapidMortalitySurveillanceReport2012.pdf

Dorrington, R.E., Bradshaw, D., Laubscher, R. and Nannan, N. 2014. *Rapid Mortality Surveillance Report, 2013*. Cape Town: South African Medical Research Council. ISBN: 978-1-920618-33-9.

Dorrington, R.E., Bradshaw, D., Laubscher, R. and Nannan, N. 2015. *Rapid Mortality Surveillance Report, 2014*. Cape Town: South Africa. SA Medical Research Council. ISBN: 978-1-928340-02-7. http://www.mrc.ac.za/bod/RapidMortalitySurveillanceReport2014.pdf

Dwadwa-Henda, N., Mfecane, S., Phalane, T., Kelly, K., Myers, L. and Hayiyiannis, H. 2010. Social Mobilisation and Communication Strategy for the Prevention of Mother-to-Child Transmission of HIV. CADRE/UNICEF: South Africa. Available at: http://www.unicef.org/southafrica/resources_16175.html

Goga, A.E, Dinh, T. and Jackson, D. 2012. *Evaluation of the effectiveness of the national prevention of mother-to-child transmission (PMTCT) programme on infant HIV measured at six weeks postpartum in South Africa. Cape Town: Medical Research Council*. Available from: http://www.doh.gov.za/docs/reports/2012/pmtcteffectiveness.pdf.

Goga, A., Dinh, T.H., Jackson, D., Dlamini, N., Mosala, T. and Lombard, T. et al. 2012. "Impact of the national prevention of mother-to-child transmission of HIV (PMTCT) program on perinatal mother-to-child transmission of HIV (MTCT) measured at six weeks postpartum, South Africa (SA)." *XIX International AIDS Conference*; *22–27 July 2012*, Washington, DC. Available from: http://repository.uwc.ac.za/xmlui/bitstream/handle/10566/462/GogaPMTCT2012.pdf?sequence=3&isAllowed=y

Goga, A.E., Jackson, D.J., Singh, M. and Lombard C. 2015. Early (4–8 weeks post-delivery) population-level effectiveness of WHO PMTCT Option A, South Africa. MRC Policy Brief 2015.

HIV Clinical Guidelines App. Press Release. Available from: https://www.health-e.org.za/2015/06/12/resource-hiv-clinical-guidelines-app/

Human Rights Watch. 2011. "South Africa: Failing Maternity Care: Abuse, Poor Accountability Cause Needless Death and Suffering." http://www.hrw.org/news/2011/08/08/south-africa-failing-maternity-care

Irani, L. and Arnoff, E. 2015. Gender Programmatic Review UNICEF South Africa Country Office.

Johnson, L.F. 2012. "Access to antiretroviral treatment in South Africa, 2004–2011." *South Afr J HIV Med* 13: 22–7.

Joint Programme of Support of the United Nations Joint Team on HIV and TB In South Africa 2013–17. http://www.undp.org/content/dam/south_africa/docs/prodocs/UNJ_%20JPS_final.pdf

Kelly, K., Hajiyiannis, H. and Rau, A. 2009. *Strengthening PMTCT through communication: A review of the literature*. CADRE supported by UNICEF: South Africa. Available at: http://www.unicef.org/southafrica/resources_16175.html

Kerber, K.J., Lawn, J.E., Johnson, L.F., Mahy, M., Dorrington, R.E., Phillips, H., Bradshaw, D., Nannan, N., Msemburi, W., Oestergaard, M.Z., Walker, N.P., Sanders, D. and Jackson, D. 2013. South African child deaths 1990–2011: Have HIV services reversed the trend enough to meet Millennium Development Goal 4? *AIDS*, 27(16): 2637–48. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3815090/

Khumalo, N. and Gerger, J. SANAC and the implementation of the NSP. *AIDS Law Project: 18 Month Review July 2007 – December 2008*.

Mabaso, M.H.L., Ndaba, T., Mkhize-Kwitshana, Z.L. 2014. Overview of Maternal, Neonatal and Child Deaths in South Africa: Challenges, Opportunities, Progress and Future Prospects. *International Journal of MCH and AIDS* 2(2): 182–9.

Mahery, P., Proudlock, P. and Jamieson, L. 2010. *A Guide to the Children's Act for Health Professionals*. 4th edn. University of Cape Town. http://www.ci.org.za/depts/ci/pubs/pdf/resources/general/ca_guide_health%20prof_2010.pdf

Mate, K.S., Bennett, B., Mphatswe, W., Barker, P. and Rollins, N. 2009. Challenges for routine health system data management in a large public programme to prevent mother-to-child HIV transmission in South Africa. PLoS ONE 2009: 4: e5483- doi: 10.1371/journal.pone.0005483 pmid: 19434234.

Mothers2mothers. 2007. Annual Report. https://www.m2m.org/wp-content/uploads/2013/10/Annual_Report_2007.pdf

Mphatswe, W., Mate, K.S., Bennett, B., Ngidi, H., Reddy, J. and Barker, P.M. 2012). Improving public health information: a data quality intervention in KwaZulu-Natal, South Africa. *Bulletin of the World Health Organ*, 90: 176–82 doi: 10.2471/BLT.11.092759 pmid: 22461712.

National Department of Health Breastfeeding Summit. 2011. The Tshwane Declaration of Support for Breastfeeding in South Africa. *South African Journal of Clinical Nutrition* 24(4): 214.

National Department of Health, South Africa. 2008. *Policy and Guidelines for the Implementation of the PMTCT Programme*. Available from: http://www.doh.gov.za/docs/policy/pmtct-f.html

National Department of Health, South Africa. 2008. *Saving Mothers 2005–07: 4th Report on Confidential Enquiries into Maternal Deaths in South Africa*. Pretoria.

National Department of Health, Medical Research Council, 2009. *Best practices in prevention of mother-to-child transmission of HIV, South Africa*. University of the Western Cape, UNICEF, USAID.

National Department of Health, South Africa. 2009. *National Antenatal Sentinel HIV and Syphilis Prevalence Survey, South Africa, 2008*. Available from: http://www.info.gov.za/view/DownloadFileAction?id=109007

National Department of Health, South Africa and SANAC. 2010. *Clinical Guidelines: PMTCT (Prevention of Mother-to-Child Transmission)*. Available from: http://www.fidssa.co.za/images/PMTCT_Guidelines.pdf

National Department of Health, South Africa. 2011. *Saving Mothers 2008–10: Fifth Report on Confidential Enquiries into Maternal Deaths in South Africa*. Pretoria.

National Department of Health, South Africa. 2011. *The National Strategic Plan on HIV, STIs and TB, 2012–16*. Available from: www.info.gov.za/view/DownloadFileAction id155622

National Department of Health, South Africa. 2014. *Saving Mothers 2011–13: Sixth Report on Confidential Enquiries into Maternal Deaths in South Africa*. Pretoria. http://www.kznhealth.gov.za/mcwh/Maternal/Saving-Mothers-2011-2013-Executive-Summary.pdf

National Department of Health, South Africa. National Action Framework for PMTCT. No child born with HIV by 2015 and improving the health and wellbeing of mothers, babies and partners in South Africa, 2012–16. http://www.sanacws.org.za/af/resource-centre/download/4feac9f1ef9ca-version-dec-15th-action-framework-emtct-5-pdf

Ngubane, G. 2010. *National PMTCT Accelerated Plan (A-plan) Status Report*. Pretoria: Department of Health. Available from: http://www.sarrahsouthafrica.org/LinkClick.aspx?fileticket=Qt5CxiOrHFc%3D&tabid=2326

Patrick, M.E. and Stephen, C.R. (eds) 2005. *Saving Children Report 2005: A Survey of Child Healthcare in South Africa*. Compiled by Child PIP Users and the MRC Unit for Maternal and Infant Health Care Strategies http://www.childpip.org.za/documents/report_saving_children_2005.pdf

Pattinson, R.C. (ed.) 2009. *Saving Babies 2006–07: 6th perinatal care survey of South Africa*. Tshepesa Press: Pretoria. http://www.ppip.co.za/wp-content/uploads/Saving-babies-2006-7.pdf

Pattinson., R.C. (ed.) 2011. *Saving babies 2008–09: 7th report on perinatal care in South Africa*. Tshepesa Press: Pretoria. http://www.ppip.co.za/wp-content/uploads/Saving-Babies-2008-9.pdf

Pattinson, R.C. 2013. *Saving Babies 2010–11: 8th report on perinatal care in South Africa*. Tshepesa Press: Pretoria. http://www.ppip.co.za/wp-content/uploads/Saving-Babies-2010-2011.pdf

Pattinson, R.C. and Rhoda, N. 2014. *Saving Babies 2012–13: 9th Report on Perinatal Care in South Africa*. Tshepesa Press: Pretoria. http://www.ppip.co.za/wp-content/uploads/Saving-Babies-2012-2013.pdf

PEPFAR. 2010. *South Africa Country Operational Plan, FY 2010*.
http://www.pepfar.gov/documents/organization/145733.pdf

PEPFAR. 2015. 2015 PEPFAR South Africa Country Operational Plan: Strategic Direction Summary.
http://www.pepfar.gov/documents/organization/250301.pdf

Republic of South Africa. 2012. National Plan of Action for Children in South Africa 2012–17. Pretoria: Department of Women, Children and People with Disabilities. http://www.unicef.org/southafrica/SAF_resources_npac.pdf

RMCH: A model for Community Based Monitoring in the Provision of Quality Maternal and Child Health Services. http://www.soulcity.org.za/projects/re-engineering-primary-health-care/resources/a-model-for-cbm-in-the-provision-of-quality.pdf/view

Rochat, T., Mitchell, C. and Richter, L. 2008. *The Psychological, Social and Development Needs of Babies and Young Children and their Caregivers Living with HIV and AIDS*. Department of Health, HSRC and UNICEF: South Africa. Available at: http://www.unicef.org/southafrica/resources_16175.html

Rollins, N., Mzolo, S., Moodley, T., Esterhuizen, T. and van Rooyen, H. 2009. Universal HIV testing of infants at immunization clinics: an acceptable and feasible approach for early infant diagnosis in high HIV prevalence settings. *AIDS* 23: 1851–7.

SANAC. 2013. Saving Babies. South African National AIDS Council. Available at:
http://sanac.org.za/2013/08/06/saving-babies/

SANAC. 2014. The Republic of South Africa Global AIDS Response Progress Report.

Section 27 and Treatment Action Campaign. 2013. Evaluation: HIV-Positive: Is South Africa Winning? NSP Review. December. Available at: http://section27.org.za/wp-content/uploads/2014/10/NSP-review-9-web.pdf

Sehovic, A.B. 2014. HIV/AIDS and the South African State: Sovereignty and the Responsibility to Respond. Aldershot: Ashgate.

Sherman, G., Lilian, R., Barron, P., Candy, S., Robinson, P. and Bhardwaj, S. 2012. Laboratory information system data is useful for monitoring the prevention of mother-to-child transmission program (PMTCT) in South Africa, *XIX International AIDS Conference*. 22–27 July; Washington, DC. Available from:
http://www.iasociety.org/Abstracts/A200745523.aspx

Sherman, G.G., Lilian, R.R., Bhardwaj, S., Candy, S. and Barron, P. 2014. Laboratory information system data demonstrate successful implementation of the prevention of mother-to-child transmission programme in South Africa, *South African Med Journal* 104 (3 Suppl 1):235–8.

Shisana, O., Rehle, T., Simbayi, L.C., Parker, W., Zuma, K. et al. 2005. *South African national HIV prevalence, HIV incidence, behaviour and communication survey, 2005*. HSRC Press. http://www.hsrc.ac.za/en/research-data/view/2093

Shisana, O., Rehle, T., Simbayi, L.C., Zuma, K., Jooste, S., et al. and the SABSSM III Implementation Team. 2009. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Cape Town: HSRC Press. https://www.health-e.org.za/wp-content/uploads/2013/05/2966e129fc39e07486250fd47fcc266e.pdf

Shisana, O., Rehle, T., Simbayi L.C., Zuma, K. et al. 2014. *South African National HIV Prevalence, Incidence and Behaviour Survey*, 2012. Cape Town: HSRC Press. http://www.hsrc.ac.za/uploads/pageContent/4565/SABSSM%20IV%20LEO%20final.pdf

Simbayi, L, Shisana, O., Rehle, T. et al. 2014. South Africa National HIV Prevalence, Incidence and Behaviour Survey 2012. Human Sciences Research Council.

Simelela, N., Venter, F., Pillay, Y. and Barron, P. 2015. A political and social history of HIV in South Africa. *Current HIV/AIDS Reports*, Springer.

South African National AIDS Council Trust, Annual Report 2013–14.

South African National AIDS Council Trust, Annual Report 2014–15.

South African National AIDS Council. 2013. "Saving Babies." http://sanac.org.za/2013/08/06/saving-babies/

South African National AIDS Council. 2013. "South Africa's New Highly Effective PMTCT Guidelines." http://sanac.org.za/2013/08/14/south-africa-s-new-highly-effective-pmtct-guidelines/

South African National AIDS Council. 2014. *Progress Report on the National Strategic Plan for HIV, TB and STIs 2012–16*. Pretoria: South African National AIDS Council. https://www.health-e.org.za/wp-content/uploads/2014/12/SANAC-NSP-Progress-Report-2014.pdf

Stephen, C.R. 2016. *Saving Children 2012–13: An 8th Survey of Child Healthcare in South Africa*. Pretoria: Tshepesa. Available: http://www.childpip.org.za/images/stories/documents/saving_children_2012-2013.pdf

Stephen, C.R. and Patrick, M.E. eds. 2008. *Saving Children Report 2006: A Survey of Child Healthcare in South Africa*. Pretoria: University of Pretoria, MRC, CDC. http://www.childpip.org.za/documents/report_saving_children_2006.pdf

Stephen, C.R. and Bamford, L.J. (eds) 2013. *Saving Children 2010–11 Report: A 7th Survey of Child Healthcare in South Africa*. Pretoria: Tshepesa, MRC, CDC. Available: http://www.childpip.org.za/images/stories/saving_children_2010-2011.pdf

Stephen C.R., Bamford, L.J. and Patrick, M.E. 2011. *Saving Children 2009: Five years of data. A 6th Survey of Child Healthcare in South Africa*. MRC and CDC.

Stephen, C.R., Bamford, L.J., Patrick, M.E. and Wittenberg, D.F. (eds) 2011. *Saving Children 2009: Five Years of Data. A 6th Survey of Child Healthcare in South Africa*. Pretoria: Tshepesa, MRC, CDC.

Stephen, C.R., Mulaudzi, M.C., Kauchali, S. and Patrick, M.E. (eds) 2009. *Saving Children 2005–07 Report: A 4th Survey of Child Healthcare in South Africa*. Pretoria: University of Pretoria, MRC, CDC. Available: http://www.childpip.org.za/images/stories/documents/Saving_Children_2005_2007.pdf

Stinson, K., Giddy, J., Cox, V., Burton, R., Ibeto, M., Cragg, C., van Cutsem, G., Hilderbrand, K., Boulle, A., Coetzee, D. and Goemaere, E. 2014. Reflections on a Decade of Delivering PMTCT Care in Khayelitsha, South Africa. *South African Journal of HIV Medicine* 15(1).

Tlebere, P., Jackson, D.J., Loveday, M., Matzirofa, L., Mbmbo, N., Doherty, T. et al. 2007. Community-based situational analysis of maternal and neonatal follow-up care in South Africa, *Journal of Midwifery and Women's Health*. 52: 342–50.

UNICEF. 2009. Consultative meeting on evaluating the impact of prevention of mother-to-child transmission of HIV (PMTCT) services in low-and middle-income countries in averting new HIV infections in children and improving child survival. Nashville: Vanderbilt University. Available from: http://www.unicef.org/aids/files/Final_Vanderbilt_Meeting_Report_March30Resized6.pdf

UNICEF. Compact 2016 – Results Matrix – South Africa – final.

UNICEF. Country Programme Document South Africa 2002–06.

UNICEF. Country Programme Document South Africa 2007–10.

UNICEF. Country Programme Document South Africa 2013–17.

UNICEF. 2015. Pursuing equity in practice – a compendium of country case studies on the application of the Monitoring Results for Equity System (MoRES).

UNICEF. SACO Annual Report 2012.

UNICEF. SACO Annual Report 2013.

UNICEF. SACO Annual Report 2015.

UNICEF. SACO Office Structure document 2012.

UNICEF. SACO Office Structure document 2013.

UNICEF. SACO Office Structure document 2014.

UNICEF. *Saving Children, Enhancing Lives: Combatting HIV and AIDS in South Africa, Second Edition, 2006*. http://www.unicef.org/southafrica/SAF_resources_unite2edition.pdf

Woldesenbet, S., Goga, A.E. and Jackson D.J. for the SA EID study group. 2010. The South African Programme to Prevent Mother-to-child Transmission of HIV (PMTCT): Evaluation of Systems for Early Infant Diagnosis in Primary Health Care Facilities in South Africa: Report on Results of a Situational Assessment. South African Medical Research Council. Available from: http://www.nhls.ac.za/assets/files/Situational%20%20assessment%20report%20final_10th%20Oct12.pdf

Yenzingane Network and UNICEF. 2010. Questions and Answers: Infant feeding in the context of HIV in South Africa.

Zaidi, J., Grapsa, E., Tanser, F., Newell, M. and Barnighausen, T. 2013. Dramatic increase in HIV prevalence after scale-up of antiretroviral treatment, AIDS 27(14): 2301–5.

OTHER SOURCES:

http://www.toolshero.com/strategy/ink-model/

http://sanac.org.za//wp-content/uploads/2015/12/SANATweb.pdf

http://sanac.org.za/wp-content/uploads/2016/05/SANATAnnualReport2014_2015_web.pdf

http://sanacws.org.za/wp/wp-content/uploads/2015/06/DOH-Consolidated-guidelines-for-PMTCT.pdf

https://za.usembassy.gov/wp-content/uploads/sites/19/2015/12/DREAMS-SA_FactSheet_Nov-6-1.pdf

Ukraine

AIDS info Online Database. Available at http://aidsinfo.unaids.org (accessed June 2016)

GoU, 2014. UNGASS report, 2014

GoU and UNICEF. 2011. Country Programme Action Plan, 2012–16

Ministry of Health of Ukraine, 2012. Ukraine Harmonized AIDS Response Progress Report: reporting period: January 2010 – December 2011. Kyiv: Ministry of Health.

UNDP. 2014. Millennium Development Goals Ukraine, annual monitoring report 2014

UNICEF. 2007. Prevention of HIV infection in Infants, documenting and learning from the Ukraine Experience, Kiev, 2007

UNICEF. 2012. Ukraine annual management plans 2012

UNICEF. 2013. Ukraine annual management plans 2013

UNICEF. 2013. Ukraine annual management plans 2014

UNICEF. 2015. Ukraine annual management plans 2015

UNICEF. 2005 Country Programme Document 2006–10

UNICEF. 2011 Country Programme Document 2012–16

UNICEF. 2014. Prevention of mother-to-child transmission and improving neonatal outcomes among drug-dependent pregnant women and children born to them in Ukraine, Final Evaluation report

UNICEF. 2014 Humanitarian Situation Report #17, 5 September 2014

UNICEF. 2015. Humanitarian Action for Children Ukraine, Programme Appeal 2015

UNICEF 2015. Historical Overview of Scaling up of UNICEF Emergency Response in Ukraine, 2015

Zimbabwe

Central Statistical Office (CSO) [Zimbabwe] and Macro International Inc. 2007. Zimbabwe Demographic and Health Survey 2005–06. Calverton, Maryland: CSO and Macro International Inc.

Chigumira G., Matsika W., Nyamadzawo J. and Chiwunze G. 2014. Review of financing of semi-autonomous health institutions in Zimbabwe, ZEPARU for TARSc and MoHCC in the Rebuild programme, Harare.

Committee on the Rights of the Child. Consideration of reports submitted by States parties under article 44 of the Convention – Second periodic reports of States parties due in 2002, Zimbabwe.

Government of Zimbabwe. 2013. Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimASSET): Towards an Empowered Society and a Growing Economy. October 2013–December 2018.

Government of Zimbabwe. 2015. Global AIDS Response Progress Report 2015 – Follow-up to the 2011 Political Declaration on HIV/AIDS. Zimbabwe Country Report January–December 2014.

Ittig, A. 2014. Independent Evaluation of the 2012–15 Zimbabwe United Nations Development Assistance Framework.

MoHCC. 2011. Report of the Review of the National PMTCT and Paediatric HIV Programme 2006–10. National AIDS and Tuberculosis Unit, Ministry of Health and Child Care.

MoHCC. 2013. An Operational Plan for the Nationwide Transition to Option B+ in Zimbabwe.

MoHCC. 2014. Report of Interim Review of the Option B+ Implementation Plan in Zimbabwe.

MoHCC. 2015. Zimbabwe National and Subnational HIV/AIDS Estimates 2014.

MoHCW. 2012. The draft National OI/ART Programme Annual Report.

MoHCW. 2012. A Call to Action for Sustainable Solutions: Looking at funding options to achieve and sustain universal access to antiretroviral therapy.

Ministry of Health and Child Health. 2014. The National Strategic Plan for Eliminating New HIV Infections in Children and Keeping Mothers and Families Alive 2014–18.

National AIDS Council & UNAIDS. 2015. 'Information note: Funding AIDS in Zimbabwe'.

National AIDS Council. 2005. Annual Report 2005.

National AIDS Council. 2006. Annual Report 2006.

National AIDS Council. 2007. Annual Report 2007.

National AIDS Council. 2008. Annual Report 2008.

National AIDS Council. 2009. Annual Report 2009.

National AIDS Council. 2010. Annual Report 2010.

National AIDS Council. 2011. Annual Report 2011.

National AIDS Council. 2011. Strategic Plan 2011–15.

National AIDS Council. 2012. Annual Report 2012.

National AIDS Council. 2013. Annual Report 2013.

National AIDS Council. 2014. Annual Report 2014.

National AIDS Council. 2015. Annual Report 2015.

UNICEF Zimbabwe. 2010. Country Programme Management Plan 2007–11, Final May 2010.

UNICEF Zimbabwe. 2012. Monitoring of Results for Equity System MoRES – L3 Monitoring Framework.

UNICEF Zimbabwe. 2013. Annual Report 2013, Zimbabwe.

UNICEF Zimbabwe. 2014. Annual review of 2014 work plan implementation.

UNICEF Zimbabwe. 2014. Annual Report 2014, Zimbabwe.

UNICEF Zimbabwe. 2014. Gender Review Report.

UNICEF Zimbabwe. Country Programme Document 2007–11.

UNICEF Zimbabwe. Country Programme Document 2012–15.

UNICEF Zimbabwe. Country Programme Document 2016–20.

UNICEF Zimbabwe. n.d. Position Authorisation tables – 2005–16.

UNICEF Zimbabwe. n.d. A Situation Analysis on the Status of Women's and Children's Rights in Zimbabwe 2005–10: A call for Reducing Disparities and Improving Equity; UNICEF Zimbabwe. 2015. Update of the Situation Analysis of Children and Women in Zimbabwe.

USAID. 2006. Management of HIV/AIDS Commodities: NatPharm & MoHCW Capacity Assessment.

USAID. 2011. Cost analysis of the Zimbabwe e-MTCT Strategic Plan, 2011–2015.

WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division Estimates. 2014. Trends in Maternal Mortality: 1990 to 2013.

Zimbabwe National Institute of Statistics. 2003. Poverty Assessment Study Survey.

Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International. 2012. Zimbabwe Demographic and Health Survey 2010–11. Calverton, Maryland: ZIMSTAT and ICF International Inc.

ZIMSTAT. 2010. Multiple Indicator Monitoring Survey MIMS 2009. August 2010.

ZIMSTAT. 2012. Zimbabwe Population Census 2012.

ZIMSTAT. 2012. 2011 Labour Force Survey Report.

ZIMSTAT. 2014. Quarterly Digest of Statistics 3rd Quarter 2014.

ZIMSTAT. 2015. Zimbabwe Multiple Indicator Cluster Survey 2014, Final Report. Harare, Zimbabwe.

http://www.unicef.org/zimbabwe/media_17101.html

http://www.voazimbabwe.com/a/zimbabwe-health-fund/3182000.html

To download the full report, visit:
https://www.unicef.org/evaldatabase/index_95015.html

For further information, please contact:

Evaluation Office
United Nations Children's Fund
Three United Nations Plaza
New York, New York 10017
evalhelp@unicef.org

unicef | for every child