

ESSENTIALS

UNDP PRACTICE AREA: HIV/AIDS
SYNTHESIS OF LESSONS LEARNED

EVALUATION OFFICE
No. 6 JUNE 2002

A Multifaceted Response to the HIV/AIDS Pandemic

Background

***"The HIV/AIDS epidemic is the world's most serious development crisis as well as the most devastating epidemic in history. It is quickly becoming the biggest obstacle to achieving the Millennium Development Goals."*¹**

HIV/AIDS is one of UNDP's primary practice areas, and in light of the magnitude of the pandemic, "it [has become] everybody's business."² Worldwide 40 million people are infected with the HIV virus, and of these, 90% are living in the developing world. Around 12 to 13 women become newly infected with HIV for every 10 men. Twenty-five million people have already died of AIDS leaving behind 13 million orphans — a figure expected to reach 40 million by 2010.

When world leaders assembled at the United Nations in June 2001, they expressed their "[deep concern] that the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society — national, community, family and individual."³

The United Nations General Assembly Special Session on HIV/AIDS issued a Declaration of Commitment in June of 2001, a first of its kind,

mapping out a strategy and measurable goals to reverse the epidemic. It also includes targets for a number of key areas (e.g. By 2005 reduce the proportion of infants infected with HIV by 20%, and by 50% by 2010), calls for resources commensurate with the challenge, and articulates follow-up at national, regional, and global levels.

What has been learned so far? And what should be done next? This *ESSENTIALS*, which synthesizes lessons learned from innovative approaches on capacity building and assessment to mitigate the impact of HIV/AIDS in UNDP projects and those of key partner organisations, should encourage further reflection on the implications of past practice to guide future programming.

Concept: What is a multifaceted response?

HIV/AIDS poses a complex multi-dimensional challenge that can only be addressed with a multifaceted response. National resources should be allocated towards HIV/AIDS priorities while institutions and actors well beyond the health sector should be mobilised. A response should not only focus on the obvious need for advances in technical inputs, like vaccines or treatment to help control the epidemic, but also deal with the developmental dimensions of the pandemic through prevention, care and treatment, and impact mitigation priorities.

The social and economic impact of HIV/AIDS is already significant in many high prevalence countries, and includes falls in life expectancy, a loss of skilled labour, weaker agricultural sectors, and the sickness and death of family income earners who in turn leave behind countless orphans, thus contributing to reduced living standards (See Box 1). These consequences need to be considered in the strategies to fight the epidemic.

Box 1 — Some Effects of HIV/AIDS

In Gaborone (Botswana) a lawyer complains that he is no longer able to get redress for his clients through the courts because the legal system has been crippled by the absence of court officials. These officials are missing because they are either caring for a sick relative or because they have fallen ill themselves.

In the Kagera Region of Tanzania, due to labour losses to households, the production of coffee beans has measurably declined. This has had a negative effect not only on the export of coffee but also on farm incomes. The latter has in turn worsened child nutrition, affected school attendance (of girls in particular), and increased poverty, ultimately making both the food and non-food production no longer sustainable.

According to a UNAIDS estimate as many as 3,000 UN staff and their dependents worldwide are living with HIV.

What to do?

National governments and partners need to coordinate their work with all stakeholders to develop and promote activities essential to stopping the spread of the epidemic. National plans should include both an advocacy component to review and refine policy and promote society-wide mobilisation, and a capacity development component to ensure national ownership — by not just the government, but also NGOs and private sector stakeholders — of the strategies being implemented.

Effective responses to date have mostly included the following elements:

- Early and coordinated action at national level (See Box 2);
- Political will, vision and leadership;
- A large-scale strategic response;
- Advocacy activities to encourage total mobilisation of government and civil society;
- A decentralized and scaled-up response;
- Capacity development in planning, management and implementation; and
- Earmarking of adequate domestic resources.

Examples:

In Uganda — where the political leadership was quick to recognise HIV/AIDS as a problem and that action against the epidemic needed to be taken at the national level — the HIV prevalence rates have in some cases nearly halved. The same realisation in Senegal led to a 68% rise in condom use among men having casual sex.

In Uganda, due to the early recognition of the epidemic as a national problem:

- ◆ *In 1986, the President himself publicly acknowledged the country's HIV/AIDS problem making a commitment to mobilize efforts against it. Right away a national budget was established solely to combat AIDS;*
- ◆ *The Uganda AIDS Commission was set up within the President's office. In addition, in several other Ministries, HIV/AIDS control programmes were set up;*
- ◆ *Political, religious and community leaders were all involved;*
- ◆ *Condom social marketing services were implemented countrywide; and*

Lessons Learned

1. Leadership and social mobilisation

Experience shows us that effective responses are characterized by political commitment of community — this includes community leaders, women's and youth groups — and regional leadership including a country's highest political echelons. Therefore, government, civil society organisations and development agencies have a major responsibility in preventing the further spread of HIV and in mitigating the impact of AIDS. Together, they can set priorities, define their respective roles and develop strategic plans to support efforts to integrate a multifaceted approach into programmes, policies and strategies. In particular, national governments can best influence social norms and promulgate legislation that affects the rights of those affected by and infected with HIV/AIDS.

- ◆ *HIV voluntary counselling and testing was made available extensively outside the formal health-care service.*

In Senegal, early recognition led to:

- ◆ *The political establishment rapidly responding against the epidemic;*
- ◆ *An unprecedented mobilization on the part of religious leaders of different faiths;*
- ◆ *Inclusion of HIV prevention in school curriculum on sex education;*
- ◆ *Availability of HIV voluntary and confidential counselling and testing; and*
- ◆ *Programmes to assist sex workers in persuading their clients to use condoms.*

Box 2 — Early Action in Bangladesh

In Bangladesh, where HIV prevalence rates are still low, over the past four years the Government has been developing its HIV surveillance capacity to improve the response to the epidemic and monitor trends.

A three-phased DFID funded programme is being implemented in collaboration with two national institutes in accordance with WHO-UNAIDS standards. The two institutes are building their capacity to establish and monitor the prevalence of HIV and syphilis among selected high-risk groups. Eventually, they will be solely responsible for national surveillance of the epidemic.

Information collected is used in the process of developing the National AIDS Programme. In fact, the Government's policy on HIV/STD's reflects the surveillance findings to date. The National HIV/AIDS strategy has been revised and a draft Strategic Implementation Plan (SIP) was prepared in September 2000. The strategy is consistent with the findings of the sero-surveillance that HIV is still at a very low prevalence among the high-risk groups. These groups remain the priority for targeting preventive interventions under the SIP. Thus, early and coordinated action can effectively build the capacity of national governments to monitor and mitigate the spread of the epidemic.

2. Mainstreaming into development planning

"It is essential that the response to HIV/AIDS becomes part and parcel of poverty reduction strategies. Viewing the response as an isolated, narrowly defined public health programme,

separate from the mainstream of development efforts, will guarantee that it continues to be under-funded, fragmented and inadequate."⁴

The rapid spread of HIV/AIDS has stopped and in some cases reversed the human development achievements of the past decades. The epidemic is undermining development efforts made in such wide-ranging areas as life expectancy, education, income, gender equality, social cohesion, and governance.

Governments, to respond to the magnitude and pace at which the epidemic is progressing, particularly among the poorest sections of society, are now faced with integrating HIV priorities into the mainstream of macroeconomic policy frameworks, development plans and poverty reduction strategies.

Responses should address the socio-economic factors that make people vulnerable to HIV and to mitigate the impact of AIDS on poor households. Poverty reduction policies and programmes can prevent people from adopting risky survival strategies and mitigate the social and financial impact of HIV/AIDS.

What to do?

Poverty alleviation ought to be at the centre of the development agenda not only in countries that are devastated by HIV/AIDS, but also those countries where the HIV prevalence rates are still low, because in many of the latter countries, situated in Asia, Eastern Europe and CIS, HIV is spreading the fastest.

Governments and development organisations should integrate HIV/AIDS into the core of development planning through the following four mechanisms:

1. National development plans and budgets;
2. Poverty reduction strategies;
3. Sector plans and budgets; and
4. National development networks and lobbies.

These mechanisms should also be established to ensure that the activities of governments, donors, and other development and civil society agencies are mutually supportive of the national response.

Example:

In Burkina Faso, where the first cases of HIV/AIDS were recognised in 1987, one in ten adults are now living with HIV. Until 2000 the Government's response to the epidemic was fragmented, lacking in political commitment to prioritise it in development plans.

However, the national response has since moved from ad-hoc activities to a fully integrated, multi-sectoral national plan. The Government has now integrated HIV/AIDS into the Poverty Reduction Strategy to put it in the mainstream of development planning. UNDP has helped Burkina Faso through this process by creating an enabling policy and resource environment for a scaled-up response. "The resulting concerted policy dialogue between different donors and the government has led to the creation of an institutional mechanism for coordinating responses to HIV/AIDS. Because this mechanism is situated at the level of the Presidency, rather than a line ministry, it has unique clout and political weight."⁵

3. Integrating human rights

The promotion and protection of human rights reduces vulnerability and enables communities and individuals to respond to the epidemic.

Women, poor people and marginalized groups are generally more vulnerable to infection, less able to protect themselves or cope with illness. Stigmatisation and discrimination against people living with HIV/AIDS have a critical impact, not only on their self-esteem but also on their physical well-being and personal safety. The stigma associated with being HIV positive prevents many people from coming forward for assistance or information. Stigmatisation and discrimination on the workplace is another critical human rights issue associated with HIV/AIDS.

What to do?

The integration of HIV/AIDS in human rights can be fostered by:

- Promoting the role and capacity of civil society and organisations (including youth and women's groups) that protect and promote human rights;

- Ensuring equitable access to accurate information (particularly for women and youth) about HIV/AIDS, STDs, and male and female condoms;
- Protecting the rights of vulnerable groups such as women and girls, sex workers, men who have sex with men, and injecting drug users;
- Assuring that HIV/AIDS issues, including testing and counselling, are treated in a sensitive, confidential manner; and
- Promoting legal reforms and formulation of anti-discrimination legislation to protect the rights of people living with HIV and AIDS.

Example:

"The appropriate tools to fight discrimination and work for more egalitarian conditions are the very same that would help us to reduce societal vulnerability to HIV/AIDS and create a better world for us all"⁶ says Rita Arauz, the founder of Nimehuatzin Foundation a Nicaraguan NGO established in 1990.

A partnership initiated in 1996 between UNDP and the Foundation established national and regional networks on ethics, human rights, and HIV/AIDS. The Foundation works, among other things, to educate policy-makers about HIV/AIDS so that legislation will address implications of the epidemic. As a result of such efforts with the Nicaraguan National Assembly, the most comprehensive HIV and human rights legislation in Latin America was passed. The legislative research and work carried out by the Nimehuatzin Foundation has been recognized as a model by UNDP.

Example:

In Brazil, where access to health care is a human rights issue, the Ministry of Health started implementing a policy of universal free of charge access to antiretroviral (ARV) therapy in 1996. At the same time, the Government also established national treatment guidelines, a National Network of Viral Load Laboratories and 424 ARV dispensary units. These measures are on one hand supported by national legislation that guarantees access to medication for all affected Brazilians who are covered by the social security system, and on the other hand supported by Brazilian intellectual property law of 1996 requiring patent holders to manufacture the product in Brazil. This program has yielded noteworthy results. "There has been a 60-80% reduction in AIDS related opportunistic

infections, a four-fold reduction in hospitalisation rates and 234,000 avoided AIDS related hospital admissions, leading to an overall savings to the Government of more than US\$670 million from 1997-2000."

*"On average, the prices of drugs produced locally fell by 72.5% between 1996-2000 while the prices of imported drugs fell by only 9.6% in the same period. Local production saved the Brazilian Government approximately US\$490 million between 1996-2000 in procurement costs alone."*⁷

4. Information, Education and Communication (IEC) for behavioural change

The foundation of HIV prevention requires a high level of public awareness to bring about behavioural change. Yet all too often HIV/AIDS education is addressed as a health issue only, ignoring the larger social dimensions of the epidemic. HIV/AIDS education should be accurately targeted using innovative IEC approaches and try to overcome traditional didactic methods for conveying relevant information. IEC can be an important tool to help young people acquire the information and practical skills they need to negotiate a safer path through life in the HIV/AIDS era (see Lesson 7).

What to do?

Successful programmes take into account most or all of the following components:

- Messages and activities are culturally, socially, contextually appropriate, gender-sensitive, and youth-friendly;
- The needs and concerns of the target group are identified and the most effective means of communication are also tailored to the target group;
- Provision of high quality IEC training of educators at all levels;
- For any target group, ownership of and identification with the message and the means of dissemination help to create change;
- Realistic options for behavioural change are provided;

- No generic materials and techniques are used, instead case specific materials and techniques are designed or adapted;
- Communities and groups are trained in the identification, design and utilisation of their own IEC; and
- IEC include careful piloting, subsequent monitoring, evaluation, analysis and follow-up.

Example:

World Vision Australia found that Burmese language IEC was not always suitable for Burmese speaking people. Although many ethnic minorities spoke the language, they were unable to read it. So all written materials were re-written in the minority languages.

Video IECs turned out to be the most popular and efficient method to reach hard to access segments of the population. Women went to video houses up to twice a week. Locally produced videos, generally featuring local villagers, were very well received.

Example:

*In Kenya, UNFPA spent three quarters of a million dollars on a project to reach 100,000 Kenyan Scouts, at a cost of \$7 per Scout reached. In comparison, it was subsequently estimated by UNFPA that a radio programme would have been equally effective at a fractional cost of a cent per person to reach the same number of youths. Mass media, radio in this instance, could have set the stage for interactions and conveying relevant information among the Scouts.*⁸

5. Getting communities involved in prevention and care

The leading role of local communities in creating a supportive environment and implementing behaviour change interventions is a crucial element of success. Their involvement increases ownership and sustainability of programs, and mobilizes community resources.

What to do?

Community ownership offers the most effective approach to HIV/AIDS prevention and care. Community action has been the thrust for many innovative and successful responses to

HIV/AIDS be it in the United States, Malawi or Thailand. The often-untapped community capacity to take forward HIV/AIDS prevention and care is pertinent given the lack of resources available to governments and development organisations to reach people.

Community mobilisation and capacity building in prevention, care, and empowerment of high-risk groups are key components of many successful projects. Community mobilisation processes help initiate appropriate and innovative responses to the epidemic; they extend the reach of the responses by facilitating interaction with vulnerable and marginal populations.

Example:

A major focus of a Save the Children/US project in Malawi, has been the formation and mobilisation of Village AIDS Committees (VACs), which encourage their communities to increase public awareness about HIV/AIDS and respond to its devastating effects on children and families. A recent evaluation established that the project has generated significantly increased social capital. Examples include: VACs mobilizing funds through their own means; VACs actively pursuing the participation of the entire community; neighbouring communities spontaneously forming VACs; and youth groups playing critical roles and receiving recognition for their contributions.

Home based care has proven to be one of the most effective entry points to develop the capacity of communities to prevent and control AIDS, by supporting individual and collective sexual behaviour change. The key factor in the success of these programmes is that they provide realistic options for behavioural change. These options are provided and supported by a credible source and there is community and peer group support for the behaviour change. Good community and home base care, however, requires effective support from local primary health care services.

Example:

In Phnom Penh, Cambodia, Home Care Teams were formed with one or two alternating nurses from the government health centres and three staff from the community-focused NGOs. Strong links were established between these Teams and community resources such as local community leaders, traditional healers and the

members of Buddhist temples. The main role of the Teams has been to teach families the management of the treatment of symptoms and to give emotional support.

Findings of a recent UNAIDS evaluation revealed that the "programme was having a significant impact on the quality of life among families affected by HIV/AIDS, that coverage was good, and that costs were competitive. Some 92% of patients and families felt that without the Home Care Teams their lives would be significantly more difficult, and 33% felt that they had been instrumental in reducing community discrimination."⁹

AIDS orphans, who are economically dependent and vulnerable to high-risk behaviour, are on the increase. Some of the many challenges faced by orphans are increased malnutrition, lack of schooling, early entry into paid or unpaid labour, loss of inheritance through "property-grabbing," homelessness, early marriage, exposure to abuse, and increased risk of HIV/AIDS. The well being of all children affected by AIDS depends in great part on the capacity of the community to support and raise them. The emotional needs of the child are met much more fully within a family setting. The most appropriate activity will often be to support those members of the extended family or of the community who are caring for the child who is, or eventually will be orphaned.

Example:

An impact evaluation study of two programmes for AIDS-affected children and their families implemented by PLAN International in Uganda found that it is essential to reach children affected by AIDS before their parents died. One way to reach children early was to link programmes for children affected by AIDS with care and support programmes for people living with HIV/AIDS. This link also strengthens the responsiveness of care and support programmes by addressing a top concern of people living with HIV/AIDS: the future well being of their children.

6. Alleviating the burden on women and girls

Women and girls are more vulnerable to HIV/AIDS for biological, epidemiological, and

social reasons. "Young women are at risk because they are usually less educated, are economically less well off and many cultures permit them few rights [nor] empower them to negotiate sexual relations on an equal basis."¹⁰

Girls are at great risk because of cultural practices and traditions, including low value of girls, limited educational opportunities, early and forced marriage, sexual abuse, Female Genital Cutting (FGC), and because they are often initiated into sex at younger and younger ages by men who believe in the myth that virgins are safer partners. In the 15-24 age group, girls are as much as eight times more likely than boys of the same age to be infected.

Furthermore, women and girls have become the primary caregivers for family members infected with HIV. Young girls are being taken out of school to care for orphans or siblings when one or both parents have died of AIDS.

What to do?

Men and women have different needs in relation to HIV/AIDS prevention and care. Since gender inequalities not only render women and girls more vulnerable to HIV/AIDS but also help fuel the epidemic, there is a need for strategies that address the basic inequities underlying women's vulnerability to HIV/AIDS. Gender equality in programming can be integrated by:

- Emphasizing the role of women and women's organizations and networks in HIV/AIDS policy development, programming, and implementation at all levels of government;
- Assuring that gender issues (including the perspectives of men, women, girls, and boys) are built into programme design, implementation, monitoring, and evaluation;
- Ensuring women's and girls' access to and control over programme benefits;
- Considering the impact of all HIV/AIDS programming on gender relations;
- Expanding women's options for employment through vocational training and small-industry development;
- Respecting human rights, and especially sexual and reproductive rights, in HIV/AIDS programming; and
- Monitoring and evaluation of outcomes of gender policies on the target group.

Example:

In a project funded by CIDA, the Southern African AIDS Training Program supports a number of local women's groups, peer education programs for commercial sex workers, and provides credit to participants to begin new businesses. It was found that participating women decreased their dependency on men to survive economically that increased their ability to negotiate safe sex.

Example:

The International Center for Research on Women conducted a study of ten different projects, which incorporated a gender perspective in their design and implementation. These projects — taking place in eight countries ranging from Mexico to Sri Lanka — explored the use of male-only, female-only, and mixed-sex discussion groups in cultures where discussion of sexual issues, even among same-sex peers, is generally taboo.

The study found that in most cases the opportunity to first gain information and experience in discussing sexual issues with same-sex peers was critical to the success of the mixed-sex discussion sessions. The study further found that mixed-sex groups encourage debate and sharing of ideas and allow participants to learn from and take the perspective of the other sex. Prior familiarity among the group members was critical for the successful functioning of the mixed-sex groups. By the end of most programmes, both peer educators and participants engaged freely in discussion in the mixed-sex groups.

7. Engaging youth

Adolescents and youth who are the fastest rising groups acquiring HIV/AIDS, are powerful communicators within their peer group. Making relevant information and services available to them is increasingly important in arresting the spread of HIV.

Young people are in the early stages of developing attitudes, communication patterns, and behaviour related to sex and relationships. This provides an opportunity to influence the behaviour of young people who are sexually active from the start of their sexual lives, thereby potentially slowing the course of the epidemic.

What to do?

Effective programmes that promote prevention among adolescents and youth include some or all of the following components:

- HIV/AIDS prevention is linked to education projects and programmes, including community education about HIV/AIDS and the health risks of commercial sex work;
- Use of youth-focused networks for support, learning and solidarity-building, including peer counselling components;
- Media collaboration;
- Meaningful participation of youth in the design, implementation, monitoring, and evaluation of programmes;
- Adolescent boys, as well as adult women and men, are involved in interventions designed to safeguard young women's sexual and reproductive health; and
- Comprehensive sex education and access to reproductive health services, especially dual protection, which is essential for girls to avoid unwanted pregnancy and STDs/HIV.

Example:

In a UNFPA funded project, Jamaican youth were reached through a radio soap opera in the first phase, followed by interventions by peer educators in the second. The project aimed to debunk myths, highlight the vulnerability of youth to HIV and the danger of casual sexual contact, promote condom use and abstinence and promote a telephone help line.

The radio social drama reportedly solicited an exceptional number of inquiries. Condoms were promoted in the soap opera and in the companion comic book, and peer educators were taught to encourage condom negotiating skills of female youth.

Example:

A project implemented by UNICEF and various other partners in the Mekong Region (Cambodia, China, Lao PDR, Myanmar, Thailand, and Viet Nam) focused, among other things, on developing the life skills of youth between the ages of 10 and 18.

A review of the project reported that in Thailand, where camps for young people affected by HIV/AIDS were organized, participating youth described their behaviour as changing from anti-social to social. In Lao, young people said they

feel able to acknowledge and speak publicly about engaging in risk behaviour, which was not the case before. Furthermore, they also said that they now understood that they have options with regard to sexual behaviour, one of which is the use of condoms. In Myanmar, youth that had participated in life skills training sessions reported that they believed they had become more thoughtful, careful and considerate and had reduced their risk behaviour. In one town participants stated that visits to commercial sex workers had dropped by 50% after training.

8. Special focus on vulnerable groups

A number of additional vulnerable groups — refugees, migrant populations, men who have sex with men, injecting drug users, and commercial sex workers — can be overlooked in HIV/AIDS prevention strategies. These groups are closely associated with high-risk behaviour for HIV transmission, and each requires distinct prevention strategies, taking into account their specific social and political circumstances. Working with national agencies and networks is a prerequisite to reach these vulnerable groups.

What to do?

While no single response can address the very diverse needs of all these groups, some common threads exist.

- Strategies should be based on the social and political context of these groups to create an enabling environment for addressing their issues.
- They must have access to high-quality condoms and other vital resources.
- There needs to be a strong outreach component — with support from national agencies and networks — to promote safer behaviour as some of these groups are not likely to seek out information and services.
- Health officials, doctors and others involved in the planning and delivery of health services to some of these people need to be educated to overcome ignorance and prejudice against them.
- Interventions ought to build on peer education and mutual support groups, as they are an effective form of communication amongst the members of a same group.

Example:

As the result of a 1995 study on men involved in prostitution in Morocco, ALCS (Association de Lutte contre le SIDA Maroc) developed an outreach programme. It focused on peer education where men from or close to the prostitution scene were recruited to communicate the prevention message to the target group. The intervention reached the most marginalised segments of the population through an ongoing presence in the places where men met, and by making use of personal contacts and refraining from all moral judgement concerning the men's conduct i.e. listening and respecting differences.

Example:

A programme encouraging abstinence for drug users in Churachandpur in North East India through health, religious, legal reform institutions and the police never reached more than half the town's drug users. When a community outreach project started to distribute bleach, as a free promotional item, participation shot up to 80% in six months.

¹ UNDP Corporate Strategy on HIV/AIDS. 2001.

² Zéphirin Diabre (Associate Administrator of UNDP) at a World AIDS Day presentation for UNDP staff on November 30, 2001.

³ UNGASS A/RES/S-26/2. 2001.

⁴ UNDP. Placing HIV/AIDS at the Centre of the Human Development Agenda. Implications for National Development Plans and Budgets, Poverty Reduction Strategies, and Sector Plans. 2001.

⁵ UNDP. UNDP's Partnership with Burkina Faso in the Fight Against HIV/AIDS. 2001.

⁶ UNDP Honours Nicaraguan Psychologist for Her Crusade Against HIV/AIDS. 2000.

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⁷ UNDP. TRIPS, HIV/AIDS and Access to Drugs. 2001.

⁸ UNFPA Evaluation Report Number 16. 1999.

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UNICEF. Children Orphaned by AIDS: Front-line responses from eastern and southern Africa. New York, NY: UNICEF. 1999. <http://www.unicef.org/pubsgen/aids/index.html>

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The World Bank. Confronting AIDS: Public Priorities in a Global Epidemic. Washington, DC: The World Bank. 1999.

Contact Institutions

United Nations

FAO — Food and Agriculture Organization.

E-mail: FAO-HQ@fao.org <http://www.fao.org/Focus/E/aids/aids1-e.htm>

UNAIDS — Joint United Nations Programme on HIV/AIDS.

E-mail: unaids@unaids.org <http://www.unaids.org>

UNDCP — United Nations Office of Drug Control and Crime Prevention.
E-mail: odccp@odccp.org http://www.undcp.org/drug_demand_hiv_aids.html

UNDP — United Nations Development Fund.
<http://www.undp.org/hiv/>

UNESCO — United Nations Educational, Scientific and Cultural Organization
<http://www.unesco.org>

UNFPA — United Nations Population Fund.
<http://www.unfpa.org/aids/index.htm>

UNICEF — United Nations Children's Fund.
<http://www.unicef.org/programme/hiv/mainmenu.htm>

UNIFEM — United Nations Development Fund for Women (a fund administered by UNDP)
E-mail: unifem@undp.org http://www.undp.org/unifem/hiv_aids/

The World Bank Group
<http://www.worldbank.org>

WHO — World Health Organization
E-mail: info@who.int <http://www.who.org>

Other Resources

ActionAid
E-mail: mail@actionaid.org.uk <http://www.actionaid.org>

The Body — AIDS and HIV Information Resource
<http://www.thebody.com>

Harvard AIDS Institute
E-mail: HAI@hsph.harvard.edu <http://www.hsph.harvard.edu/organizations/hai/>

International HIV/AIDS Alliance
E-mail: mail@aidsalliance.org <http://www.aidsalliance.org>

Managing Desire — Information about safe sex, testing and counselling, etc.
<http://www.managingdesire.org>

Monitoring the AIDS Pandemic (MAP) Network
<http://www.census.gov/ipc/www/hivmn.html>

The Synergy Project. Adding Value to International HIV/AIDS Prevention and Care.
E-mail: synergy@tvassociates.com <http://www.SynergyAIDS.com>

USAID Center for Development Information and Evaluation (CDIE)
USAID Development Experience Clearinghouse (DEC)
E-mail: docorder@dec.cdie.org http://www.dec.org/health_pop.cfm#4

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