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UNDP SUPPORT FOR THE GLOBAL PROGRAMME

ON AIDS: THE COUNTRY PERSPECTIVE - An

**Assessment of the Role of the United Nations
Coordinator/UNDP Resident Representative**

**A REPORT COMMISSIONED BY
THE CENTRAL EVALUATION OFFICE (CEO), UNDP**

Prepared by

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**Assessment team members:
Reginald AMONOO-LARTSON, M.D., M.P.H.
Marc Daniel GUTEKUNST, PhD.
Aminata Fall MBACKE, D.S.P.**

September 1993

CEO Evaluation Studies No. 2/93

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**"The views expressed herein are those of the author(s)
and do not necessarily reflect the views of
the United Nations or of the United Nations Development Programmes."**

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This report reflects the views of Drs. Reginald Amonoo-Lartson, Marc Daniel Gutekunst, Aminata Fall-Mbacke, who had difficult assignments in their field visits. Owing to the limitations of time and the logistics of location, it was not possible for them to review the draft report. Thus, the analyses and conclusions are my responsibility.

W. Haven North

January 1993

20

CONTENTS

	Page
PREFACE.....	i
RECENT STATEMENTS ON THE HIV/AIDS PANDEMIC.....	iii
SUMMARY OF MAIN POINTS.....	v
I. INTRODUCTION.....	1
II. FACTORS SHAPING RESPONSES TO THE HIV/AIDS PROBLEM IN DEVELOPMENT.....	3
III. THE UNITED NATIONS RESIDENT COORDINATOR AND HIV/AIDS PROGRAMMES	14
IV. THE UNDP RESIDENT REPRESENTATIVES AND MULTI- MINISTRY, MULTI-SECTOR APPROACHES.....	20
V. UNDP HIV/AIDS PROGRAMME INITIATIVES	35
VI. ASSESSMENT OVERVIEW	39
VII. ALTERNATIVE SCENARIOS FOR UNITED NATIONS RESIDENT COORDINATORS/ UNDP RESIDENT REPRESENTATIVES IN HIV/AIDS PROGRAMMES	52

Annexes

I. Terms of reference	58
II. Summary of main reports and guidance	63
III. Bibliography.....	68

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UNDP SUPPORT FOR THE GLOBAL PROGRAMME ON AIDS: THE COUNTRY PERSPECTIVE

PREFACE

This present report responds to the request of the Governing Council of the United Nations Development Programme (UNDP) for an assessment of UNDP's activities to combat human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). The terms of reference for the study stressed that the assessment be forward looking. This perspective will help UNDP and others build on experience with the development and implementation of HIV/AIDS strategies in the developing countries. However, to do so, it is necessary to review the present situation to the extent time and reports permit.

In preparation for this report, the four team members reviewed UNDP and World Health Organization (WHO) reports, studies, and policy statements and met with senior staff in UNDP headquarters and WHO staff based in Geneva, Brazzaville, New Dehli, Manila, and Alexandria (Egypt). We visited 11 countries where the HIV/AIDS problem was considerably advanced and those where it is just being, or hardly, recognized. These visits provided an opportunity to meet with government officials, UNDP resident representatives and their staffs, WHO representatives and staffs and representatives of other United Nations agencies and bilateral donors. The countries visited included: Brazil, Congo, Cote d'Ivoire, Honduras, India, Pakistan, Rwanda, Thailand, Uganda and Zambia. In addition, we met with officials in several donor capitals. Sixty-one resident representatives responded to the questionnaire sent out by the Central Evaluation Office of UNDP.

The report provides our observations, assessments and possible scenarios for the future. It lays out the main factors that bear on the coordination of HIV/AIDS programmes and the encouragement of multi-sectoral and multi-ministry approaches. The role of the United Nations resident coordinator within the United Nations system of agencies is examined as it relates to the HIV/AIDS activities of United Nations agencies, including support to WHO. It reviews the UNDP resident representatives' involvement in HIV/AIDS activities, including support to government leadership and private sector participation (Non-Governmental Organizations (NGOs), businesses, community organizations) and related capacity-building initiatives. Our report concludes with a summary assessment and possible scenarios for future approaches to the HIV/AIDS

pandemic in the field. The report, in focusing on forward-looking and developing-country perspectives, does not review the history of UNDP and WHO roles in the pandemic and does not address the international relationships of United Nations agencies and donor Governments. It also does not evaluate HIV/AIDS programmes and their impact.

RECENT STATEMENTS ON THE HIV/AIDS PANDEMIC

• Global Strategy for the Prevention and Control of AIDS: 1992 Update

"There are already more than 10 million HIV-infected people, and over 5,000 persons are infected every day. In the hardest-hit areas, whole families and villages are dying out. Countries are losing their most productive people—men and women in the prime of life who were the mainstays of agriculture, industry, commerce, education, health, not to mention the sole supporters of the very young and the elderly. And those parts of the world which have been spared such dire consequences, thus far, are living on borrowed time. By the time the first cases of HIV infections or AIDS are identified in a population, the virus has often spread far and wide." (p.4.)

• Statement of Director, HIV and Development Programme, Bureau for Policy and Programme Evaluation/UNDP, 13 July, 1992

"The HIV epidemic will pose an unprecedented challenge to communities, nations and the international community: a challenge to human survival, human rights and human development. It is difficult to visualize the devastating effect of the HIV epidemic within our lifetime and beyond. WHO estimates that already 1 in every 250 adults in the world is infected and that by the year 2000, 40 million people will be infected and there will have been 20 million cases of AIDS. This means that by the year 2000, apart from an estimated 50 million adults who are infected, sick or dead, another 150 to 200 million dependants will have been affected: traumatized by the loss of their parents or children, left destitute, families scattered or children homeless.... The extent of illness and death caused by the epidemic could deplete critical sections of the labour force, undermine the public sector capacity to govern, lead to social and civil unrest and adversely affect every sector of the economy, including agriculture, industry, transport, health and social welfare."

• Director of the World Health Organization's AIDS programme

"Fighting AIDS in developing countries will cost at least \$2.5 billion a year, 20 times more than what is now being spent, the Director of the World Health Organization's AIDS programme said today." (The New York Times, December 1, 1992. p. A16.)

"AIDS and Africa: An Agenda for Action" adopted by the Organization of African Unity at its Twenty-eighth OAU Summit, 1992

• "AIDS is not just another disease competing for attention with the myriad of health problems of the African continent. It is special because we have no drugs or vaccines to prevent or cure it. It is special because HIV, the AIDS virus, spreads through the basic human drive for love, intimacy, physical closeness and the reproduction of the species, and because controlling and channelling this drive is the only way to ensure our species' survival. It is special in its impact on African society because, unlike other widespread diseases, AIDS leads to frustration and despair; AIDS selectively kills young and middle-aged adults, who are the mainstay of the family, the backbone of the workforce, and the key to development.

"These extraordinary challenges call out for an extraordinary response from Africa's heads of State—and from the world:

1. African heads of State must give their fullest political commitment to mobilizing society as a whole for the fight against AIDS;
2. African heads of State must step up action to prevent the sexual transmission of HIV;
3. African heads of State must plan for the care of people with HIV infection and AIDS and the support of their families and survivors.

"In just eight years, Africa will have had a cumulative total of 18 million HIV infections."

SUMMARY OF MAIN POINTS

The HIV/AIDS pandemic is a major global development problem with potentially devastating consequences for developing countries. This is the view expressed in the Global Strategy statement, in UNDP's report to the United Nations Economic and Social Council, and in the resolution of the African Heads of States (see pp. iii-iv). These statements are the context for the team's assessment of the United Nations resident coordinators'/ UNDP resident representatives' role in HIV/AIDS programmes. The team concludes that the United Nations system of agencies and its principal representatives in the developing countries are not now in a position to provide the leadership and support that the developing countries require to address the HIV/AIDS pandemic. Where Governments are strong and have their own resources, they should be able to provide much of the leadership required. But most of the developing countries, which are in financial difficulty, critically short of trained personnel, and confronting a number of crises, need substantial support in planning, managing, coordinating, and executing HIV/AIDS programmes in all sectors. This applies to Governments and to the private sectors—at the national, district and community levels.

An awareness of the actual and potential impact of HIV/AIDS should become a powerful stimulus to accelerate the flow of resources and carry forward with greater determination those programmes already mandated to address basic development problems. This is particularly the case for health sector programmes where the HIV/AIDS prevention and care responsibilities impose an additional heavy burden on commonly weak health care systems. It is also the case for assistance to the poorer households, communities and districts throughout the developing countries and their local organizations that are on the front-lines of the pandemic. It is notably the case for women in development activities aimed at strengthening women's economic and social security.

WHO is providing the technical policy support in-country on HIV/AIDS that is required by the Ministries of Health. Given the enormous burdens that HIV/AIDS imposes on these ministries, WHO, along with other donors interested in working in the health sector, has a major task ahead in this sector alone. Substantial improvements in health sector capacities are important to building the essential core of prevention and health care services required for HIV/AIDS and to focusing on the key interventions and target groups most likely to reduce the transmission of HIV.

Greater attention is required, in addition, to HIV/AIDS-related development requirements in the other sectors and to supporting community and NGO activity. In this work, the United Nations system of agencies in the developing countries has the potential for providing constructive support and leadership that can be critical in confronting the development crisis HIV/AIDS presents. But without substantial direction from United Nations leadership and systematic processes for coordinating plans and operations in the field, this United Nations role will not materialize and separate agency initiatives will only add to coordination and execution difficulties.

Five main factors shape how the United Nations resident coordinators/UNDP resident representatives and their staffs are responding to the HIV/AIDS problem in the developing countries. These factors include (i) the distinctive characteristics of the HIV/AIDS pandemic in development generally, (ii) the prevalence of HIV/AIDS in each country and the country's perception of this situation, (iii) the statements and guidance on United Nations system policy, strategy and programming related to HIV/AIDS that have been provided the field offices, (iv) the role of other donors, and (v) field office understanding of sound coordination processes and their capabilities for promoting them. We observed aspects of all of these factors during our country visits.

Assessment of United Nations resident coordinators/UNDP resident representatives role in HIV/AIDS programmes

This assessment of the United Nations resident coordinators'/ UNDP resident representatives' role in HIV/AIDS programmes is a snapshot in time. It reflects their understanding of HIV/AIDS, interpretation of the local situations and the guidance provided them prior to 1992. Their involvement will likely change significantly in 1992 and after to more active leadership. Their increased involvement will result from a growing realization of the seriousness of the HIV/AIDS pandemic in the countries in which they are working and the increased intensity and specificity of the guidance messages and meetings set up to educate them about the problem and their role in addressing it.

The priority assigned to the HIV/AIDS pandemic by the United Nations system and UNDP and the guidance on the role of the United Nations resident coordinators/UNDP resident representatives in addressing it have been uneven and unclear across the regions. The four regions of UNDP have interpreted available guidance differently and with different degrees of concern and priority. This has, in turn, affected how the coordinators/representatives have acted or not acted. Given the many priorities the regions and the field offices are asked to address, the differences in

interpretation and action may be understandable. The representatives also are, of course, very much influenced by government concerns and priorities and by government views on United Nations agency participation.

Part of the explanation for the variations in the coordinators'/ representatives' responses lies in the uncertainties about leadership responsibilities in the field between WHO/Global Programme on AIDS (GPA) and UNDP. In addition, the distinctions between those prevention, care, and impact activities that are directly health-related and those that are associated with the social and economic dimensions are not as clear cut as may appear at first. More elaboration of the spectrum of components of a comprehensive HIV/AIDS strategy is required to guide the planning of specific interventions. For the most part, the United Nations resident coordinators/UNDP resident representatives have cooperated with the WHO representative and worked to support their activities.

UNDP resident representatives and multi-sector approaches

Efforts to promote multi-sectoral approaches appear to be developing rapidly. Several of the UNDP resident representatives have been effective in engaging a broad spectrum of ministries with the WHO representatives participating with technical support. The guidance for non-health ministries, however, is less clear on their responsibilities for addressing the HIV/AIDS pandemic, other than awareness sensitization and information, education, communications (IEC) activities. The most important dimension of multi-sector approaches is the involvement of the private sector. Several UNDP representatives have been particularly sensitive about working with the NGOs, building on their earlier established relations and drawing them into HIV/AIDS activity. On the other hand, their work to engage the business community in HIV/AIDS activities appears to be minimal but a more detailed review is required to determine what is taking place.

Coordination of HIV/AIDS activity in-country

Support for the coordination of HIV/AIDS activities and related assistance stands out as one of the primary tasks for the United Nations resident coordinators/ UNDP resident representatives both as the country coordinators for the United Nations system and as UNDP's programme managers. The overall purpose of well-orchestrated coordination is to counterbalance the strong compartmentalization tendencies of donors and their government agency counterparts with their

competitive drives for funds, projects of special interest, and skilled personnel. The coordination process, above all, must keep the larger goals and objectives of HIV/AIDS programmes and programme achievements (or lack thereof) consistently and forcefully before all participants.

The primary prerequisite for effective coordination is to have a clear purpose (national goal) for the coordination effort and an agreed strategy with objectives for achieving it and with a broad base of public and private sector and donor participation and endorsement. Effective coordination requires careful planning and skilful leadership; it is not something that can be left to ad hoc impulses and simply agreeing to have meetings from time to time. It should engage the Governments' planning, budgetary and resource allocation systems rather than operate outside them.

Another feature of the coordination process is the need for a competent secretariat. The insertion of a central coordination unit for a special development problem into established governmental bureaucracies frequently causes difficulties and resentments. It takes a politically savvy manager, with more than technical expertise and skills in administration, to lead these units.

In several of the countries reporting and visited, the coordination mechanisms were in a state of transition and turmoil. This was evident in personnel changes (lack of political savvy, for example), changing organizational arrangements within Ministries, shifting locations of responsibility within government and shifts in the scopes of responsibility for the coordinating bodies. In some of the countries, this turmoil is a result of frequent changes in Ministry of Health leadership and in ministry reorganizations, primarily towards decentralization of operations. Such situations are unfortunate as they divert attention from urgent programme tasks. They are, perhaps, inevitable as the HIV/AIDS pandemic spreads, the need to intensify services grows, and Governments adjust to changing circumstances.

For the most part, the UNDP representatives do not appear to be particularly active in promoting and supporting government mechanisms for the coordination of HIV/AIDS programmes. They have taken the lead in calling and chairing special meetings for awareness purposes or for mobilizing funds, but there is little evidence of support for institutionalizing government coordination arrangements. There are a few examples of training and facilities support but no systematic approach to capacity building to strengthen government coordination of HIV/AIDS programmes has been observed.

While the situation varies by country, the resident donors, generally, do not wish to have the UNDP resident representatives formally lead the coordination process. However, they do look to the representatives to provide opportunities for information exchanges and organize occasional gatherings on issues of common concern. And they do expect UNDP to assist in strengthening government coordination. The common official view is, of course, that Governments should lead coordination efforts. The stronger Governments take on this responsibility without question. The weaker Governments often defer to UNDP and/or WHO to provide some of the leadership in coordination such as for the mobilization of resources. They both look to UNDP to provide more active support in strengthening their coordination capacities.

Information and coordination: One of the most practical, effective, and relatively easily accomplished coordination tasks is the provision of up-to-date information on who is doing what and where in HIV/AIDS programmes. This task is essentially the same as the one UNDP carries out with Governments in the preparation of the Development Cooperation Reports (DCRs). Current information on programmes and their status can be particularly effective in facilitating coordination. There are few instances where this work is being done systematically. It is essential for monitoring progress and accomplishments.

Decentralized coordination: One of the main tasks of government coordination activity is to encourage and facilitate decentralized coordination—coordination on the front-lines of HIV/AIDS prevention and social and economic support. This involves decentralization of coordination for technical and policy issues and for the participation of NGOs, district governments, community-based organizations, and private businesses. Much of the technical guidance and policy development required for HIV/AIDS programmes needs to be delegated to those with appropriate competences.

The NGOs generally welcome some coordination, provided it does not become directive and regulative. UNDP, with its linkages with the NGO community, can perform a useful role in facilitating and promoting NGO coordination. It can also help moderate the relationships of NGOs with Governments that are often characterized by mutual distrust. It can provide through coordination mechanisms the small amount of resources in funds and technical services that are critical to improving NGO programme planning, financial management, and field operations.

The other important dimension of decentralized coordination is support to district and community-based HIV/AIDS operations. The key to success in HIV/AIDS prevention and related support services is the stimulation of local government, community, and group self-help activity.

NGOs are an important participant in this work, but district governments and village organizations also need support in coordinating HIV/AIDS activities in their communities.

In sum, effective coordination, and related capacity building, is a full-time job as the above suggests. It requires thoughtful and experienced leadership. A strategy for coordination should be a major component of national AIDS strategies.

UNDP programming for HIV/AIDS activity

UNDP field office programming for HIV/AIDS activities seems to fall into several categories, i.e.:

- Use of non-IPF resources (SPR, regional projects) for awareness-promotion activities and related studies;
- Small allocations of IPF funds for special HIV/AIDS projects;
- Integration of HIV/AIDS activities into an established project;
- Integration of HIV/AIDS activities in sectors of concentration;
- A major sector of concentration just for HIV/AIDS projects.

The team did not review these programmes specifically but noted what appears to be a lack of guidance from headquarters on how best to address the HIV/AIDS pandemic in UNDP programming. It may be that the above variations are appropriate and suitable to the local situations. But, as the pandemic grows, clearer guidance will be required. It will be directly pertinent to aiding the coordination and programme management functions of the United Nations coordinators/ UNDP representatives.

United Nations resident coordinators, other United Nations agencies, and a unified strategy

The review of United Nations resident coordinators' leadership in coordinating United Nations agency participation in HIV/AIDS programming brings out the relatively ad hoc nature of United Nations agency coordination in the field. Each United Nations agency in the field is developing its own HIV/AIDS activities and only loosely coordinating with other agencies and donors. The agencies are responding to their own headquarters' directives, to the general Economic and Social Council encouragement to participate because of the multi-sectoral nature of the pandemic, and to separate government requests. Such initiatives are desirable. Their impact and their visibility are diffused, however, and the influence of the United Nations system dissipated as a consequence.

It would, thus, seem desirable for the United Nations in each country to have a unified strategy consistent with that of the Governments or, where the latter is lacking, leading the way. The development of such a unified strategy by the United Nations agencies in-country would help to ensure that each contribution is complementary, gaps are identified and addressed, and common approaches are followed for cross-cutting concerns. Such concerns include national execution and implementation, capacity-building measures, transparency in use of funds, support services for women and orphans, social and economic impact studies, monitoring and evaluating procedures, common approaches to counterpart ministries where each agency has distinctive influence, and, most important, interventions to change HIV/AIDS-infecting behavior. Such a unified strategy would benefit from interrelating the experience and specializations of the United Nations agencies.

With a unified strategy, the United Nations system of agencies would be in a better position to influence Governments and other donors and provide more significant leadership in the country. The United Nations resident coordinator is well placed to provide the leadership within the United Nations system to oversee the development of such a strategy and related coordination activity.

UNDP does not now have in the field the staff capacities to plan and administer an expanded programme for HIV/AIDS. UNDP representatives can and do draw on WHO representatives on matters of technical policies and practices and on the other agencies in their area of specialization. However, the capacities of the United Nations agencies in the field for expanded HIV/AIDS programmes also appear limited.

The staff limitations are particularly troublesome when policies and plans are implemented. The team did not examine the questions of HIV/AIDS programme implementation. But the implementation issue came up repeatedly as a major concern about United Nations agency performance. These problems, while in some instances systems problems, reflect the shortage of skilled, experienced personnel in the field offices with time to devote to HIV/AIDS activities.

Alternative scenarios for United Nations resident coordinators/ UNDP resident representatives in HIV/AIDS programmes

Four alternative scenarios appear open to the coordinators/representatives for the future. There can be, of course, numerous variations but these four present the basic features. In all of the scenarios, it is assumed that Governments have the primary coordination and decision-making

responsibility, although the degree of government initiative and capability varies substantially from country to country (see below for a detailed description of the scenarios).

Scenario 1: HIV/AIDS is WHO/GPA's business.— UNDP resident representatives and UNDP not or only minimally involved.

Scenario 2: Co-coordinators: HIV/AIDS is the joint responsibility of the UNDP resident representatives and the WHO/GPA representatives.

Scenario 3: UNDP leads coordination: HIV/AIDS is the UNDP resident representatives' responsibility to lead, relying on WHO/GPA for technical guidance.

Scenario 4: United Nations resident coordinators take the lead responsibility and UNDP becomes a major donor; WHO/GPA provides technical guidance; other United Nations agencies join in a unified United Nations strategy for HIV/AIDS developed under the United Nations resident coordinators leadership.

The prevalence of HIV/AIDS in each country, the Governments' perceptions of the seriousness of the problem, and guidance from United Nations Headquarters will determine which scenario is the most appropriate and adopted. However, in view of the importance of vigorous action in low prevalence countries to limit the spread of HIV, it would seem desirable to adopt a variation on scenario 4 calling for developing a unified United Nations strategy focusing on early prevention actions and reinforcing the WHO/GPA initiatives.

Next steps

HIV/AIDS is a major development problem that will have an extremely costly impact in the developing countries. It is a long-term development problem requiring persistent, sustained, well-organized, and coordinated governmental and donor action. The United Nations system of agencies has the opportunity to provide significant leadership in helping Governments mount major HIV/AIDS prevention and support actions. Although the major flow of resources may come from other donors—bilateral and multilateral, they would welcome effective leadership from Governments working with the United Nations and its agencies.

The next step should be for the United Nations agencies in the field to receive instructions from the Secretary-General to join in developing in each country a unified United Nations strategy for a United Nations HIV/AIDS programme. The United Nations resident coordinator should be instructed:

- To lead the development of a unified United Nations strategy for addressing the HIV/AIDS pandemic (the choice of scenarios depends on the country situation but all field offices should lay out their strategies as evidence of a deliberate and systematic consideration of the problem);
- To identify areas for UNDP and other United Nations agency interventions as complements to other donor programmes (including United Nations cross-cutting concerns for women, children and orphans and requirements for capacity building in national execution, programme approaches, and national and decentralized coordination);
- To create local staff support for the resident coordinator for HIV/AIDS programmes to assist with the preparation of a unified strategy and the monitoring of implementation (staff to come from UNDP, WHO, and other participating United Nations agencies);
- To present to United Nations Headquarters the proposed unified strategy (with any inter-agency issues that may require resolution) for its approval.

The basis for this action has recently been established in General Assembly resolution 47/199 of 22 December 1992, entitled "Triennial policy review of the operational activities of the United Nations development system" (See excerpts Box F.) The global HIV/AIDS pandemic provides an important opportunity for the United Nations to apply the directives of this resolution in a practical form in each developing country. Both the United Nations system and the global country-by-country attack on HIV/AIDS will benefit from such an action.

I. INTRODUCTION

The UNDP Governing Council and the terms of reference for this assessment specify that:

"the Administrator conduct, through the Central Evaluation Office, an assessment of United Nations Development Programme activities to combat HIV/AIDS, beginning with a group of developing countries, with the particular purposes of:

"(a) Examining the degree to which the United Nations Development Programme is using the coordinating role of resident representatives to support the World Health Organization Global Programme on AIDS in the implementation of the Global Strategy and is encouraging national leadership to take a multi-sectoral and multi-ministry approach to addressing the AIDS threat and the consequences of the pandemic for economic and social development; and

"(b) Identifying those activities that have been effective, citing the specific reasons for their success and problems encountered."

In addition, this resolution reaffirms the importance of the WHO/UNDP partnership in combating the pandemic; urges UNDP to strengthen further this collaboration in particular at the country level; emphasizes the need for increased attention and complementary action at the field level by UNDP and its partners in the United Nations development system; and emphasizes the need to mobilize community-based organizations, NGOs, HIV-related regional institutions, private sector organizations, and other institutions and groups in the planning and implementation of national efforts to address the pandemic.

The resolution and terms of reference focus on two basic tasks for United Nations resident coordinators/ UNDP resident representatives in their support of national strategies for HIV/AIDS. First, how are the resident coordinators helping to support the Global Strategy for the Prevention and Control of AIDS in the country setting? Specifically, this role involves the support of WHO field staffs in their work to assist Governments become aware of the HIV/AIDS problem, develop a strategy and programme for its prevention and control, and help implement the medical/health aspects of the programme. In addition, the resident coordinators are designated as responsible for the coordination all United Nations agency activities in-country. They are, thus, called upon to facilitate the engagement of other United Nations agencies in this work, recognizing WHO officials in-country as having a predominant role among the agencies owing to their technical expertise on HIV/AIDS and the WHO/GPA strategy.

Second, what are the UNDP resident representatives, as the leaders within the United Nations system for United Nations development activities in-country across all sectors, doing to encourage national leadership to take responsibility for the HIV/AIDS pandemic? The emphasis in this requirement is to work to engage a wide spectrum of ministries and private organizations in (i) prevention and control activities and (ii) addressing the social and economic impacts of AIDS and their consequences for national development.

The first task is largely a within-the-system responsibility, working to facilitate the activities of WHO/GPA in the field and, in addition, ensuring that other United Nations agencies are also supporting the aims of the Global Strategy in the developing countries.

The second task calls for an outward orientation drawing on UNDP resources and mandates to support government development programmes, support government coordination of external assistance, and promote capacity-building objectives in public and private development activity. For HIV/AIDS strategies, this involves support for epidemiological surveillance, awareness promotion, prevention initiatives, social and economic support undertakings, and their coordination. As one moves along the spectrum of these dimensions of a national HIV/AIDS strategy, HIV/AIDS health/medical interventions blend into other related development initiatives, and non-health/medical technologies, skills, and programmes become more important. This second task also involves facilitating the coordination of the donor community directly but mainly by supporting government coordination efforts.

These two tasks, while presented as distinct, are clearly interrelated calling for effective internal United Nations system mechanisms for coordinated action to back up the broad development mandate of UNDP and the specialized mandates of the United Nations technical agencies. Central in UNDP's mandate is its responsibility for ensuring that the HIV/AIDS strategy and related programmes give adequate attention to building national capacities for carrying forward essential activities. Before reviewing the specific actions of the United Nations resident coordinators/UNDP resident representatives in the developing countries related to these two orientations, it is useful to have in mind the main factors that bear on their response to the HIV/AIDS situation in their countries.

II. FACTORS SHAPING RESPONSES TO THE HIV/AIDS PROBLEM IN DEVELOPMENT

Five main factors shape how the United Nations resident coordinators/UNDP resident representatives and their staffs are responding to the HIV/AIDS problem in the developing countries. These factors include (i) the distinctive characteristics of the HIV/AIDS pandemic in development generally, (ii) the prevalence of HIV/AIDS in each country and the country's perception of this situation, (iii) the statements and guidance on United Nations system policy, strategy, and programming related to HIV/AIDS that have been provided the field offices, (iv) the role of other donors, and (v) field office understanding of sound coordination processes and their capabilities for promoting them. We observed aspects of all of these factors during our country visits.

The nature of the HIV/AIDS pandemic

The characteristics of HIV/AIDS that influence how the developing countries and donors respond are unique. In many respects, however, their implications for a country's development resemble the impact of other fundamental development problems such as high population growth rates, environmental degradation, or even low or no economic growth rates, that cut across all economic and social sectors.

As a WHO/Medium-term Plan guide stresses, "Once infected, a person will remain infected for life. The incubation period is very long: 10 years after infection 50 percent will have developed AIDS, and after 20 years, 90 percent. During these years, the HIV-infected person may appear to be perfectly healthy and without symptoms, but may transmit the infection to his/her sexual partner(s) and unborn children." Thus, the cause-to-consequences relationship appears remote and not connected until a crisis surfaces in an exponential growth in AIDS cases. In a world of urgent social and economic crises, numerous development demands, and fragile political circumstances, this remote relationship makes it difficult to mobilize people and Governments to face a new development problem. Unfortunately, this difficulty comes at a time when prevention and control is most effective in saving lives and minimizing economic and social costs.

Secondly, the linkages of AIDS to opportunistic diseases tends to disguise the original causes; the identification of these linkages is still evolving, particularly for women. This characteristic can result in under-reporting and failure to act expeditiously in treatment and care. Where recognized, these opportunistic diseases call for costly treatments, ample supplies of appropriate drugs, and adequate long-term care facilities.

Thirdly, the period from identification of HIV-positives through AIDS to death, although certain, can be prolonged. This period results in extraordinary emotional, social and financial burdens on the individuals infected and their families and communities and on supporting care systems, particularly, but not only, the health care system. There is no vaccine, no cure, and no immunity build-up process as for many other diseases. At best, drugs, at high cost, can prolong life and ease the pain.

Fourthly, the common association of AIDS with groups with distinctive sexual practices, intravenous drug users, or as a "foreigner's" disease, and its association with sexual transmission generally, results in avoidance of, as well as restraints on, open and public discussion and information sharing. AIDS can generate a high degree of anger and hopelessness among those infected or closely affected with adverse consequences for families and communities. The stigmatization of those HIV/AIDS-infected and subsequent discrimination is, unfortunately, a common uninformed reaction that works against efforts at prevention and care. Yet where accepted and understood, substantial positive action and support can result.

Fifthly, the only available methods for prevention and control—abstinence from sexual activity, use of condoms, mutual fidelity, limited partners—involve deep-seated psychological, socio-cultural and economic factors influencing behaviour that are not easily influenced. Knowledge of the causes of AIDS has, by itself, proven to be insufficient in changing behaviour patterns leading to HIV/AIDS prevention. A complex of health and social services, group and community action, and supportive social and economic activities, in addition to knowledge, have been found to be essential for changing behaviour. This complex of activity calls for a wide range of sectoral activity and community participation. Moreover, the dependence on condom use as the primary intervention for prevention introduces difficult problems of acceptability (willingness to use and use consistently), availability, affordability, and marketing and distributing tens of millions of condoms annually in each country.

Sixthly, AIDS is particularly evident among the skilled and productive segments of populations, commonly among technically trained and managerial groups. These are the people on whom societies depend to preserve and advance household, community, business, and national well-being. The premature disabling and death of people in these groups, along with accompanying increases in the numbers of orphans—young and old, becomes a serious development problem. Although the impact of AIDS on the social and economic fabric of society is only beginning to be appreciated, it can be devastating where AIDS is pervasive. It is a persistent and long-term problem that taxes patience and demands the sustained attention of all who become involved.

These characteristics of HIV/AIDS set it apart from other diseases in its medical and multiple developmental dimensions. They influence the perceptions—positively and negatively—of Governments and their people. They are evident in all countries—developed and developing. They affect the attitudes of the donors and their staffs as well. HIV/AIDS, thus, becomes everybody's problem—personally and professionally.

Country perceptions

Government and country responses to HIV/AIDS reflect a resistance to openly recognizing the pandemic as a development issue—in its causes, methods of prevention, and implications—particularly during its early stages. They reflect a lack of appreciation of the existing and potential pervasiveness of HIV/AIDS. Governments are preoccupied with numerous other issues that clamor for attention such as economic and financial crises and reforms, drought, civil unrest, new democratic Governments, persistent poverty. Thus, an initial and persistent question for Governments is: where does HIV/AIDS fit in the priorities of development problems to be addressed? Countries at different stages in the prevalence of HIV/AIDS have different views on its priority, as we observed.

Within governments, ministries tend to perceive HIV/AIDS as a medical/health problem to be addressed by Ministries of Health. As the multi-sectoral requirements become evident, it calls for introducing another multi-sector coordination process into established line agency systems. This step typically meets with resistance even when high political authorities speak out and support it. It is another problem added to the lengthening list of issues that require the personal attention of heads of Government.

Perhaps the most significant factor bearing on government and donor perceptions of the HIV/AIDS problem is the surge of the non-governmental, community, and business organization responses. These organizations are on the front-lines of the impact of the HIV/AIDS pandemic and the major country resource for coping with it. They are the first to be confronted with the grief, the mounting need for care, the troubling concerns of cultural, social and economic values, and the consequences in social and economic disruptions. In some countries the response of these organizations has been extraordinary despite their lack of resources and skilled staffs and managers. They are forcing a more forthcoming government response while nervous about government controls.

Those Governments, with vigorous development action in their economic and social sectors that is directly beneficial to the general population, will find an HIV/AIDS prevention strategy easier to integrate. At the same time, the actual and potential impact of HIV/AIDS should become a powerful stimulus to accelerate the flow of resources and to carry forward with greater determination those programmes already mandated to address basic development problems. This is particularly the case in the health sector where the HIV/AIDS prevention and care responsibilities impose an additional heavy burden on commonly weak health care systems. It is also the case for assistance to the poorer households, communities and districts throughout the developing countries and their local organizations that shoulder the major burden of the pandemic. It is notably the case for women and the development activities aimed at strengthening women's economic and social security.

Government perceptions of the HIV/AIDS problem are particularly important for UNDP and the United Nations agencies. For in large measure country programmes are viewed as government-owned and, thus, any new initiatives for IPF funding must reflect the Government's priorities and interests. In this situation, it may be difficult to take the initiative on a controversial development issue.

United Nations system guidance on HIV/AIDS

A third influence shaping the response of the United Nations resident coordinators/UNDP resident representatives and their staffs is the type of analyses, reports, briefings, and policy guidance being received from United Nations agencies headquarters (UNDP, WHO, UNICEF, et al.) The initial Global Strategy Statement of 1986 and the WHO/UNDP Alliance agreement of

1988 were among the first comprehensive guidance documents. However, 1992 was a distinctive year for statements and reports on HIV/AIDS strategies as evident from the number of reports, policy statements, and instructions to the field that have been issued during the year.

The most important of these is the 1992 update of the "Global Strategy for the Prevention and Control of AIDS" that has been prepared and issued by WHO. This statement reflects the consensus of the international donor community. It incorporates the results of experience and research since the mid-1980s when the world first became aware of the HIV/AIDS problem and began to perceive its larger dimensions and implications. It serves as the basic guide for country programme activities and the orientation of United Nations agency and UNDP initiatives. This year is also distinctive for the number of country programmes which are just beginning, or will begin in 1993, their second medium-term plans (MTP2s).

For UNDP the most complete statement of policy guidance is the policy paper "The Role of UNDP in combatting HIV/AIDS: Policy framework for the response of UNDP to HIV/AIDS" of May 1991. This policy framework establishes UNDP's responsibilities for "increasing the awareness of the development implications of the pandemic, strengthening and expanding the capacity of communities to respond to the pandemic, promoting and assisting in prevention, care, support, and treatment programmes for women, and assisting Governments to develop effective multi-sectoral HIV/AIDS strategies and to minimize the devastating consequences of widespread infection." It also sets forth short- and long-term goals, priorities for HIV/AIDS policy, proposed delivery mechanisms, collaboration responsibilities, support for institutional development, guiding principles for policy development, and monitoring and evaluation tasks.

Other reports and guides include:

- "The Report of the External Review of the World Health Organization Global Programme on AIDS." (January 1992);
- "GPA Management Committee Report" (April 1992);
- "Report of the Conclusions of the GPA Management Committee" (12 June 1992);
- Economic and Social Committee resolution, July 1992;
- "WHO/UNDP Memorandum of Understanding for the Implementation of the WHO/UNDP Alliance to Combat AIDS", as an amendment to the 1988 "WHO/UNDP Alliance to Combat AIDS" document (July 1992);
- WHO's revised guidance for the second round of medium-term plans (October 1992);
- UNDP's "Policy Framework for the response of UNDP to HIV/AIDS", reported to the Governing Council in May 1991;

- "Assessment of HIV/AIDS Coordination Mechanisms at Country Level" (October 1992);
- A number of other UNDP policies and initiatives that bear on UNDP's role in HIV/AIDS programming, such as those on capacity building, national execution, support to country external assistance coordination tasks, the programme approach.

(Annex II below provides a summary of these various statements, strategies, and agreements that are providing the framework for guiding field operations.)

These documents carry common themes about country responsibilities for the HIV/AIDS pandemic:

First, they establish that "there is a general recognition that HIV/AIDS, a health problem for individuals, is also of wide-ranging developmental significance for society as a whole. Thus, the important social and economic factors associated with the transmission of HIV as well as its prevention and care require that all sectors must be seriously involved in responding to the challenge posed by the pandemic." An added dimension noted in the Global Strategy is that "immediate planning in anticipation of the socio-economic impact of the pandemic" is required. This dimension moves beyond the prevention and care concerns to considerations that involve a country's development processes generally.

Second, they make clear that the developing country Governments are primarily responsible for the leadership and coordination of HIV/AIDS programmes. The Governments should take the lead in developing national AIDS strategies that involve a wide spectrum of public and private agencies across all sectors. How this process takes place and who in the Government provides the leadership as the strategies move from the medical/health components to more comprehensive integration of HIV/AIDS prevention activities and socio-economic support initiatives is less clear. While the decision is the Governments', the donor community has a role in encouraging Governments to act and organize with some suggestions on what may be required. The UNDP resident representative can and should have an important role in this process, according to the guidance.

A third common theme is the repeated statement that, within the United Nations system, WHO is responsible for providing advice on health sector policy and technical issues. Other agencies should be encouraged to participate in their areas of specialization. UNDP should assist Governments to coordinate overall donor inputs helping to strengthen government capacities for coordi-

nating external assistance in general and for HIV/AIDS specifically. The United Nations resident coordinator has a key role in initiating and facilitating inter-agency consultations on HIV/AIDS programming.

A fourth theme is accented in the WHO/UNDP Memorandum of Understanding. This document emphasizes the joint WHO/UNDP involvement in multi-sectoral policy development and strategic planning and that WHO and UNDP will jointly and actively assist countries in the mobilization of national and international human and financial resources. Yet, apart from modifications in responsibilities for project development, financing and administration—the main concern of this memorandum—this memorandum does not spell out how these joint responsibilities are to be carried out in the field.

Fifth, it is clear from various documents that WHO should provide the United Nations expertise on HIV/AIDS and has the responsibility for those activities that fall within the sphere of the Ministries of Health with UNDP project-funding support as required. WHO also, through the mechanisms of the MTP and its national AIDS programme (MTP2) guidance, oversees the main instrument for assisting in the development of the Governments' national HIV/AIDS strategies. It should also be involved in providing technical guidance on health aspects of other sector activity. UNDP is responsible for facilitating support to the HIV/AIDS activities of other sectoral ministries and private organizations. This is evident in the UNDP policy statement, cited above, that charges UNDP with:

- Increasing awareness of the development implications of the pandemic;
- Increasing the capacities of communities to respond to the pandemic;
- Assisting with prevention, care, support, and treatment programmes for women;
- Assisting Governments to develop effective multilateral HIV/AIDS strategies.

While roles for each organization may be relatively clear from these guidance statements, they allow for considerable overlapping and uncertainty about responsibility in the field. This overlapping becomes more of concern as the multi-sectoral and development impact dimensions of the HIV/AIDS pandemic evolves. The guidance for the MTP strategy mechanism itself may require redesigning to accommodate these dimensions. Overlapping becomes a concern as UNDP develops HIV/AIDS programmes as part of its country programmes and IPFs and takes a more active leadership role. Moreover, as the WHO/UNDP Memorandum of Understanding specifies, funding, execution and implementation responsibilities are changed and now constitute a mix of WHO direct (Global Trust Fund), UNDP project funding (IPF and other sources), other

United Nations agency project funding (direct and with UNDP/IPF) and WHO, national, other execution, and local/international organization implementation. Within the United Nations system where, in fact, is the primary responsibility for leadership and coordination in the field?

Sixth, the reports and guidance make a point of calling for the participation of other members of the United Nations system. United Nations Children's Fund (UNICEF) has been particularly active focusing on women and children (orphans). United Nations Population Fund (UNFPA) is integrating HIV/AIDS in its activities and other agencies are beginning to determine how they should participate at the urging of United Nations resolutions. A coordinated strategy at the field level to define respective United Nations agency roles, however, is not evident and, for Governments and other donors, the United Nations agencies are considered separate and independent donors.

Other bilateral and multilateral donor perceptions and activity

The discussion in United Nations guidance on the HIV/AIDS pandemic tends to underplay the significance of other donor activity—a fourth factor shaping responses. In the field, particularly, this activity is substantial and growing. In the early periods of discovery of HIV/AIDS, WHO and Ministries of Health stood out as the primary focal points and resources for addressing the problem. The donors' approach was largely to leave it to WHO/GPA. This situation was manifest in the formation of the Global Trust Fund as the main instrument for transferring resources for country programmes. Over the past three to four years, however, the donors have chosen to take a more direct role in addressing the HIV/AIDS development issue and, as the problem grows, have provided major resources over a wide range of HIV/AIDS prevention and support activity. For example, USAID in Uganda is a major donor with a \$12 million programme covering a wide spectrum of interventions. USAID has just signed a \$19 million programme in Zambia with a concentrated focus on prevention in key areas of the economy. Within the last four years, USAID has developed HIV/AIDS intervention strategies and provided technical assistance for more than 700 prevention and control activities in 70 developing countries.⁴ Box A provides a summary of the World Bank's engagement in HIV/AIDS programmes with increasing amounts and numbers of countries assisted. In addition, EEC and most of the major bilateral donors are assisting with some aspect of the HIV/AIDS programme in many of the developing countries. Overall, 47 percent of the total resources (\$864.29 million) for the global AIDS strategy between 1986 and 1991 has been provided by bilateral donors directly to the developing country. It was about 35 percent in 1987 rising to 55 percent in 1991.⁵

Box A

World Bank and HIV/AIDS

The first World Bank lending in support of AIDS control was to the Africa region and was provided as a component in the Zimbabwe Family Health Project, approved in 1987. Because grant financing for national AIDS programs was plentiful from the World Health Organization's Global Programme on AIDS and bilateral donors, Bank loans and credits were at first useful primarily in shoring up the foundations of health systems on which AIDS programs were constructed, and in filling gaps. However, as the number and absorptive capacity of AIDS programs increased, countries began to request the Bank to play a larger role. The first Bank free-standing AIDS project was an \$8.1 million credit to Zaire in fiscal 1989. In addition, Bank health projects in Burundi, Lesotho, and Malawi have included funding for substantial parts of those countries' AIDS control programs.

In the LAC region, the severe epidemic in Brazil led to the inclusion of two AIDS components in a 1988 Bank project, one to finance research on prevalence and economic impact and one to control the disease in the northeast region of the country. A Bank project in Haiti also funds AIDS control.

In the Asia region, the Bank's second free-standing AIDS control project, in India, was recently approved. In addition to funding a major improvement in the safety of India's blood supply, this project emphasizes the control of sexually transmitted diseases. The Bank is in the early stages of a policy dialogue on AIDS in the Philippines and Indonesia, where rigorous AIDS surveillance is just beginning.

Through 1992, the Bank has AIDS project activities, as whole or portions of projects, in 28 countries.

Other activity

In 1986, the Bank's central Population Health and Nutrition Department recognized the seriousness of the AIDS epidemic and recommended that Bank assistance be offered to borrower countries, wherever possible and appropriate. Subsequently, in response to a request from WHO/GPA, the Bank agreed to assist in estimating the economic impact of a case of HIV infection. This work concluded in 1988. More recently, in response to the perceived need to prioritize interventions in national AIDS control programs, work has focused on the costs and effects of alternative interventions. This work contributed to an important collaboration between the Southern Africa Department and WHO/GPA in a comprehensive analysis of the impact of the epidemic and the cost-effectiveness of alternative interventions in Tanzania.

In addition to the Bank's analytical work, the Bank's Special Grant Program is supporting research, with \$1 million each year provided to WHO/GPA in 1989, 1990, 1991, and 1992. GPA is using these funds to strengthen its collaboration work on the links between AIDS and tuberculosis, tropical disease, and human reproduction and to commence operational research on the cost-effectiveness of alternative AIDS interventions.

Excerpts from "World Bank Activities on AIDS" report, April, 1992.

This substantial increase in the direct involvement of bilateral donors and other multilateral donors reflects their growing realization of the seriousness of the pandemic, the need for substantial increases in the flow of assistance, and the problems of funnelling major funding through the WHO/GPA Global Trust Fund. It is causing a fundamental shift in the approach to the pandemic and the need for well-developed multi-sectoral strategies, strengthened government leadership, and more effective coordination and implementation mechanisms. It also increases the demand for technical policy advice and leadership capabilities at all levels of governmental and community action.

Approaches to coordination

A fifth factor bearing on the shape of the United Nations resident coordinators'/ UNDP resident representatives' responses to the HIV/AIDS pandemic in the developing countries is their understanding of the coordination task.

The HIV/AIDS pandemic, in its requirements for coordination, presents a relatively unique situation. On the one hand, it is in many ways an emergency like famines or natural disasters requiring immediate assistance as the number of AIDS patients multiplies, the impact becomes more widespread, and the prevention task becomes more demanding. For the poorer countries, the impact of HIV/AIDS may precipitate a widespread crisis for their societies generally as it tips the scales against those living on the margins of survival. On the other hand, for those societies better off as well as the poorer communities, HIV/AIDS is a long-term development issue that can seriously complicate all aspects of a country's development efforts. The coordination task may need to differentiate between the surveillance and prevention actions, the care and coping burdens, and the social and economic consequences. For those countries where it appears that the incidence of HIV/AIDS is verifiably limited, coordinating actions can be more focused and zero in on containment through vigorous prevention and control activities. But in time, HIV/AIDS requires the involvement of people and organizations in all sectors—public and private—a task of major proportions comparable to the management of development generally.

In these circumstances, the approach to coordination mechanisms needs to be flexible to adjust to the shifting dynamics of the HIV/AIDS pandemic. It needs, of course, to be adapted to the idiosyncrasies of each country situation. The coordinating mechanism including its location in government should be capable of encompassing the full dimensions of the HIV/AIDS development issue and not be locked into one of its specializations. It should reflect the level of commit-

ment and political engagement of national leadership. In most instances, capacities will be limited and, thus, it is important for the donors to concentrate on strengthening the professional and organizational capacities of those participating—public and private—in HIV/AIDS management and coordination activities and not simply take over the function or fill operating gaps for staff and resources.

The coordination task is also demanding because other donors and United Nations agencies are not easily guided. They are competitive, have their special interests, requirements, procedures and governmental relationships. They are, however, willing to cooperate where coordination leadership is competent and facilitative and policies, strategies and objectives are clear. This situation places a distinctive demand on government coordination units and should, in turn, on United Nations resident coordinators/ UNDP resident representatives.

A thorough understanding of HIV/AIDS—its dynamics, the scope of action called for, and the rapid changes in donor and local participation—is essential to guide approaches for coordination. United Nations resident coordinators/UNDP resident representatives are responding to the coordination task with varying degrees of understanding, concern, commitment and competence. The next chapters review the various approaches taken by United Nations resident coordinators/ UNDP Representatives and UNDP staff both within the United Nations system and with Governments.⁶ Also the "Assessment overview" chapter provides a fuller discussion of the coordination task.

Factors shaping United Nations field office responses to HIV/AIDS: summing up

These five broad features of the HIV/AIDS pandemic are influential in shaping how the United Nations resident coordinators/UNDP resident representatives, UNDP and other United Nations agencies are responding to the HIV/AIDS pandemic. They are clearly faced with a rapidly evolving situation both in the spread of the disease and in the growth of government and donor responses. The major constraints are less a matter of resources—although substantially more are required—or of knowledgeable programme strategies and available technologies—though continuing research is essential—than they are of commitment and coordination in the affected developing countries. What is the situation on coordination in these countries? How are the United Nations resident coordinators/UNDP resident representatives and UNDP field offices fulfilling their roles? These questions are discussed in the next chapters.

III.

THE UNITED NATIONS RESIDENT COORDINATOR AND HIV/AIDS PROGRAMMES

"The WHO/UNDP Alliance to Combat HIV/AIDS combines the strength of WHO as the directing and coordinating authority in international health work, including health policy formulation as well as in scientific and technical matters relating to health, and of UNDP as the central funding and coordinating mechanism for United Nations system operational activities in the field." Memorandum of Understanding for the Implementation of the WHO/UNDP Alliance to Combat Aids. 1992.

"..Requests the relevant agencies of the United Nations system, in elaborating improved country-level coordination mechanisms, to take into account the important role the resident coordinator should play in such mechanisms to ensure effective implementation of the updated global strategy..." Economic and Social Council resolution July 1992.

"...the degree to which the United Nations Development Programme is using the coordinating role of resident representatives to support the World Health Organization Global Programme on AIDS in the implementation of the Global Strategy." Governing Council resolution 92/14⁷

The United Nations resident coordinators are responsible within the United Nations system for coordinating United Nations agency programmes and administrative activity, as the above United Nations system guidance for HIV/AIDS establishes. While their designation gives them a form of primus inter pares status, the resident coordinators have little authority over the work of the United Nations agencies with their separate headquarter directives and diplomatic representation status. Also, for example, they often manage a minority share of the resources available in-country from the United Nations system. As one resident coordinator puts it, "my ability to provide leadership and coordination is largely a function of my personal relationships and friendships with the heads of the other United Nations agencies in the field." It also, of course, depends on the resident coordinators' own capabilities and their immediate staffs' analytical, programming, and administrative skills.⁸

The coordination role of the United Nations resident coordinators for HIV/AIDS activities, in addition to the formal designation within the United Nations system, derives from the source of local programme funds, personal commitment, rapport with agency heads, their interpretation of United Nations system guidance, and government perceptions of the pandemic. They are encouraged to support WHO/GPA's leading role in-country but also to take a leading role. The response of the United Nations resident coordinators and UNDP field offices to the HIV/AIDS pandemic has varied with the realities of the local situation. They all start from the common

base of WHO/GPA as the principal technical agency. As we have learned from our field visits and the questionnaires, the role of the United Nations resident coordinators in their relations with other United Nations agencies has evolved in various patterns.

In the early stages, WHO/GPA has taken the lead with little or no participation of the United Nations resident representatives. With its own GPA Trust Funds, it has been able to establish initial programme structures (MTPs) and HIV/AIDS programme units in Ministries of Health. WHO/GPA's accomplishments in this effort are evident in the fact that 124 (as of November 1991) countries have, at least, a first round of Medium-Term Programmes with the standard core features of the MTPs, i.e., programme management, epidemiological surveillance, laboratory support, and health education (IEC). WHO/GPA is now assisting 26 countries with their second MTP. The level of annual funding directly through WHO/GPA reached \$100 million by 1990 beginning in 1986—a relatively short period of extraordinary growth.⁹ The resident coordinator's participation in the initial stages of this work has been relatively passive. The field reports point out that WHO and UNDP resident representatives have consulted on the coordination of HIV/AIDS in most countries. However, without more explanation, it is not clear what this means, as consultations can range from perfunctory to serious engagement.

This initial phase has over time been reinforced by the United Nations resident coordinator becoming more active and allocating local IPF funds to HIV/AIDS activities. Of the 61 United Nations resident coordinators responding to the questionnaire, 29 reported having allocated country IPF funds to WHO/GPA and to HIV/AIDS projects in the period 1988-1992. In 1988, only three had done so. The total commitment of country IPF funds is about \$15.5 million since 1988. Of these countries 21 are in Africa, 4 in Latin America and the Caribbean, 3 in Asia and the Pacific, and 1 for the Arab States. The major part of these funds—over 60 percent—were transferred to the WHO Global Trust Fund to support local MTP activities. The balance has been allocated to UNDP field office projects to support government awareness programmes (seminars and international conference travel), capacity building and administrative support for national AIDS offices, and local NGO organizations.

In two thirds, or 40, of the countries reporting, United Nations system leadership for coordination was assumed by the WHO representative. In the remaining third, the United Nations resident coordinator has taken the lead. Most of the coordination activity led by the WHO representative or United Nations resident coordinator has involved arranging meetings, together or separately,

of government officials, donors and other interest groups for awareness and education, resource mobilization and MTP planning activity. Their roles are illustrated by the following excerpts from country reports responding to the CEO questionnaire:

1. WHO/GPA leadership and coordination; little or no United Nations resident coordinator involvement.

Burundi: "Within the context of GPA, the Government and WHO put in place a national AIDS programme in March 1988. The first AIDS resource mobilization meeting of the National AIDS Programme was held in July 1988 (jointly by the Government and WHO), the National AIDS Programme became operational in 1989 and second resources mobilization meeting took place in July 1990. UNDP was only one of several donors participating and pledging support. No particular consultation between WHO and UNDP took place and WHO has been working directly with Government without any coordination involvement from UNDP. Coordination was to be performed within the framework of the National AIDS Programme; however, since most activities occur outside the programme, no real coordination exists. Several donors no longer participate in the consultative committee. A new coordination framework is, therefore, badly needed and UNDP is ready to play an active role in establishing this throughout the 5th Programme Cycle."

Colombia: "Colombia has been following the WHO Global Programmes on AIDS guidelines. UNDP participated through WHO/PAHO. Apart from WHO funds and the national budget, the MTP has not received other financial assistance. AIDS has to be included in all health programmes and the financial support of United Nations agencies is also needed. Some agencies such as UNDCP and UNFPA have included AIDS in their programmes particularly IEC. They should be articulated with the activities of the MTP. "

Papua New Guinea: "WHO played the coordinating role because it alone was in a position to provide the required financial assistance and staff contributions. No IPF funds provided."

India: "WHO and UNDP consulted on 2 major HIV/AIDS activities and UNDP participates in regular donor meetings organized by WHO."

Zambia: "WHO provided the leadership with UNDP resident representative support and participation in donor meetings as one of the minor donors."

Pakistan: "Only WHO/GPA is involved. WHO has the key role in terms of advocacy, technical assistance, funds, resource mobilization and information sharing. UNICEF and USAID are willing to participate" ¹⁰ (Note: From a July 13, 1993 field report on recent developments: "At present, there is a Donor Inter-Agency Task Force on HIV/AIDS formed as a result of a joint initiative of the Resident Coordinator and WHO. The National AIDS Committee was assisted by the Task Force in finalizing the next Medium Term Plan and identifying priority areas in HIV/AIDS for donor assistance. Some commitments were made by donors in the Task Force for areas such as STD, IEC, and capacity building of NGOs. ... It is important that the Field Offices be involved in decisions about the Global Programme funds and have access to some funds from the Regional Programme or SPR.)

2. WHO leadership on technical aspects and MTP planning; United Nations coordinator leadership on coordination.

Central African Republic: "Both UNDP and WHO offices consulted on major HIV/AIDS activities: formulation of project documents, timing and needs for coordination with the Government and donors. The UNDP Resident Representative was regularly briefed on HIV/AIDS by WHO. WHO took the lead for technical activities with respect to *inter alia*, conducting training seminars, liaising with technical partners, undertaking programming or research activities with the Centers for Disease Control, Atlanta, and the Institut Pasteur. WHO also took the lead in the reformulation of the MTP after initiating a review of activities during the first MTP year. UNDP took the lead with respect to coordination following close coordination with WHO. UNDP filled naturally its role due to its privileged relationships with the coordinating ministry (Plan), with the line ministries involved (health, education, justice, interior) and with donors."

Sri Lanka: "In Sri Lanka the national programme on AIDS is funded by UNDP IPF and it is executed by WHO." The Resident and WHO Representatives consulted "regularly, share coordinating responsibilities but the Resident Representative requested the WHO Representative to chair the United Nations inter-agency working group."

3. Principally United Nations resident coordinator leadership on coordination with consultations with WHO.

Uganda: "There always were and still are regular cross consultations between the WHO Representative and UNDP office on matters of the AIDS epidemic: the UNDP Resident Representative plays the coordinating role as the overall coordinator of the United Nations activities in the country. The bilateral donors have cooperated closely with the United Nations system and accept the coordination role of UNDP regarding AIDS-related activities of the United Nations systems. ..., many bilaterals actively participate in the United Nations-sponsored coordination meetings."

Gabon: "Our office (UNDP) and the WHO representative cooperated very closely since 1989 and thereafter with the UNDP Resident Representative playing the lead role in representing the United Nations system and in assisting the Government in its efforts to mobilize and coordinate external aid support, and with the WHO office assuming the main responsibility to advise on technical matters."

Ghana: "The WHO Representative and the UNDP office have been consulting each other in the formulation and implementation of the National AIDS Programme; UNDP playing a coordinating role in the process of formulating the short-term and medium term plan. In the process of formulating the short- and medium-term plan the UNDP Resident Representative coordinated and convened meetings, including the first donor sensitization meeting. UNDP is currently supporting the implementation of the MTP. The reasons given for the choice of coordinator in these and other country situations relate to the source and control of the funds, knowledge of the subject, and ties with the Government."

In most instances in the first years, WHO/GPA controlled the funds, was linked with the government AIDS control units in the Ministry of Health and, of course, was the acknowledged expert in the field within the United Nations system. In the other instances, the United Nations resident coordinators served as coordinators in view of their designated responsibility within the United Nations system, ties with government central planning, the necessity and growth of a multi-ministry approach, responsibility for IPF funds, and ability to integrate WHO expertise with other agency expertise. In other instances, the coordination function has been shared. Shifts in coordination leadership also reflect the growing complexity and dimensions of the HIV/AIDS pandemic and issues of implementation capacities and performance."

In most of the above instances, Governments were, at least nominally, involved in coordination activities. In Thailand and Botswana, government leadership of coordination is particularly distinctive, dominating intergovernmental, NGO, and donor participation.

Among the countries examined by the team members, we found the following approximation of coordination effectiveness of intergovernmental involvement in HIV/AIDS initiatives :

		Government commitment to multi-sector coordination	
		A. Strong	B. Weak
I. High current prevalence HIV/AIDS		Rwanda* Uganda* Thailand	Cote d'Ivoire Zambia India Honduras Congo
	II. Low current prevalence but rapidly rising HIV/AIDS		Pakistan Philippines

In the asterisked countries, the United Nations resident coordinators have been active in providing leadership. In some of the others, they are becoming involved or have plans to be more active during the Fifth Programme Cycle but this is not uniform nor certain.

Additional coordination activity in the United Nations field offices

Other coordination activity of the United Nations resident coordinators includes the discussion of HIV/AIDS at United Nations agency monthly coordinating meetings. In several countries—Zambia, Uganda, Rwanda, for example—the resident coordinators are organizing seminars for all United Nations staff on HIV/AIDS. Given the large number of employees of which many are nationals, this is an important step which can have a multiplier effect in the country. United Nations policy guidance on HIV/AIDS for United Nations personnel has been provided.¹¹ A follow-up seminar series is being considered by some United Nations resident coordinators. These follow-up seminars would focus on the question of how the HIV/AIDS pandemic will affect the United Nations projects of the United Nations agencies and what steps might be taken

to integrate HIV/AIDS prevention, support, and/or socio-economic analysis activities in these projects. This is already being done, for example, by UNICEF in its women and child service activities.

There are instances where the United Nations resident coordinator has taken the initiative within the United Nations group to form inter-agency task forces to address some aspect of the HIV/AIDS problem. The task forces are led by the United Nations agency that has the primary interest but with other agencies participating where they can be supportive. Some examples from Uganda are the recently established inter-agency task force on orphans or the task force for the northern province—a particularly neglected area.

The UNDP resident representatives in their reports indicated that in only five countries did United Nations agencies other than WHO participate in UNDP-funded HIV/AIDS activities. However, 24 of the 44 Governments responding reported that they were receiving assistance from United Nations agencies in addition to UNDP and WHO. The principal agencies involved are UNICEF, UNFPA, UNDCP, UNESCO and WFP. The trend is towards more United Nations agencies becoming involved in HIV/AIDS projects as separate activities or as components of their ongoing programmes.

As the HIV/AIDS problem intensifies and becomes an issue for more sectors and programmes, the coordination task within the United Nations system of agencies will need to become more formalized and structured. Some government officials expressed the wish that the United Nations agencies get better organized and provide a more coordinated United Nations system approach, although individual government line agencies may not share this view.

The United Nations resident coordinator function, while largely focused on coordination within the United Nations system, overlaps with the UNDP resident representative function, particularly in matters of multi-sectoral development activity and specific social and economic issues. These latter functions are the subject of the next chapter.

IV.

UNDP RESIDENT REPRESENTATIVES AND MULTI-SECTOR, MULTI-MINISTRY APPROACHES

"4. A key component of the reforms taking place in the United Nations system is coordinated, complementary and harmonious action by all its bodies. Within that system, UNDP plays the lead role, at the country level, regarding social and economic development. The UNDP resident representative in any country is, at the same time, the resident coordinator of the United Nations system's operational activities for development. UNDP is therefore the natural body to ensure coordinated support by the United Nations system for socio-economic matters in countries." WHO/UNDP Alliance to Combat AIDS 1988.

An explicit requirement for the UNDP resident representative and staff work on the HIV/AIDS pandemic is, thus:

"...encouraging national leadership to take a multi-sectoral and multi-ministry approach to addressing the AIDS threat and the consequences of the pandemic for economic and social development." UNDP Governing Council resolution 92/14

The important distinction in this guidance, reflected in other guidance documents, lies in (i) addressing the AIDS threat (discovery, prevention and care) and (ii) addressing the consequences for a country's economic and social development. While the implications for United Nations roles and coordination functions are not spelled out, there appears to be, among some, an assumption that the latter is UNDP's "territory" and the former WHO/GPA's. In fact, they, and other United Nations agencies, are engaged in both dimensions. What are these dimensions and their implications for UNDP resident representatives' approaches?

The multi-sectoral dimensions of HIV/AIDS programmes

The dimensions of a programme response to the HIV/AIDS pandemic are illustrated in the matrix figure 1.¹² They involve:

1. Maintaining epidemiological surveillance to track national prevalence and trends of HIV/AIDS and identify focal points of infection;
2. Eliminating transmission in blood transfusions, drug-user injections, health care settings, and perinatal infection;
3. Reducing sexual transmission of the HIV through promoting awareness and information by engaging government agencies and private sector organizations in IEC activities related to their areas of responsibility. The primary task is to facilitate the channeling of

Matrix figure 1

MULTI-SECTORAL DIMENSIONS OF A NATIONAL STRATEGY FOR HIV/AIDS PREVENTION, CONTROL, AND SOCIO-ECONOMIC IMPACT

(based on the Global Strategy for the Prevention of AIDS: 1992 Update)

I. EPIDEMIOLOGY AND SURVEILLANCE

- A. *Establish and maintain sentinel posts, AIDS Information Centres, reporting systems*
- B. *Undertake medical research on HIV/AIDS transmission and treatment*

II. PREVENTION AND CONTROL

- A. *Change behaviour (sexual practices and mores)*
 - 1. Information and education: general, women, youths, high-risk groups
 - 2. Health and social services
 - detect/treat STDs
 - educate, counsel, test (voluntary)
 - 3. Supportive environment
 - establish prevailing protective social norms
 - eliminate legal barriers
 - counter stigmatization/discrimination
 - promote economic support to counter effects of poverty
 - reduce vulnerability of women
 - 4. Condom supply and use
 - establish production, procurement, social marketing
 - promote use (peer pressure, example, enforcement)
- B. *Prevent blood-borne transmission*
 - 1. Blood transfusion
 - blood screening/safety
 - reduced transfusions
 - 2. Drug injections/infections
 - behaviour change
 - health/social services
 - information and education
 - economic environment
- C. *Prevent HIV transmission in health care setting*
 - 1. Train staff in safe procedures
 - 2. Protect equipment
- D. *Prevent perinatal transmission*
 - 1. Information and Education for Women
 - 2. Health and social services
 - 3. Supportive environment
 - 4. Counseling on child-bearing implications

III. PERSONAL, HOUSEHOLD, COMMUNITY IMPACT

- A. *Provide care, including counseling and clinical management*
 - 1. Make hospital and outpatient services appropriate, accessible, continuous
 - 2. Train health care providers
 - 3. Provide essential drugs, e.g. TB control
 - 4. Counsel re infection; provide understanding, compassion
 - 5. Establish home care with effective nursing care
- B. *Provide social and economic support for patients and families*
 - 1. Promote income opportunities and alternatives for women
 - 2. Promote household income support
 - 3. Promote community economic and social development
 - 4. Establish support for "orphans"- young and old.

IV. SOCIAL AND ECONOMIC IMPACT ON PUBLIC AND PRIVATE SYSTEMS

- A. *Determine and introduce cost/effective practices for prevention and care*
- B. *Determine and address impact on skills and workforce by industry*
- C. *Determine and address consumer/investor loss*

V. COORDINATION: NATIONAL AND INTERNATIONAL EFFORTS IN-COUNTRY

- A. *Promote advocacy over denial and complacency*
- B. *Promote advocacy to counter stigmatization*
- C. *Promote broad sectoral commitment- ministries and related organizations*
- D. *Promote and strengthen NGOs community-based organizations, district leadership*
- E. *Develop and strengthen national coordination mechanisms for policies, strategies, resources.*

- AIDS prevention information to their respective groups; reduce stigmatization and discrimination; overcome legal and attitudinal impediments to public information and discussion, develop peer groups to help reinforce the prevention messages, and provide counseling and condom services;**
- 4. Engaging government agencies and private organizations in promoting and providing local care and support services for the AIDS- and STDs-infected;**
 - 5. Providing social and economic support and income alternatives for the infected and affected. This includes alternative incomes for women and families, impacted communities, local group support for orphans.**
 - 6. Analysing and countering economic and social consequences of the impact of AIDS on national social service systems, such as education and health, and on economic production systems, such as loss of middle management, skilled workers, consumers, investors, ...**

These dimensions of the HIV/AIDS pandemic in a country setting suggest that, as the pandemic spreads, it increasingly pervades all aspects of a country's development activity. While at the outset the prevalence of AIDS may appear minimal in number of reported cases¹³ and relatively localized among the population groups and communities, the range and numbers of HIV+ infected population are dramatically larger. Thus, a broad spectrum of public and private response and action is called for.

The multi-sectoral dimensions of the HIV/AIDS programmes are particularly evident in interventions related to prevention through behavioural change, support for impacted households and communities, and counter measures for economic and social consequences. These interventions cannot be compartmentalized as they are interactive with effective prevention and behaviour change requiring, for example, household and community support and action on social and economic consequences.

Work on promoting behaviour change has brought out the need for multi-dimensional approaches to be effective. Information campaigns are essential for promoting awareness among the population in general. But effective information for prevention must be adapted to fit specific target groups: the message and the medium needs to be varied depending on whether the target group is, for example, the military, truck drivers, commercial sex workers, married, single, or potentially child-bearing women, young schoolchildren, adolescent schoolchildren, children not in school, employees in the workplace, etc. The understanding and the involvement of governmental and private organizations, knowledgeable about the characteristics and dynamics of each group, are

essential and go beyond the medical aspects of prevention messages. For example, TASO (The AIDS Support Organization) in Uganda has centres in districts specifically to counsel truck drivers along the Trans-African Highway.

Experience, however, has shown that information campaigns are not sufficient. Knowledge of the causes of AIDS has not induced widespread nor sustained changes in behaviour. Reports from Uganda and Zambia, for example, indicate that 80-90 percent of the population are aware of AIDS and its principal means of transmission. Yet the evidence of changes in behaviour from awareness alone by adopting prevention practices is not encouraging. Information needs to be reinforced by counseling and support services, peer-group example and motivation and, in some instances, by enforcement. For example, the Thailand Government has focused on commercial sex workers who are a major source of HIV infection in the country—education backed up by enforcement. And these efforts need to be reinforced by basic changes in the mores and life styles of large sections of society.

A UNDP report on behaviour change¹⁴ points out that “influences on an individual’s capacity to change include: faith, religion, education, economics, and environmental influences.” It emphasizes the importance of community support and a positive approach to encouraging behaviour changes by promoting alternative economic and social opportunities for individuals at risk. USAID supports in Uganda and Zambia AIDS Information Centres (AICs) to provide confidential testing and counseling to vulnerable population groups. Preliminary reports indicate that over 60,000 people have visited these centres in Uganda. One of the main reasons cited is the desire to know one’s future and, thus, how to plan, protect and prepare, if necessary. A WHO/GPA report on “Effective Approaches to AIDS Prevention” states that “the empowerment and improved status of many affected communities is a prerequisite for effective behaviour. Community programmes are an important component of AIDS prevention strategies.”¹⁵

These considerations make clear that the prevention and control of HIV/AIDS must involve a wide spectrum of groups in all sectors guided by a strategy that identifies the high-risk and most-vulnerable groups. In addition, compassionate care for those already infected is an important part of the process of reinforcing behavior changes among those who are not. Such care is an essential part of HIV/AIDS programming, in any event.

The need to reduce the personal, household, community (including private business) impact of AIDS is also multi-sectoral. First, of course, is the demanding task of caring for the increasing numbers of infected, often with long periods of illness and costly treatments for opportunistic diseases such as TB. This requirement places a major burden on the health care systems which cannot cope without the substantial involvement of community support. It calls for community action to support alternatives to overloaded hospital and clinic services such as home-based care. For example, 60 percent of the hospital beds in Rwanda are occupied by AIDS patients.

At the same time, the impact of AIDS requires support mechanisms for households and communities which lose their economic, parenting and leadership support as their most productive members and their incomes diminish and the numbers of orphans (young and old) increase. And as the HIV/AIDS pandemic becomes more pervasive, the essential economic and social institutions of a developing society are threatened. Schools lose their teachers, health care systems their medical staffs, businesses their trained employees, farms their labourers. The extent and timing of the broad economic and social consequences for the public and private sectors varies among countries and regions and within countries. For those countries more advanced with the AIDS pandemic, the social and economic consequences of AIDS are widespread; for the rest such consequences are only a matter of time, unless the spread of HIV is contained. A World Bank assessment of AIDS in the United Republic of Tanzania illustrates this point.

The report points out that "the rapid spread of AIDS will have far-reaching implications in Tanzania over the next several decades. The National AIDS Control Programme (NACP) estimates that about 800,000 people, or about 3.2 percent of the population, are currently infected with the disease (i.e., are HIV sero-positive). Of these, approximately 60,000 have already developed AIDS... The remainder will develop AIDS sometime between less than one and up to 20 years from the date of infection.... Annual deaths from AIDS are at present estimated at between 20,000 and 30,000, which is 5-7 percent of total deaths. AIDS is believed to have recently surpassed malaria as the leading killer among diseases in adults, and is likely to do so for children in the very near future." The report notes that:

- "the number of infected will reach 5.8 to 17.4 percent of the population by the year 2010. These HIV-infected individuals will suffer debilitating illness ... often in the prime of life. In addition, a much larger number will be indirectly affected: as relatives, many of whom will incur significant costs on account of AIDS victims; as survivors, many of whom will be left in greater poverty; as earners, employers, or self-employers who will experience productivity losses; or as sufferers of other diseases in AIDS-induced resurgence;

- "demographic changes will alter the composition of the population and work force. Earners will have more dependants to provide for, as the ranks of working-age adults are thinned by rising mortality, while the young and the infirm become more numerous...;
- "some sectors, industries, regions, and subgroups will feel the effects much more than others. Kagera region, the worst-hit area so far, will experience massive increases in mortality rates and unattached dependants (orphans, widows, etc.). It is already feeling the labor pinch, with crop production reportedly being adversely affected..."¹⁶

Comparable analyses of the impact and consequences of HIV/AIDS can be cited for other countries in the advanced stages of the pandemic. For those countries, where the number of reported AIDS cases is still relatively small, these heavily afflicted countries stand as a warning of the potential consequences of the spread of HIV among their populations and the need to accelerate not postpone prevention activities. They demonstrate the broad economic and social consequences of the pandemic.

In sum, the multi-sectoral feature of HIV/AIDS programmes stands out as a distinctive characteristic and, thus, a guide for the definition of strategies and the critical importance of effective coordination. The term multi-sectoral tends to obscure the major importance of private organizational roles in districts, village and urban community groups, voluntary service organizations, and businesses. These organizations are the most affected; but they are particularly well placed, given resources and guidance, for addressing prevention, impact and the consequences.

Multi-ministry/organizational dimensions of HIV/AIDS programmes

Matrix figure 2 illustrates the multi-ministry/organization dimensions of governmental and private organizational involvement. Ministries of Health and associated organizations in the health sector carry a major burden of the pandemic in all of its dimensions. However, in the areas of behaviour change, social and economic impact, and economic and social consequences most public and private organizations and community groups have responsibilities and some of them are and should be taking the lead role.

Some examples of multi-ministry roles include:

- **The Ministries of Health:** major responsibilities for epidemiology/surveillance, technical advice on prevention and control policies and interventions to all agencies involved, management of the blood supply and transfusions, education of health care workers, treatment of the infected, addressing the consequences for the health care system over the long term;

MULTI-ORGANIZATIONAL COMPONENTS OF HIV/AIDS STRATEGIES

AREA OF ACTIVITY	ORGANIZATION	GOVERNMENT AGENCIES	NGOS, COMMUNITY, & OTHER SERVICE ORGANIZATIONS	PRIVATE BUSINESS
I. DISCOVERY/ AWARENESS/TRENDS A. <i>Epidemiology: Surveillance/Testing;</i> B. <i>Information contacts: conferences, meetings</i>		Health (Sentinal centres, hospitals and clinics)	NGOs in health	Private hospitals and clinics Business associations Major industrial corporations/parastatals
II. PREVENTION AND CONTROL A. <i>Change behaviour: IEC for general population, high risk groups, youths, workers, women, detect/treat STDs; establish protective norms; eliminate barriers to IEC and prevention methods; counter stigmatization and discrimination; support vulnerable women;</i> B. <i>Promote condom procurement, social marketing and distribution;</i> C. <i>Prevent blood-borne transmission: blood transfusions reduction and screening; drug injections transmissions;</i> D. <i>Prevent HIV transmission in health care setting: train staff, protect equipment;</i> E. <i>Prevent pernatal transmission: IEC, testing, counseling on child-bearing implications</i>	Health, education, labour, defence, social affairs, justice, information Medical stores Health (hospitals and clinics), Information, social services	NGOs generally and their associations, urban/rural community groups NGOs in health	Private hospitals and clinics Business associations, Industrial corporations/parastatals. Commercial suppliers Private hospitals and clinics Business Associations Major industrial corporations/parastatals	
III. REDUCE PERSONAL, HOUSEHOLD, COMMUNITY IMPACT A. <i>Care of the infected: counseling, clinical management; hospital, outpatient and home care services; drug treatment supplies; training of health care staff;</i> B. <i>Social and economic support for patients and families: individual and household income opportunites; family counseling services; community support activities; care of orphans-young and old.</i>	Health (hospitals, clinics, health posts) Medical supplies org. Health, industry, agriculture, labour, education, social services, community development, district offices, finance	NGOs in health NGOs generally and their associations, urban/rural community groups	Private hospitals and clinics Company health units Business associations Major industrial corporations/parastatals	
IV. REDUCE ECONOMIC AND SOCIAL CONSEQUENCES FOR PUBLIC AND PRIVATE SYSTEMS A. <i>Develop through R&D cost/effective practices for surveillance, prevention, care;</i> B. <i>Determine consequences for economic sectors from skills loss, workforce deterioration, consumers, and investors — direct and indirect economic costs to country;</i> C. <i>Determine consequences for social service sector systems.</i>	Economic planning and finance, health, education, information. Economic planning and finance, industry, agriculture, universities and research orgs. Economic planning and finance, health, education, social services, community development, universities and research orgs.	Universities and research Orgs. Universities and research Orgs. Universities and research Orgs.	Business R&D Business associations Major industrial corporations/parastatals Business associations Major industrial corporations/parastatals	

- **The Ministries of Information:** general public awareness and education with their expertise in information technology, dissemination and oversight of major communications media, and the concern for information systems employees;
- **The Ministries of Defence:** addressing prevention, control, and care within the military at all ranks—a high-risk group;
- **The Ministries of Education:** educating schoolchildren, teachers, and school administrators on prevention and addressing the consequences for the educational system over the long term;
- **The Ministries of Social Affairs and Community Development:** working with non-school youth, women's groups, drug users, commercial sex workers, social security programmes, and concern for their own services staffs;
- **The Ministries of Justice:** addressing impediments to HIV/AIDS information dissemination, AIDS infected discrimination, and enforcement requirements, and impact on legal and policing staffs;
- **The Ministries of Labour:** promoting workplace prevention programmes and care support requirements;
- **The Ministries of Interior and Local Government:** supporting provincial and district engagement and community involvement in HIV/AIDS education, prevention, and social and economic impact and consequences;
- **The Ministries of Industry and Agriculture:** determining AIDS consequences for their economic functions and supporting employment and income-generating activity in affected communities and concerns for their large staffs. The industry and agricultural category includes the numerous parastatals such as in mining, export crops, etc., which often have large workforces that are particularly vulnerable to HIV/AIDS;
- **The Ministries of Finance and Economic Planning:** determining the social and economic consequences for national development and the introduction of policies and programmes to counter the impact.

As noted, the private sector represented by the vast complex of community organizations, private voluntary organizations, businesses, educational and research institutions, and religious organizations also have important roles in addressing the HIV/AIDS pandemic. Their involvement is critical and the most important resource for prevention and for reducing the social and economic impact. They present a distinctive dimension to the coordination task. In sum, the multi-sectoral features of HIV/AIDS cut across the entire development process and, thus, must be viewed as a basic development problem to be addressed as a component of all development activity.

The UNDP resident representative's role in encouraging a multi-ministry/sectoral approach to the HIV/AIDS pandemic

Given the above multi-sectoral characteristics of the HIV/AIDS pandemic, how have UNDP resident representatives and their staff helped to promote a broad governmental and non-governmental approach? The answer also has to take into account that the primary responsibility for multi-ministry/ sectoral coordination lies with the Governments.

Of the 45 Governments that provided information on multi-ministry involvement in HIV/AIDS programmes, 29 have engaged 3 or more ministries in addition to the Ministries of Health and 12 are limited to the Ministry of Health only. The extent of other ministry involvement ranges from Thailand involving all the main government ministries (14), the private business sector, and the NGOs, to Cameroon, Nigeria and Honduras, which involve one other ministry, usually education. The pattern of ministry involvement, in addition to the Ministry of Health, is approximately as follows: Education (25), Information/Communications (18), Youth and Sports (16), Defence (12), Social Affairs (11), Labour (8), Justice (8), Internal Affairs (6), Women's Affairs (5), Lands/Housing (4), Tourism (4), Planning and Cooperation (5), Rural and Community Development (3), Foreign Affairs (2), Prime Minister's office and General Secretariat (2) and one each for Trade, Trade Unions, Public Enterprises, Agriculture, Scientific Research.¹⁷

This range of participation is, of course, not static and, as each country perceives the extent of the problem and the actions required, HIV/AIDS programmes will become more pervasive in government operations. The predominance of participation by Ministries of Education, Information, Youth, Defence, and Social Affairs at this point suggests that there is, appropriately, primary concern with prevention activities for the target groups within their spheres of interest except for the Ministries of Information which are largely society wide. The initial work of the Ministries of Health with WHO/GPA support have encouraged a multi-ministry approach for prevention activities.

The UNDP resident representatives' activity has also contributed to the growth of the multi-ministry approach. Of the 60 UNDP resident representatives responding to the questionnaire 48 said that they had undertaken some form of activity to encourage a multi-ministry approach. This activity was largely in the form of sponsoring special multi-ministry meetings, workshops, seminars, and briefings. Some examples of their efforts follow:

Gabon: Within the framework of our GAB/85PO3: Family education project, seven regional workshops have been organized in 1991-92 with the participation of representatives of key ministries (Planning, Education, Health, Culture, and Information) to promote awareness among decision makers in sectoral ministries, community groups and the general public of the importance of family health issues, including STDs and HIV/AIDS, for socio-economic development.

India: A subregional conference held in the northeast was an outgrowth of a field office proposal which the Regional Project took on as one of its activities. WHO played a consulting role in coordination and technical assistance in this workshop. A second activity sponsored by the Regional Project was a briefing for the Planning Commission and DEA; again UNDP, the Regional Project and WHO played a major role in coordination and presentation. The north-east conference brought together NGOs and ministries to raise awareness and to design community intervention initiatives. Results have been good in the north-east conference area with many proposals and activities resulting. The results have been more disappointing in the Planning Commission meeting, as interest still needs to be sparked.

Senegal: Three seminars have been held to encourage a multi-sectoral approach in particular IEC, with the Ministries of Health, Women, Youth Education, and NGOs for Youth and Women.

Nigeria: A multi-sectoral and multi-ministry needs assessment exercise, also including the health ministry, was carried out in 1991, which forms the basis for formulating donor support programmes. UNDP naturally filled its role due to its privileged relationships with the coordinating ministry (Plan), with the line ministries involved (health, education, justice, interior) and with donors.

Central African Republic: UNDP helped the Government to draw up relevant policies but acted as an adviser, leaving full responsibility to national authorities. Advice related to institutional aspects in particular was given.... Direct contacts and involvement of national NGOs in HIV/AIDS activities were favoured by the UNDP NGO focal point; consultations involving the following ministries and public institutions were undertaken:

- Ministries of Plan, Health, Education, Justice, Interior, Scientific Research, Communication and Art, Civil Service;
- National public health laboratory, Red Cross, university, churches, town hall, parent associations in schools, national NGOs, district associations in cities, women's national party associations (UDFC);
- Research institutes such as Institut Pasteur;

UNDP was instrumental in *inter alia*:

- Ensuring relevant parties were referred to in the UNDP funded project;
- Approving needed institutional infrastructure aimed at improving coordination within the HIV/AIDS national programme;
- Integrating the HIV/AIDS item on the agenda for the Ministers of Plan meeting held at the subregional level of Libreville in July-August 1991; and in providing advice to the Government.

Results were satisfactory in general. As reflected in two 1990 reports the involvement of various ministries and institutions helped mobilize public opinion thanks to: media activities, legal instructions reducing the cost of commercially sold condoms, the cooperation of some religious groups, the participation of artists, advertisements during campaigns on HIV/AIDS issues, organization of workshops and meetings by several social groups of ministries, etc....

Chad: This [encouraging national leadership] was done through the approval of the MTP in 1989 and its implementation started in 1990; the plan is still in effect. The AIDS project had organized a number of meetings to inform and to sensitize risk groups such as prostitutes. Meetings also

took place with the Army. Results achieved so far are very good. The following Ministries participate in all AIDS-related activities: Planning and Cooperation (government coordination body), Health and Social Affairs, and Education.

Guyana: The National AIDS Committee which guides the National AIDS Programme has representatives from different Ministries (Health, Education, Home Affairs, etc.) The implementation of the NAP is done through multi-sectoral and multi-ministry activities including numerous workshops, seminars and meetings both in and outside the capital. Main activities: epidemiological surveillance, strengthening laboratory services, treatment and counseling of HIV/AIDS patients, health education public information, management of the NAP including decentralization to local levels of the health system.

Nepal: In 1990, UNDP sponsored a workshop to sensitize donors and the government officials on the issue and to encourage His Majesty's Government/Nepal to adopt a multi-prong approach to the problem. All concerned ministries such as the Ministries of Health, Tourism, Education, Home and the National Planning Commission, participated in the meeting and arising from UNDP's encouragement HMG has formed a high-level AIDS Action Committee to guide the implementation of the Government's strategy for AIDS Prevention and Control. UNDP has taken the lead in the following areas: (a) in organizing the sensitizing meeting in 1990, (b) in producing a tele-film on the AIDS epidemic, which was broadcast over Nepal national television and which was well received and very popular and effective. The coordinating role of UNDP will be enlarged once the project "Economic, Social, and Educational Interventions for HIV/AIDS Prevention and Control" which will be funded by UNDP, has been approved. Main activities: training for health care personnel, rehabilitation and skills training opportunities for female workers who are high-risk category, IEC activities, testing and counseling activities, blood screening activities.

Box B for Botswana provides a more complete story and example of a UNDP resident representative's efforts to promote multi-ministry and sectoral engagement in HIV/AIDS activities. It also brings out the special attention that the UNDP resident representative has given to the social and economic consequences of AIDS. This dimension of the HIV/AIDS pandemic has been less featured in other UNDP resident representatives' work on promoting a multi-sectoral approach. Much of the attention, understandably, has been on prevention activities but more is required to ensure that the national leaders appreciate the seriousness of the issues of the social and economic impact and consequences of the pandemic as described for the United Republic of Tanzania earlier in this report. They also need to understand that behaviour change requires more than just information and education; social support services are also essential.

However, a few UNDP resident representatives referred to efforts to advance government understanding of the broader dimensions of AIDS for social and economic development generally. In Papua New Guinea, the Resident Representative reports that "in 1992 WHO and UNDP co-sponsored a Seminar on the Social and Economic Impact of AIDS in Papua New Guinea with a wide variety of government and non-government leaders invited and participating." In Zambia,

Box B

UNDP Resident Representative's report from Botswana (excerpts)

"Consultations with the WHO Representative are conducted on a regular basis. Since October 1991, I have been participating in the monthly meetings of the AIDS Coordinating Team chaired by the Programme Manager of the National AIDS Control Programme (NACP) and in which the WHO Representative and the WHO adviser on AIDS also participate. I was invited to become a member of the AIDS coordinating team because the NACP management saw the need to involve all sectors of the economy in its programme and the UNDP Representative was seen as the most appropriate person to assist in this effort.

I took the lead role in contacting ministers and other senior government officials to impress upon them the importance of addressing HIV/AIDS as a societal problem rather than as a simply health problem. I was accompanied in all of these meetings by the WHO Representative. These initial contacts paved the way for the March 1992 briefing for all Members of Parliament.

On 26 March 1992, a briefing was organized by the NACP for Members of Parliament. The President of Botswana and officials from WHO, UNDP, and the Ministry of Health also attended this briefing. At this briefing ways in which MPs could assist communities in AIDS preventive activities were discussed. Those MPs who hold ministerial portfolios were encouraged to develop relevant plans for their respective ministries for AIDS prevention. I made a presentation on the socio-economic consequences of HIV/AIDS and the WHO Representative focused on the epidemiological aspects of the disease in her presentation.

On 8-9 July 1992, a two-day meeting was organized by the NACP to discuss the socio-economic consequences of HIV/AIDS at the household, community, country levels and the policy, legal, and financial implications. I chaired a half-day session on the policy legal and financial implications....

The results of the briefings of MPs were very encouraging. Articles started appearing in the news papers on a regular basis reporting on consultations help by MPs with their constituencies on the importance of taking preventive measure against the disease. District health teams were encouraged by several MPs to contact them directly to discuss how MPs could contribute to the teams' activities in AIDS prevention."

the Resident Representative has plans for including an analysis of social and economic impact as part of the country's Long-Term Perspective Studies. Four other donors in Zambia (USAID, World Bank, SIDA, UK/ODA) are either already engaged in some aspect of such studies or are planning to undertake them. This is clearly an area for coordination with, perhaps, a sharing of the costs and/or dividing up the task among sectors or by other criteria. The recently approved HIV/AIDS programme for Uganda includes funding for social and economic studies and the World Bank has just completed some projections of HIV/AIDS impact for Uganda and the report quoted earlier on Tanzania. Other UNDP field offices may have undertaken similar initiatives but in a less formal and systematic manner which now needs to be pursued.

UNDP resident representatives and donor coordination activity

Another dimension of the resident representatives' responsibilities is their work to facilitate coordination among the numerous donors to support multi-sectoral approaches. Such activities are, of course, closely linked to the the UNDP resident representatives' efforts to support the WHO/GPA activity as resident coordinator and to encourage multi-ministry participation. The coordination of the donor Governments, however, is a distinct function that involves either direct leadership of coordination events and/or behind-the-scenes support to other United Nations or bilateral donors and particularly to the Governments' donor coordination responsibilities. This work has generally involved the organization, for the donor community, of sensitization and information meetings on HIV/AIDS, resource mobilization meetings, planning coordination, and, at times, special sessions to coordinate donor views where they may be in conflict or need joint expression to government. In some instances, however, the UNDP resident representatives in their activities to advance donor coordination have encouraged government leadership and worked to strengthen its coordination capacities. Some examples from field reports illustrate how these approaches are being carried out.

Rwanda: "The UNDP Resident Representative and WHO Representative had several meetings with ministers with a view to advocating the need for a multi-sectoral and multi-ministry approach towards the epidemic and for creating the Commission National de Lutte contre le SIDA, which is the national organ coordinating all AIDS interventions in the country. This commission will soon be operational and the Prime Minister agreed on 8 October 1992 to chair it.

"The joint actions of the UNDP Resident Representative and WHO Representative have led the Government to decide to prepare the second plan of action to combat the spread of AIDS and to submit it to donors in June 1993. The Government decided to hold a seminar on developing strategies for the Medium Term Plan on AIDS (MTP2) with UNDP's financial support along

with the technical expertise of WHO/GPA. The seminar was held 28-30 November 1992 in Kigali. The Prime Minister gave the opening speech; sessions were attended by seven other cabinet ministers, all involved in AIDS activities."¹⁸

Gabon: "In the process of formulating the short- and medium-term plan, the UNDP Resident Representative coordinated and convened meetings, including the first donor sensitization meeting. UNDP is currently supporting the implementation of the MTP. UNDP with the technical support of the office of the WHO Representative has convened and/or chaired meetings with the AIDS National Coordinator and donors representatives on the implementation of the National Programme to Combat AIDS, including three external aid donors meetings in 1989, 1991, 1992 respectively. Donors (EEC, France, Belgium, Germany and Canada) look forward to close coordination and have reacted positively to UNDP's involvement in assuming a lead role for this coordination jointly with WHO."

Ghana: "Both the WHO Representative and the UNDP Representative participated in the formulation and implementation of the plan. The UNDP Representative chaired the sessions for discussing the draft MTP and also coordinated the donor sensitization meetings before the Resource Mobilization Meeting was held."

Senegal: "The UNDP office has taken specific responsibility for management, coordination of AIDS donors, donors meetings, evaluation and reprogramming."

In some countries such as Botswana and Thailand, the reports state that the Government is in control of donor coordination and requires little or no assistance from UNDP, for example:

Botswana: "Donor coordination on HIV/AIDS-related matters is done satisfactorily by the NACP. Bi-annual meetings are held to inform all interested parties of the progress of implementation of the MTP, review the coming year's work, and identify areas regarding which external support (technical, financial) is required. As a result of these meetings the NACP has been able to obtain almost the totality of its required funding for its proposed programmes."

The Thailand Government has clearly taken the lead; changes in coordination arrangements are just now in place, however. It was suggested to a team member that some assistance from UNDP for training coordination staff would be desirable.

However, many of the reports indicate that where the HIV/AIDS situation calls for substantial donor assistance, there is a need for improvements in donor coordination by Governments. Comments such as the following are common: "lack of clear functional relationship between the National AIDS Programme and local and international NGOs (Angola), "constant change of authorities in the Ministry of Health has a negative impact on coordination" (Brazil), "National AIDS Programme is outside of Government's mainstream development programme and follow-up to donor meetings and reporting by the office of the AIDS Coordinator is also weak" (Gabon), "there is a need for more sharing of information" (Ghana), "there is a need for the Ministry of Health to explore the feasibility of integrating the NACP into the overall structure of the existing governmental institutions" (Lesotho), "need to involve donors" (Nigeria), "there is a

need for donors to collaborate with Government" (Philippines), "a problem of the dispersal of HIV/AIDS-related small project (Rwanda), "government indifference" (Sierra Leone), "absence of timetable for coordination meetings" (Swaziland), "many uncoordinated bilateral donors" (United Republic of Tanzania), "there is a need to coordinate NGO activity" (Tunisia), "problems of direct funding of beneficiaries" (Uganda), "there should be regular meetings to discuss HIV/AIDS issues" (Zambia). These comments bring out the several features of coordination requirements. Information sharing is basic and one of the most important. The UNDP/Central African Republic report notes that "diffusion of information is poor and usually informal. A magazine Info SIDA has been produced to close this gap."

As the HIV/AIDS pandemic grows and donor involvement increases, the coordination process will become more critical and the UNDP Resident Representative and the United Nations system should be in a position to lead efforts to bring about improvements.

V.

UNDP HIV/AIDS PROGRAMME INITIATIVES

The terms of reference for this report did not call for a review of UNDP programme initiatives for addressing the HIV/AIDS pandemic. As these initiatives are an important tool of the United Nations resident coordinator/UNDP resident representative, however, we would be amiss not to refer to them. They are becoming each year an increasingly important part of the United Nations system's response to HIV/AIDS. They are an added dimension to the coordination task within the United Nations system and for the Governments and donors.

The UNDP HIV/AIDS policy statement calls on UNDP to give particular attention to "strengthen and expand the capacity of communities to respond to the pandemic and promote and assist prevention, care, support and treatment programmes for women." The UNDP mandates for capacity building, national execution, programme approach, national policy development, long-term perspective studies are also applicable to HIV/AIDS programming. A separate study will be required to identify all of the UNDP-funded activities and determine their effectiveness. Most of them are very new and, thus, not yet amenable to performance evaluations. However, a systematic examination of UNDP initiatives along with those of other United Nations agencies should be undertaken as an important base of information for any coordination activity.

A preliminary review of country plans for the coming cycle reveals a number of important, though for the most part, modest initiatives. In the Africa region, 15 of 35 countries have specific IPF allocations for HIV/AIDS activities for the 5th Cycle ranging from \$50,000 in Equatorial Guinea to \$15.5 million for Uganda. IPF allocations were not specified for 11 of the countries, in large part because the HIV/AIDS activity has been integrated into other areas of programme concentration, such as "Health and Education" in Mali. Overall, 26 of the 35 African programmes are planning HIV/AIDS projects for the 5th Cycle. Nine had no plans or information was not available.

In the Asia and Pacific region (13 countries), 3 countries have made specific IPF allocations: \$105,495 for Myanmar, \$150,000 for Papua New Guinea, and \$1.1 million for Sri Lanka. The Thailand programme for HIV/AIDS is integrated in its Human Resources Development concentration. In the Latin America and Caribbean Region (15 countries), the only IPF allocation is for Jamaica of \$250,000. In the Arab States region (9 countries), IPF allocations have been made for 3 countries, i.e., Djibouti, Morocco and Algeria.

Box C

**UNDP Uganda Areas of IPF activity
1992-1996**

A. HIV transmission

1. IEC: raising effectiveness, building capacity, training
2. Evaluating behavior change: developing new models
3. Areas of low infection: developing and applying interventions
4. Women's vulnerability to HIV: analysis and service delivery
5. STDs: programme support, drugs/supplies with a focus on women
6. Prisoners and refugees: evaluation of needs and focus on their HIV risk factors
7. Other activities (e.g. focus on the military, formation of blood donor clubs, promotion of cheap HIV testing)

B. Economic and social impacts

1. Effects of female morbidity and mortality on socio-economic performance
2. Social indicators: prediction and policy strategies
3. Human resource balance: prediction and policy
4. New approaches to modeling economic and social impact
5. Micro-projects: community grants
6. Community monitoring and follow-up activities
7. Impact studies in agriculture and education

C. Caring

1. Community-based care
2. Orphans and other vulnerable children: evaluating structures and needs; development of interventions
3. Community development

D. Strengthening organizational structures

1. Local administration: evaluation of needs and capacity building
2. Uganda AIDS Commission: professional development, consultancies, studies support
3. Ministry of Finance and Economic Planning: professional development, new planning model
4. Private sector: structural evaluation and institutional innovation
5. Strengthening NGO and community-based structures, evaluation of activities, strengths, weaknesses, support including capacity building
6. Workshop programme for all sections
7. Support to ministries AIDS Control Programmes.

From "Uganda HIV/AIDS and Development Programme:
UNDP Strategy for Cooperation: 1992-1996"

In addition to the country IPFs, there are regional HIV/AIDS programmes which are available to support country initiatives. In sub-Saharan Africa, the IPF for 1992 is \$770,000 to finance the continuation of the \$1.2 million project "Confronting the socio-economic impact of AIDS in sub-Saharan Africa" which began in 1991. A \$5 million regional project for the 5th IPF Cycle finances the continuation of the "Strengthening multi-sectoral and community responses to the HIV/AIDS epidemic" project. A total of \$7.6 million is available from the SPR funds to improve the quality and effectiveness of IPF-funded programmes and to support activities aimed at minimizing the impact of HIV/AIDS on development. This latter began in 1992 and is primarily for the Africa and Asia/Pacific regions.

The country funds are intended to support national AIDS programmes in such areas as prevention, home-based care, orphans, education and training, information, government coordination support, community-based organizations and women's groups, decentralization of AIDS control activities to district and community levels, strengthening NGO capacities. As was discussed in the chapter on the United Nations resident coordinator function, some of these allocations are for WHO executed activities and tie in directly with the MTPs. Other amounts are allocated for the social and economic impact aspects of HIV/AIDS. The Congo, Cote d'Ivoire, Malawi, Rwanda, Swaziland, Uganda, Zambia, Papua New Guinea (possibly others) are planning social and economic impact studies and seminars. Regional funds are also available for this purpose.

Uganda stands out in its IPF allocation of \$15.5 million for a HIV/AIDS programme for the 5th Cycle. Its recently approved five-year programme will concentrate on four areas. They are, with percentages of planned funding: HIV transmission (18 percent), economic and social impacts (25 percent), caring (26 percent), and strengthening organizational structures (25 percent). The balance—6.5 percent—is for programme management. Box C above summarizes the main activity components under each of these categories. About three quarters of the funding is planned to address aspects of social and economic impact and related consequences. Support for NGO and community based organizations through direct micro-grants and local institutional strengthening is a major thrust of the programme helping those individuals and groups adversely affected by HIV/AIDS as well as those infected. Increasing the knowledge base about HIV/AIDS and its impact and policy ramifications and related professional development are also to be supported. The activities in the HIV transmission area reflect the fact that most assistance from other donors is for prevention activity. Thus, the UNDP programme has identified possible gaps to address such groups as women's vulnerability and exposure to STDs, prisoners and refugees, infected but neglected regions. Capacity building is a theme throughout the various activities.

The "Grants for Micro-project Programme to Combat AIDS" is a major activity for UNDP/ Uganda's HIV/AIDS programme. The field office has already had some beneficial experience with such grants and is enthusiastic about enlarging the programme. Its aim is to "reduce the adverse effects of the disease by providing financial resources and technical assistance. The target groups are households and communities considered most vulnerable. The grants are to NGOs and community-based organizations. Some of the micro-grants have been used to support home care for orphans involving poultry and trading as income sources; a piggery and poultry project for a sub-county group of orphans, women, men and AIDS patients; a tailoring project for a local NGO assisting orphans, women, men and HIV/AIDS patients; and a dairy and farming project for 115 orphans.

An interesting variation on UNDP involvement in HIV/AIDS programmes is the recent proposal in Brazil that, at the request of the Ministry of Health, UNDP administer a \$125 million World Bank loan for HIV/AIDS. UNDP is expected to help with institutional development by providing management support including planning assistance for state and municipal institutions. The Ministry of Health is also asking UNDP to assist in screening and evaluating HIV/AIDS project proposals.

UNDP programming for HIV/AIDS activities will be growing rapidly over the coming months and years. Some of the UNDP projects to date suggest possible types of beneficial activity; however, a more in-depth examination is required followed by more precise guidance than is available currently. UNDP's increased direct assistance on HIV/AIDS activities supporting multi-sectoral/ministry involvement, however, needs to be balanced with its important responsibilities for strengthening government coordination functions.

VI. ASSESSMENT OVERVIEW

This assessment of the United Nations resident coordinators'/ UNDP resident representatives' role in HIV/AIDS programmes is a snapshot in time. It reflects their understanding of HIV/AIDS, interpretation of the local situations, and the guidance provided them prior to 1992. Their involvement will likely change significantly in 1992 and after to more active leadership. Their increased involvement will be the result of the growing realization of the HIV/AIDS pandemic in the countries in which they are working and the increased intensity and specificity of the guidance messages and meetings set up to educate them about the problem and their role in addressing it.

The range of responses, described earlier, suggests that the priority assigned to the HIV/AIDS pandemic by the United Nations system and UNDP and the guidance on the role of the United Nations resident coordinators/UNDP representatives in addressing it, have been uneven and unclear across the regions. The four regions of UNDP have interpreted available guidance differently and with different degrees of concern and priority. This has, in turn, affected how the coordinators/representatives have acted or not acted. Given the many priorities the regions and the field offices are asked to address, the differences in interpretation and action may be understandable. The representatives also are, of course, very much influenced by government concerns and priorities and by government views on United Nations agency participation.

These factors may explain, in part, why, for example, UNDP/Uganda has a \$15.5 million UNDP HIV/AIDS programme resulting from considerable headquarters participation but UNDP/Zambia with a similar HIV/AIDS situation has only a minor involvement. They may explain why the UNDP Asia/Pacific region is just beginning to be engaged and the UNDP Latin America and Caribbean and Arab States regions, are essentially not engaged. The importance of early action to limit the spread of HIV with consequent substantial savings in costs to national economies and lives has not been fully recognized within UNDP. And where it has, hesitations about pressing unaware and unconcerned Governments have predominated. The reluctance of some Governments to permit the use of IPF funds for HIV/AIDS activities is certainly inhibiting, although in some instances regional funds have provided an alternative resource.

Part of the explanation for the variations in the coordinators'/ representatives' responses lies in the uncertainties about leadership responsibilities in the field between WHO/GPA and UNDP. At the outset, the message, even after taking into account the UNDP/WHO Alliance guidance of

1988, has been that HIV/AIDS is WHO's problem to address with the Ministries of Health and, thus, the responsibility of the WHO representative. Initially, available IPF funds were to be transferred to WHO/GPA. This message has been reinforced by the WHO/GPA MTP guidance, which focuses on some essential, but narrowly defined, components of a national AIDS strategy. This guidance is not United Nations system-wide guidance. In addition, the distinctions between those prevention, care and impact activities that are directly health-related and those that are associated with the social and economic dimensions are not as clear-cut as may appear at first. More elaboration of the spectrum of components of a comprehensive HIV/AIDS strategy is required to guide the planning of specific interventions. However, for the most part the United Nations resident coordinators/UNDP resident representatives have cooperated with the WHO representative and worked to support their activities.

Multi-sector approaches

Efforts to promote multi-sectoral approaches appears to be developing rapidly. As cited earlier, several of the UNDP resident representatives have been effective in engaging a broad spectrum of ministries with the WHO representatives participating with technical support. They have also been helpful in involving the private NGO community. The activities of the UNDP Representatives in Rwanda, Botswana, the Central African Republic and Nepal appear to be examples of what works.

However, the guidance for non-health ministries is less clear on their responsibilities for addressing the HIV/AIDS pandemic, i.e., other than awareness sensitization and IEC activities. Beyond IEC activities directed at interest groups pertinent to each ministry's affairs, have they been encouraged to provide social and economic support for affected employees, households and/or communities within the scope of their responsibilities? Have they been encouraged to undertake the analyses of social and economic impact and consequences for their sector? Do they have personnel policies on AIDS for their staff? In sum, have "scopes of work" been prepared for each ministry and agency involved? Perhaps this has been done, but our field visits and the questionnaires did not indicate that it had. Moreover, if they have, have they also received resources from Government and donors to carry out their assignments as has been the case in Thailand?

The most important dimension of multi-sector approaches is the involvement of the private sector. Several UNDP representatives have been particularly sensitive about working with the NGOs building on their earlier established relations and drawing them into HIV/AIDS activity.

Box D

Main requirements of successful national programme coordination

Successful coordination of national programmes requires:

- 1. Comprehensive and current information and analysis of the development issue in its several dimensions and trends and its relative priority among other development goals and objectives;**
- 2. A broad awareness and understanding by leaders in public and private roles of the issue and its implications;**
- 3. Well-defined statement of goals, objectives, and target/beneficiary groups with measurable/observable indicators of performance and impact developed through a board-based participatory process and with a strategy spelling out the complementary roles of who does what;**
- 4. A mechanism such as a commission or committee which is broadly representative of public and private organizations with high-level support to provide guidance on objectives, promote collaboration, identify basic issues of cooperation and performance, and promote wide communication;**
- 5. A commission/committee chair and membership selected for their ability to provide knowledgeable inputs, facilitate cooperation, and inspire participation and with a clear mandate for their mission;**
- 6. A programme management unit reporting to the commission/committee which has high managerial competence and technical capacity for developing a national strategy and operating policies (i) linking objectives with current knowledge of the relevant technological, economic, social, and institutional approaches and capacities; (ii) orchestrating (not controlling or implementing) public and private participation in planning and implementation; (iii) mobilizing domestic and external resources with financial plans and their integration in established budget systems; (iv) maintaining broad political support; (v) facilitating other public and private organizational implementation, (vi) monitoring and evaluating performance and results; (note: as a rule those responsible for managing/orchestrating the national programme strategy should not have implementation responsibilities for any part of it) ;**
- 7. A system for open and frequent reporting and information sharing (periodic meetings, workshops, conferences) with (i) an up-to-date database on who is doing what, where, when, and what works, and (ii) opportunities for problem identification, policy guidance, and collaboration on areas of common interest and special policy or programme issues;**
- 8. Complementary coordination mechanisms associated with different participating group interests such as the NGOs and community-based organizations, private businesses, affected peer groups, technical specializations (blood screening, AIDS information centres, etc.)**

The overall purpose of well-orchestrated coordination is to counterbalance the strong compartmentalization drives of donors and their government agency counterparts and their competitiveness for funds, projects of special interest, and skilled personnel. The coordination process, above all, must keep the larger goals and objectives of national programmes and the monitoring of their achievements (or lack thereof) consistently and forcefully before all participants.

The NGOs' requirements include technical and managerial guidance, a modest level of resources (over-funding can be as disruptive as under-funding), and support in obtaining government cooperation and guidance without control. The micro-grants programme and related institutional assistance in Uganda appears to be responsive and working to address immediate needs resulting from the HIV/AIDS epidemic. This type of programme will need more systematic support from government services such as in primary health care, education facilities, etc. to be sustainable over the long term. The UNDP resident representatives' work to engage the business community as part of their multi-sector tasks for HIV/AIDS appears to be minimal but a more detailed review is required to determine what is taking place.

Coordination of HIV/AIDS activity

Support for the coordination of HIV/AIDS activities and related assistance stands out as one of the primary tasks for the United Nations resident coordinators/ UNDP resident representatives both as the country coordinator for the United Nations system and as UNDP's programme manager. This role is not unique to the HIV/AIDS pandemic but the pandemic accentuates and focuses the need for more effective action on coordination. The overall purpose of well orchestrated coordination is to counterbalance the strong compartmentalization tendencies of donors and their government agency counterparts and their competitive drives for funds, projects of special interest, and skilled personnel. The coordination process, above all, must keep the larger goals and objectives of HIV/AIDS programmes and their achievements (or lack thereof) consistently and forcefully before all participants.

Effective coordination requires careful planning and skilful leadership; it is not something that can be left to ad hoc impulses and simply agreeing to have meetings from time to time. Box D above provides a conceptual framework of the elements of successful programme coordination. A basic feature is the importance of weighing the costs and benefits to the participants. For example, what is the effect of the coordination activity on the time and resources of those asked to join? Will they benefit in new learning and opportunities to share concerns and promote needed policy changes? Will the new requirements flowing from coordination activity be backed up by additional resources or are the participants being asked to take on new tasks with their existing resources? Are the levels of officials participating appropriate for making commitments to jointly agreed actions and, generally, speaking authoritatively about their activities? Is there a systematically developed and up-to-date database on who is doing what and where?

There have been many meetings and sessions to coordinate HIV/AIDS programmes reported in the responses to the questionnaires and observed from the team's field visits. Several reports and field visits indicate difficulties in organizing national HIV/AIDS committees or commissions, despite high-level encouragement. These problems may result from the failure of leadership, lack of definition of functions and authorities, or reluctance to become engaged in HIV/AIDS matters. Also the difficulties reflect the shifting scope of the HIV/AIDS problem from primarily a health issue to a development issue and to the major increases in the number of donors—governmental and NGO. In some countries little or no coordination is taking place or once started has not been sustained. The excessive competitiveness of the donor community also seems to impede coordination. Some officials have expressed concerns about the effectiveness and efficiency of some of the coordination meetings. Meeting only twice a year, as many reported, does not seem adequate for the dynamic engagement of participants in policy and programming, particularly for HIV/AIDS programmes which are evolving rapidly with many new players. The absence of knowledgeable representation and the lack of opportunities for policy and programming dialogues are also concerns; many meetings tend to be dominated by government officials lecturing participants rather than facilitating exchanges.

The primary prerequisite for effective coordination is to have a clear purpose (a national goal) for the coordination effort, an agreed strategy with objectives for achieving the goal. Effective coordination also requires a broad base of public and private sector and donor participation and endorsement. In the initial period, the MTPs may have helped to serve this purpose, yet, as has been found, some donors and government agencies involved in HIV/AIDS activity are not cooperating with the MTPs. This lack of cooperation stems from failure to include participants in the MTPs planning processes, the narrow scope of the MTPs, and the tendency to see them as the preserve of the Ministries of Health and WHO/GPA. They are not truly national HIV/AIDS plans and strategies with broad bases of public and private sector and donor endorsement. They should engage the Governments' planning, budgetary and resource allocation systems rather than operate outside them, as seems to be the pattern. In Thailand, all of the ministries have their own budgets for HIV/AIDS activities coordinated through the budget system.

Another feature of the coordination process is the need for a competent secretariat. Most secretariats often involve added workloads to those already fully employed. For HIV/AIDS, they are for the most part based in the Ministries of Health. As the dimensions of the pandemic become more widespread and a matter of national urgency, they will likely move to a separate commission-cum-secretariat reporting to the head of government and the cabinet. However, the insertion of a central coordination unit for a special development problem into established governmental

bureaucracies frequently causes difficulties and resentment. Where they are funded by donors such as in Uganda (World Bank, USAID, UNDP, UNICEF)—no matter how necessary—they can be a lightning rod for criticism for receiving favoured treatment and extra benefits compared to the rest of the bureaucracy. If they attempt to take on operational activities, they can generate opposition from those who consider such activities their responsibility. It, thus, takes a politically savvy manager to lead these units with more than technical expertise and skills in administration.

In several of the countries reporting and visited, the coordination mechanisms were in a state of transition and turmoil in personnel changes (lack of leadership and political savvy, for example), changing organizational arrangements within Ministries, and shifting locations of responsibility within government. Shifts in the scope of responsibility of the coordinating body add to the turmoil: a council for HIV/AIDS alone, a council for national health including HIV/AIDS, or integration in national planning bodies. In some of the countries this turmoil is a result of frequent changes in Ministry of Health leadership and ministry reorganizations, primarily towards decentralization of operations. This turmoil is unfortunate as it diverts attention from urgent programme tasks. It is, perhaps, inevitable as the HIV/AIDS pandemic spreads, the need to intensify a wide range of services grows, and Governments adjust to these changing circumstances..

Thailand is probably the most advanced in having an effective coordination mechanism for HIV/AIDS; yet this mechanism is new and largely dependent at the centre on the skills of one able person. The Government seeks support from UNDP to strengthen the staff operations of its coordination unit. Uganda has had difficulties with the formation of the national commission and with its secretariat; it is only within the coming months that it is likely to become fully effective. Zambia had a national committee but it did not function and was terminated; a new National Health Council is being planned. Rwanda is working to integrate the HIV/AIDS issues into its overall development planning processes.

For the most part, the UNDP representatives do not appear to be particularly active in promoting and supporting Government mechanisms for the coordination of HIV/AIDS programmes. They have taken the lead in calling and chairing special meetings for awareness purposes or for mobilizing funds, but there is little evidence of support for institutionalizing government coordination arrangements. There are a few examples of assistance with training and facilities but no systematic approach to capacity building to strengthen government coordination of HIV/AIDS programmes has been observed.

While the situation varies by country, the resident donors, generally, do not wish to have the UNDP resident representatives formally lead the coordination process. However, they do look to the representatives to provide opportunities for information exchanges and organize occasional gatherings on issues of common concern. And they do expect UNDP to assist in strengthening government coordination. The common official view is, of course, that Governments should lead coordination efforts. The stronger Governments take on this responsibility without question but look to UNDP, at times, for support. The weaker Governments often defer to UNDP and/or WHO to provide some of the leadership in coordination, such as for the mobilization of resources. Similarly, they look to UNDP to take on a more active support role to help build national capacities for coordination and operations.

Similarly, the UNDP resident representatives as resident coordinators have not been particularly vigorous in organizing systematic coordination arrangements with the United Nations system of agencies for HIV/AIDS programming. While the topic is discussed in monthly inter-agency meetings and occasional special sessions, there is no framework for well-coordinated action. As the various United Nations agencies become more involved with HIV/AIDS projects, there will be a need for more structured arrangements such as having a common strategy for United Nations programming. The recent requirement that UNDP organize IEC sessions for all United Nations staff on AIDS is an important first step.

Information and coordination: One of the most practical, effective and relatively easily accomplished coordination tasks is the provision of up-to-date information on who is doing what and where in HIV/AIDS programmes. Those individuals at the centre of HIV/AIDS activity tend, of course, to have a personal knowledge of what is going on in AIDS programmes. But the team found almost no instances of systematic efforts to gather, analyse, and disseminate information on the many programmes being carried out by Government, donors, NGOs, and private business. Some of the national strategy documents list donor activity but these tend to be in aggregates and thus not helpful for coordination on specific activities such as who is working on blood-screening, who is assisting with orphans, or what socio-economic studies are under way or planned. This task is essentially the same as the one UNDP carries out with Governments in the preparation of the Development Cooperation Reports (DCRs). Current information on programmes and their status can be particularly effective in facilitating coordination. Periodic meetings where participants report on their work needs to be reinforced by regular reports. Such information is essential for monitoring progress and accomplishments.

Effective coordination through information sharing needs most of all to have the encouragement of top management in each of the participating organizations. Some donor staffs have commented that they coordinate very well at the informal level but they are constrained by superiors who, for various reasons, want to "hold their cards close the chest."

Decentralized coordination: One of the main tasks of government coordination activity is to encourage and facilitate decentralized coordination—coordination on the front-lines of HIV/AIDS prevention and social and economic support. This involves decentralization of coordination for technical and policy issues and for the participation of NGOs, district governments, community-based organizations, and private businesses.

The creation of a central secretariat to lead national government planning and coordination under a national commission can lead to the over-centralization of HIV/AIDS programme management and control. Much of the technical guidance and policy development required for HIV/AIDS programmes needs to be delegated to those with appropriate competences. Policies on such topics as discrimination, access to condoms, home-based care services, confidential testing are a few examples of the many topics that require the attention of knowledgeable experts. While the central coordination commission and secretariat may take the lead in identifying areas needing policy guidance, the work should be delegated to knowledgeable groups. The team noted situations where the failure to delegate has created disruptive frictions. UNDP in its support for coordination can help promote more systematic planning and delegation for this policy work through its advice and funding of policy studies.

The NGOs generally welcome some coordination provided it does not become directive and regulative. The rapid growth in the numbers of NGOs, in general and in HIV/AIDS activity, is notable. To gain the most benefit from their initiatives, they require mechanisms for sharing experience, learning about as well as influencing policies and practices, avoiding duplicative activity, and constraining those NGOs with exploitative tendencies. UNDP with its linkages with the NGO community can perform a useful role in facilitating and promoting NGO coordination. It can also help moderate the relationships of NGOs with governments that are often characterized by mutual distrust. It can provide through coordination mechanisms the small amounts of funds and technical services mentioned earlier that are critical to improving NGO programme planning, financial management and field operations. (See Box E below.)

Box E

What local NGOs can do—an example?

The Director of the Family Health Trust in Zambia told about one of their success stories. They are working with a family in which both parents have died from AIDS. The parents supported 13 children. The oldest child—now 26 and married—determined to return to help her brothers and sisters. (Her husband left her when she made this decision, it appears.) How was she to support her siblings?

The social worker from Family Health Trust agreed to work with the family. As a result, they developed together a small enterprise to provide sandwiches at lunch-time for office workers. The children help prepare the sandwiches and market them throughout the city. In time, the income from this activity has enabled this family to become more self-sufficient and rent a larger house to accommodate all of them.

The social worker continues to provide counseling. But this AIDS-affected family has become self-supporting.

To multiply this type of service for HIV/AIDS activity, the Director noted that the NGOs need help with simple educational materials suitable for their clients, technical assistance in management and accounting practices, and some additional funding. They also need opportunities to exchange information on experiences and best approaches with other NGOs and experts on HIV/AIDS.

The other important dimension of decentralized coordination is support to district and community-based HIV/AIDS operations. The key to success in HIV/AIDS prevention and related support services is the stimulation of local government, community, and group self-help activity. NGOs are an important participant in this work but district governments and village organizations also need support in coordinating HIV/AIDS activities in their communities. The Governing Council's guidelines emphasize this work as a priority for UNDP. Some of the field offices are engaged in this dimension of HIV/AIDS activity. In Zambia, UNDP has a pilot project with United Nations Volunteers (UNVs) working with three district governments; UNDP/Uganda's micro-grants programme is another example. The UNDP HIV/AIDS programme in Ethiopia emphasizes support at the district level. Generally, support for associations of community organizations locally and nationally is desirable to improve coordination of rapidly growing HIV/AIDS activities. Similar associations among the business community are also important and, where lagging, an area for UNDP initiatives.

In sum, effective coordination is a full-time job as the above suggests. It requires thoughtful and experienced leadership. A strategy for coordination should be a major component of national AIDS strategies.

UNDP programming for HIV/AIDS activity

UNDP field office programming for HIV/AIDS activities seems to fall into several categories, i.e.:

- Use of non-IPF resources (SPR, regional projects) for awareness promotion activities and related studies;
- Small allocations of IPF funds for special HIV/AIDS projects;
- Integration of HIV/AIDS activities into an established project;
- Integration of HIV/AIDS activities in all sectors of concentration
- A major sector of concentration just for HIV/AIDS projects.

The team did not review these programmes specifically but noted what appears to be a lack of guidance from Headquarters on how best to address the HIV/AIDS pandemic in UNDP programming. It may be that the above variations are appropriate and suitable to the local situations. But, as the pandemic grows, clearer guidance will be required. Such guidance will be directly pertinent to aiding the coordination and programme management functions of the United Nations coordinators/UNDP representatives.

United Nations resident coordinators, other United Nations agencies and a unified strategy

The review of United Nations resident coordinators' leadership in coordinating United Nations agency participation in HIV/AIDS programming brings out the relatively ad hoc nature of United Nations agency coordination in the field. Certainly the AIDS issue is discussed in United Nations coordinators' monthly meetings. Also, there are instances where two or three agencies have joined together on common activities. The UNDP/WHO relationship in the field, which is of particular importance, has also been illustrated.

What appears to be happening, however, is that each United Nations agency in the field is developing its own HIV/AIDS activities and only loosely coordinating with other agencies and donors. The agencies are responding to both their own headquarters' directives, to the general Economic and Social Council encouragement to participate because of the multi-sectoral nature of the pandemic, and to separate government requests. Such initiatives are desirable. Their impact and the visibility are diffused, however, and the influence of the United Nations system dissipated as a consequence.

Thus, it would seem desirable for the United Nations in each country to have a unified strategy consistent with that of the governments or, where the latter is lacking, leading the way. The development of such a unified strategy by the United Nations agencies in-country would help to ensure that each contribution is complementary, gaps are identified and addressed, and common approaches are followed for cross-cutting concerns. Such concerns include national execution and implementation, capacity-building measures, transparency in use of funds, support services for women and orphans, social and economic impact studies, monitoring and evaluating procedures, common approaches to counterpart ministries where each agency has distinctive influence, and, most important for HIV/AIDS, behaviour change interventions. Such a unified strategy would benefit from inter-relating the experience and specializations of the specialized agencies such as those of WHO for medical technologies, UNFPA on family planning approaches, UNICEF on children, WFP on community and family food support, and UNDP on capacity building.

Each strategy would reflect the stage in the development of the HIV/AIDS pandemic in the country but allow for modifications to ensure the anticipation of requirements as the pandemic evolves. Having such a strategy for each country should not inhibit each agency in following through with its own project design and implementation as its agency's policies dictate. With a unified strategy, the United Nations system of agencies would be in a better position to influence

governments and other donors and provide more significant leadership in the country. The United Nations resident coordinator is well placed to provide the leadership within the United Nations system to oversee the development of such a strategy and related coordination activity.

United Nations staff capacities in the field offices

UNDP does not now have in the field the staff capacities to plan and administer an expanded programme for HIV/AIDS. UNDP can and does draw on the WHO representatives on technical policy matters and practices and on the other agencies in their area of specialization. However, their capacities for expanded programmes appear limited. The UNDP office in Uganda, reflecting its major HIV/AIDS programme plans, has a Ugandan public health officer, a project development officer, and UNV assigned to its HIV/AIDS unit. Given the size and complexity, even this generous staffing will be stretched in its work to design, implement and monitor all of the numerous activities in the \$15.5 million programme. This staffing is not the rule, however, as most UNDP offices do not have anyone with full-time responsibility for AIDS activities and, at best, the part time of one of the staff members already preoccupied with other responsibilities.

The staff limitations are particularly troublesome when policies and plans are implemented. The team did not examine the questions of HIV/AIDS programme implementation. But the issue came up repeatedly as a major concern about United Nations agency performance. Awareness promotion, and the expectations it generates, is both relatively easy and dangerous if the more difficult task of implementation does not follow with rapid, effective responses. The team was told of problems in such areas as the prompt recruitment of competent technical personnel, delivery of supplies (particularly condoms), and the disbursements of grants. Problems with design, information, and reporting requirements and lack of transparent accounting and reporting were also mentioned. These problems, while in some instances systems problems, reflect the shortage of skilled, experienced personnel in the field offices with time to devote to HIV/AIDS activities.

Overview of UNDP and United Nations agency roles in HIV/AIDS programmes

Pages iii and iv of the present report contain statements about the HIV/AIDS situation worldwide and in Africa—present and prospective. They reflect the views of those most directly engaged in the HIV/AIDS pandemic and, with the adoption of the 1992 Global Strategy statement, those of

the principal donors. The views of the African heads of State is summarized since Africa is the region with the most advanced prevalence of HIV/AIDS and forewarner of what may be expected in other regions.

The HIV/AIDS problem reflected in these statements makes it clear that it is a major global development problem with potentially devastating consequences for developing countries. These statements are the context for the team's assessment of the United Nations resident coordinators'/UNDP resident representatives' role in HIV/AIDS programmes. The team concludes that the United Nations system of agencies in the developing countries is not now in a position to provide the leadership and support that the countries will require to address the HIV/AIDS pandemic. Other donors—multilateral and bilateral—are moving, some reluctantly, to assume this role. Where Governments are strong and have their own resources, they should be able to provide much of the leadership required. But most of the developing countries, which are in financial difficulties, critically short of trained personnel, and confronting a number of crises, need substantial support in the planning, management, coordination, and execution of HIV/AIDS programmes in all sectors. This applies equally to Governments and to the private sectors—at the national, district and community levels.

WHO is providing the technical policy support in-country on HIV/AIDS that is required by the Ministries of Health. Given the enormous burdens that HIV/AIDS imposes on these ministries, WHO, along with other donors interested in working in the health sector, has a major task ahead in this sector alone. Substantial improvements in health sector capacities are important for building the essential core of prevention and health care services required for HIV/AIDS and for focusing on the key interventions and target groups most likely to reduce the transmission of HIV.

In addition, however, greater attention is required to HIV/AIDS development requirements in the other sectors and to supporting community and NGO activity. In this work, the United Nations system of agencies in the developing countries have the potential for providing constructive support and leadership that can be critical in confronting the development crisis HIV/AIDS presents. But without substantial direction from United Nations leadership and systematic processes for coordinating plans and operations in the field, this United Nations role will not materialize and separate agency initiatives will only add to coordination and execution difficulties. The United Nations system needs to be mobilized to undertake this task.

VI.
**ALTERNATIVE SCENARIOS FOR
UNITED NATIONS RESIDENT COORDINATORS/
UNDP RESIDENT REPRESENTATIVES
IN HIV/AIDS PROGRAMMES**

How should the United Nations resident coordinators/UNDP resident representatives respond to the HIV/AIDS pandemic in their respective countries? The discussion in the previous chapters illustrate how some have and have not responded. Four alternative scenarios appear open to them for the future. There can be, of course, numerous variations but these four present the basic features. In all of the scenarios it is assumed that Governments have the primary coordination and decision-making responsibility, although the degree of government initiative and capability varies substantially from country to country.

Scenario 1: "HIV/AIDS is WHO/GPA's business."— UNDP not or only minimally involved.

This approach leaves to WHO and the MOH the task of addressing the HIV/AIDS problem as a medical and health concern. The United Nations resident coordinator/UNDP resident representative may provide some minimal support, help facilitate the WHO representatives work, and provide small sums to WHO/GPA. However, the UNDP resident representative takes no independent action with the Government. The resident coordinator arranges IEC meetings for United Nations personnel on HIV/AIDS and United Nations personnel policies. HIV/AIDS is discussed in the coordinator's monthly United Nations staff meetings. Other United Nations agencies proceed independently as instructed by their headquarters. UNDP attends donor meetings as one of the donors, if IPF funds are to be provided.

Scenario 2: Co-coordinators: HIV/AIDS is the joint responsibility of the United Nations resident coordinators and the WHO/GPA representative.

This approach, as some field offices have adopted, calls for both the WHO and UNDP resident representatives to provide leadership on policy and programme coordination. It requires an allocation of tasks as to when each takes the lead, largely based on which representative can be effective with Governments and donors. Similarly, such funds as are available from regional or IPF sources are allocated to the GPA Trust Fund and to special UNDP projects executed by WHO and/or the MOH. Other agencies continue independently joining in some activities of

common interest. The resident coordinator arranges IEC meetings for United Nations personnel on HIV/AIDS and United Nations personnel policies. HIV/AIDS is discussed in the coordinator's monthly United Nations staff meetings. UNDP attends donor meetings as one of the donors, if IPF funds are to be provided.

Scenario 3: UNDP leads coordination: HIV/AIDS is the United Nations resident coordinator's/UNDP resident representative's responsibility to lead relying on WHO/GPA for technical guidance.

This approach, also evident in field actions, requires that the UNDP resident representatives actively take the lead in coordinating HIV/AIDS policy and programming with the Government. They lead the planning work with WHO guidance, organize multi-sector awareness and resource mobilization meetings, provide support to government coordination units, allocate IPF funds for ad hoc HIV/AIDS projects for government/WHO or other agency execution, call donor meetings when situations require it, work with NGOs as a liaison on coordination with the Government. WHO provides technical support and guidance to UNDP and other agencies and works with the MOH on planning improvements in health services linked to AIDS. UNDP initiates meetings and studies on the social and economic impact of AIDS. The resident coordinators arrange IEC meetings for United Nations personnel on HIV/AIDS and United Nations personnel policies. HIV/AIDS is discussed in the coordinator's monthly United Nations staff meetings. They also promote reviews of the impact of HIV/AIDS on United Nations activities and encourage selective United Nations agency joint programming on HIV/AIDS activity. UNDP attends donor meetings as a lead donor in addition to facilitating the organization of donor meetings.

Scenario 4: United Nations resident coordinators /UNDP resident representatives take the lead responsibility and UNDP becomes a major donor; WHO/GPA provides technical guidance; other United Nations agencies join in a unified United Nations strategy for HIV/AIDS.

This fourth scenario calls on the United Nations resident coordinator to take substantial initiatives in leading the United Nations agencies in the development of a unified strategy in collaboration with Governments. WHO provides the main technical policy guidance in concert with other agency expertise on topics in their areas of expertise. UNDP assists governments with multi-sector planning, mobilization of resources, coordination processes (national and decentralized), implementation, monitoring and evaluation, and with well-planned approaches to capacity building for HIV/AIDS programme coordination and implementation. UNDP develops for the

Fifth Cycle a major HIV/AIDS programme as a separate area of programme concentration and/or integrated with the other IPF sectors. Major UNDP programme activities are aimed at assisting NGOs, community-based organizations, local governments, women and other neglected groups, and the initiation of social and economic impact studies in concert with relevant ministries and other donors. UNDP attends donor meetings as a major donor in addition to facilitating government-led meetings, calls special meetings as issues arise, and ensures HIV/AIDS is featured in round table and consultative group meetings.

The prevalence of HIV/AIDS in each country, the Governments' perceptions of the seriousness of the problem, and guidance from United Nations headquarters will determine which scenario is the most appropriate. However, in view of the importance of vigorous action in low-prevalence countries to limit the spread of the HIV, it would seem desirable to adopt a variation on scenario 4 calling for a unified United Nations strategy focusing on early prevention actions and reinforcing the WHO/GPA initiatives.

Next steps

HIV/AIDS is a major development problem that will have an extremely costly impact in the developing countries. It is a long-term development problem requiring persistent, sustained, well-organized, and coordinated governmental and donor action. The United Nations system of agencies has the opportunity to provide significant leadership in helping Governments mount major HIV/AIDS prevention and support actions. Although the major flow of resources may come from other donors—bilateral and multilateral, they would welcome effective leadership from Governments working with the United Nations and its agencies.

The next step should be for the United Nations agencies in the field to receive instructions from the Secretary-General to join in developing in each country a unified United Nations strategy on HIV/AIDS. The "Global Strategy on AIDS Prevention and Control," prepared by WHO, provides an essential policy base. But it will have to be adapted to each country situation, gaps identified, and priorities relevant to each country established. This work will, of course, have to be carried out in collaboration with the Governments and reflect the national HIV/AIDS strategies already adopted. The process, however, should cover areas across the spectrum of HIV/AIDS prevention, care, and impact actions and stress those areas that need greater attention.

The United Nations resident coordinator will need to be instructed:

- **To lead the development of the United Nations unified strategy for addressing the HIV/AIDS pandemic (the choice of scenarios depends on the country situation but all field offices should lay out their strategies as evidence of a deliberate and systematic consideration of the problem);**
- **To identify areas for UNDP and other United Nations agency interventions as complements to other donor programmes (including United Nations cross-cutting concerns for women, children, and orphans in development and requirements for capacity building in national execution, programme approaches, and national and decentralized coordination);**
- **To create staff support for the resident coordinator for HIV/AIDS programmes to assist with the preparation of a unified strategy and the monitoring of implementation (staff to come from UNDP, WHO and other participating United Nations agencies);**
- **To present to United Nations Headquarters the proposed unified strategy (with any inter-agency issues that may require resolution) for its approval.**

The basis for this action has recently been established in draft resolution A/C.2/47/L.82 of 14 December 1992 entitled "Operational activities for development." (Selected relevant excerpts are provided in Box F below.) The global HIV/AIDS pandemic provides an important opportunity for the United Nations to apply the directives of this resolution in a practical form in each developing country. Both the United Nations system and the global country-by-country attack on HIV/AIDS will benefit from such an action.

Box F

**Triennial policy review of the operational activities of the United Nations development system
General Assembly resolution 47/199 of 22 December 1992**

Selected excerpts*

[The General Assembly,]

- ...
- Stressing that national plans and priorities constitute the only viable frame of reference for the national programming of operational activities for development of the United Nations system,
 - ...
 - Reaffirming further that the United Nations development system has a critical and unique role to play in enabling developing countries to take a lead role in the management of their own development process.
 - ...
 - Stresses the need for an overall improvement of the effectiveness and efficiency of the United Nations development system in delivering its assistance;
 - ...
 - Emphasizes that the recipient Government has primary responsibility for coordinating, on the basis of national strategies and priorities, all types of external assistance, including that provided by multilateral organizations, in order effectively to integrate the assistance into its development process;
 - ...
 - Stresses that, on the basis of on the priorities and plans of recipient countries, and in order to ensure the effective integration of assistance provided by the United Nations system in the development process of countries, with enhanced accountability, and to facilitate the assessment and evaluation of the impact and sustainability of that assistance, a country strategy note should be formulated by interested recipient Governments with the assistance of and in cooperation with the United Nations system under the leadership of the resident coordinator in all recipient countries where the Government so chooses, taking into account the following:
 - (a) The country strategy note should outline the contribution the United Nations development system could make to respond to the requirements identified by recipient countries in their plans, strategies, and priorities;
 - (b) The contribution of the United Nations system to the country strategy note should be formulated under the leadership of the resident coordinator, in order to promote greater coordination and cooperation at the field level;
 - (c) The country strategy note should be transmitted to the governing body of each funding agency as a reference for the consideration of its specific country programme;
 - (d) The specific activities of each funding organization of the United Nations system, within the broad framework of the country strategy note, should be outlined in a specific country programme prepared by the recipient Government with the assistance of the funding agencies;
 - ...
 - Stresses that the strengthened resident coordinator function is necessary to assist the Government in mobilizing technical expertise both from inside and outside the United Nations system and ensuring coordination at the country level through, inter alia, the country strategy note, in order to respond to national needs and priorities in the most cost-effective and efficient manner and to maximize the impact of the United Nations system on the development process;
 - ...
 - Calls upon resident coordinators to take the necessary steps, in those countries where the scale of the activities of the United Nations and the number of funds and agencies so justify, to establish, in consultation with host Governments, an appropriate field-level committee, which will normally comprise all resident United Nations system representatives and which, under the leadership of the resident coordinator, will serve as a United Nations coordinating mechanism in the countries concerned.

...

* Underlining added.

Notes

1. p. 1. From decisions adopted by the UNDP Governing Council at its thirty-month Session: Geneva. May 1992. 92/14 Human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS).
2. p. 3. WHO/GPA "Planning the second generation of National AIDS Programmes (NAP)." 1 October 1992
3. p. 8. "Report of the Ad Hoc Working Group of the GPA Management Committee." 24 April 1992. p.8.
4. p. 10. "Confronting AIDS in the Developing World." August 1992. USAID.
5. p. 10. From table 12.4, "Funding of the global AIDS strategy by official development assistance agencies and international organizations. 1986-1991", p. 524. "AIDS in the World", eds. Mann, et al..
6. p. 13. For a more in-depth discussion of UNDP and coordination, see the CEO/UNDP report: "Capacity Building for Aid Coordination in the Least Developed Countries." May 1991, CEO Evaluation Studies No. 4/91. The analysis, conclusions and recommendations are relevant for the coordination of HIV/AIDS programmes although it addresses the coordination question more broadly in terms of building national capacities to manage development.
7. p. 14. Underlining added.
8. p. 14. See paragraphs 3.1.3 Resident Representative Competence (p.12) and 6.6 Implications of the mandate and strategy for UNDP field offices and headquarters (p.31) in "Capacity Building for Aid Coordination in the Least Developed Countries. Vol. I", A report commissioned by the Central Evaluation Office, UNDP, May 1991.
9. p. 15. "SIDA/AIDS: Report of the External Review of the World Health Organization Global Programme on AIDS," January 1992. pp 7-11.
Total funding for AIDS programmes in 1990 was \$255.47, of which 53 per cent was direct bilateral assistance to countries. The global total for the period from 1986 to 1991 is \$864.28 million of which 47 per cent was for bilateral programmes and 43 per cent for WHO/GPA funding (both direct and multi/bilateral. (Source: "AIDS in the World Mann, Tarantole, Netter eds. 1992) p.524.
10. p. 16. From the field report by Dr. Mrs. A.F. Mbacke, Consultant and member of the assessment team.
11. p. 18. See United Nations HIV/AIDS Personnel statement.
12. p. 20. Adapted from the Global Strategy on AIDS:1992 Update.
13. p. 22. As of April 1992, of the 164 countries reporting, 107 worldwide had less than 100 AIDS cases (26 reporting 0 cases), 35 had over 1,000 cases, and 10 with over 10,000 cases. WHO/GPA report of April, 1992.
14. p. 23. "Behavior Change: a Central Issue in the Response to the HIV Epidemic. Summary Report of the Informed Consultation." Dakar, Senegal. 12-15 December, 1991.
15. p. 23. "Effective Approaches to AIDS Prevention. Conclusions of a meeting 26-29 May 1992." WHO/GPA/IDA.
16. p. 25. "The Tanzania AIDS Assessment and Planning Study." The World Bank. 1992. pp. i and iii..
17. p. 28. The numbers are approximate as Governments are organized differently, with some areas listed as separate ministries where in other Governments they are part of other ministries.
18. p. 33. From the country report on Rwanda prepared by Dr. Marc Gutekunst, assessment team member.

**TERMS OF REFERENCE
ASSESSMENT OF UNDP COORDINATION EFFORTS
IN SUPPORT OF
WHO GLOBAL PROGRAMME ON AIDS**

I. Background

1. A WHO/UNDP Alliance to Combat AIDS was established in 1988 in order to bring together the strengths of WHO as the international leaders in health and the strengths of UNDP as the coordinator of development activities at the country level. The Alliance was expected to be an essential tool for ensuring coordinated support to national AIDS programmes.

2. In May 1992, the UNDP Governing Council adopted a decision on HIV/AIDS urging UNDP to strengthen collaboration with WHO and emphasizing the need for complementary action at the field level by UNDP and its partners in the United Nations development system, taking into account the mandate and comparative advantages of each organization. The need for the mobilization of community-based organizations, non-governmental organizations, HIV-related regional institutions, private sector organizations, and other institutions and groups in the planning and implementation of national efforts to address the pandemic was not only recognized but also highlighted as a viable and forward-looking strategy to fight against the spread of HIV/AIDS throughout the world.

3. The UNDP Governing Council decided to request the Administrator of UNDP to conduct, through the Central Evaluation Office, an assessment of UNDP activities to combat HIV/AIDS, beginning with a group of developing countries, with the particular purposes of:

(a) Examining the degree to which UNDP is using the coordinating role of the resident representative to support the WHO Global Programme on AIDS in the implementation of the Global Strategy and is encouraging national leadership to take a multisectoral and multi-ministry approach to addressing the AIDS threat and the consequences of the pandemic for economic and social development; and

(b) Identifying those activities that have been effective, citing the specific reasons for their success and problems encountered.

II. Purpose and scope

4. This is an assessment of the coordinative activities undertaken by UNDP resident representatives at the country level with the sole aim of determining whether and to what extent such activities supported HIV/AIDS-related activities implemented by WHO within the framework of GPA as defined in the WHO/UNDP Alliance of 1988. It is also an assessment of the extent to which the UNDP resident representatives have encouraged national leadership to take a multisectoral and multi-ministry approach to addressing the threat of AIDS. The assessment aims at identifying a series of activities carried out by resident representatives which reflect effectiveness in encouraging the adoption of a multisectoral and multi-ministry approach by national leadership at the country level.

5. Field visits will be made to the following countries: Brazil, Congo, Cote d'Ivoire, Honduras, Pakistan, Rwanda, Thailand, Uganda and Zambia.

III. Procedures

A. Organization

6. The assessment shall be undertaken by consultants selected by the Central Evaluation Office (CEO). Members of the assessment team will:

- Assemble first at UNDP headquarters, New York, in October 1992 for briefing sessions with the Regional Bureaux, the HIV and Development Programme in DGIP and other concerned offices as well as review background documents provided by CEO;
- Prepare the outline and draft table of contents of the assessment report during the briefing period at UNDP headquarters, discuss and agree on responsibilities of each team member;
- Proceed from New York to Geneva for briefing by WHO headquarters;
- Visit Brazzaville, Congo (leader of the mission) to consult with the WHO Regional Office for Africa;

• Undertake field visits to selected countries for the purposes of consulting with the UNDP resident representatives, WHO country representatives, ministries and departments concerned with the prevention and control of the spread of HIV/AIDS and any other parties, bilateral or multilateral, private or public or intergovernmental institutions;

• Gather data and information through interviews, observations and review of material and documents from any source. (Each member is expected to maintain brief notes on field visits for report writing purposes);

• Prepare an assessment report (the team leader), in English, containing the main findings, conclusion and recommendations of the mission and submit it to CEO in December 1992. Such a report should be succinct, objective, constructive, analytical rather than descriptive, and forward-looking (deal not only with "what" should be done but also "how" it should be done).

B. Specific terms of reference

• Examine the provisions of the WHO/UNP Alliance to combat the spread of HIV/AIDS with a view to identifying/indicating:

- What the expected results or outputs were;
- How the results/outputs were to be achieved;
- What the role of each participant in the Alliance was to be;
- What implementing modalities were expected to be in place to ensure attainment of the anticipated results.

• Examine the manner in which and the extent to which UNDP has used and is using the coordinating role of the resident representatives to support the WHO/GPA in the implementation of the Global Strategy on AIDS.

- Identify UNDP activities (seminars, meetings, workshops, clinical, epidemiological, etc.) and indicate the extent to which such activities were and are supportive to the WHO/GPA;
- In reviewing past annual (1989, 1990, 1991), UNDP country work plans, identify activities that involved the participation of WHO, other

United Nations agencies and the Government and indicate the manner in which and extent to which each activity was supporting to WHO/GPA;

- Examine the responses of WHO representative, other United Nations agencies, bilateral, multilateral, private and non-governmental organizations to activities undertaken by UNDP resident representatives: were they supportive, not supportive, or indifferent?
- Examine whether or not the resident representative played an advocacy role and if so the extent to which the advocacy role has led to the allocation of the country IPF for HIV/AIDS activities:
 - Identify activities undertaken by the resident representative to encourage national leadership to take a multisectoral or multi-ministry approach to the threat of AIDS;
 - What were the expected specific outputs and to what extent were they achieved;
 - What other institution/organization(s) participated in those activities;
 - Which department, ministries, government agencies and local institutions benefited from or at least participated in the activities designed to promote a multisectoral approach to the AIDS problem;
 - Identify and examine any follow-up activities which are direct results of UNDP-funded activities in the country;
- Review WHO/UNDP (especially and particularly) UNDP-financed activities and indicate those activities that have been effective in either:

- Examine the extent to which both UNDP resident representatives and WHO representatives were briefed with regard to their respective mandates and responsibilities under the WHO/UNDP Alliance. Describe the
- Examine the extent to which the country (i.e., ministries/departments, national institutions, NGOs, private sector organizations, foreign institutions operating in the country) has appreciated
 - Examine the short-term or medium-term plans;
 - Identify and examine the role being played by each entity, i.e., ministry, department, NGO, United Nations agency, bilateral, multilateral, etc.

7. The leader of the mission will be _____ and the members will be _____.

Planned Itinerary

- (a) New York/Geneva/Lusaka/Kampala/New York;
- (b) New York/Geneva/Abidjan/Brazzaville/Kigali/New York;
- (c) New York/Geneva/Islamabad, Bangkok, New York;
- (d) New York/Geneva/Brasilia/Honduras/New York.

Funding

8. The cost of the assessment will constitute, as is the normal practice, a charge to the programme budget that is being assessed. Budget estimates range from US\$80,000 to US\$90,000 for a team of four consultants.

SUMMARY OF MAIN REPORTS AND GUIDANCE DOCUMENTS ON HIV/AIDS

1. The "Global Strategy for the Prevention and Control of AIDS: 1992 Up-date. (See report.)

2. Assessment of HIV/AIDS Coordination Mechanisms at Country Level

This is the latest report of WHO on the coordination of HIV/AIDS programmes in the developing countries. It was completed in October 1992 and "outlines a process for improving country-level coordination based on the assessments done in these six countries" (Chile, Congo, Senegal, United Republic of Tanzania, Thailand, Zambia). The reports discuss several factors that affect coordination: socio-economic development, government commitment, social, political, cultural, and religious characteristics, HIV prevalence, external actors, area and population size. It also discusses the processes of coordination such as rationale, basic principles, structures, national HIV/AIDS management team, technical support structures, NGO consortia, external actors, informal processes, instruments for coordination, sectoral plans, ongoing systems for information gathering and exchange, reporting and evaluation, and some lessons learned about coordination.

The report has three recommendations:

5.1 National Governments should adopt the processes for coordination outlined in this report.

These processes consist of three key elements: (i) an open participatory approach; (ii) high-level political commitment, (iii) adequate financial and technical support.

5.2 All actors involved in national HIV/AIDS activities should participate in these processes and respect their results. Financial and technical support should be offered within the framework of the national strategic plan and sectoral plans.

5.3 The transition to these processes will take time and will have to be well planned and sensitively managed. All actors involved in HIV/AIDS activities (both at the national and global levels) should strongly commit themselves to supporting national Governments in this effort."

3. GPA Management Committee Report

In April, 1992, an Ad Hoc Working Group of the GPA Management Committee issued a report—the Rundin Report—which touched on a number of issues relevant to country-level coordination and United Nations agencies' roles. The recommendations state:

- "At the country-level, the main instrument for a cohesive and coordinated dialogue with donors should be a multisectoral national AIDS strategy developed according to a set of clear principles...
- "Arrangement for inter-agency coordination at the country level should remain flexible, and develop in response to what will be effective in meeting the specific needs of the country programme and its particular set of institutions and external donors;
- "In defining their effective role at the country level, within the concept of national execution, agencies of the United Nations family should consider their comparative advantage and capacity when responding to requests for assistance. In this regard, suggestions are made for WHO and UNDP:

"(a) WHO should use its comparative advantage by giving advice on health sector policy and technical issues and assist Governments to coordinate do not inputs in the the health sector. WHO could also either be the executing agency or cooperate with national entities in implementation of health sector projects.

"(b) UNDP should assist Governments, on request, to coordinate overall donor inputs. As a funding agency, UNDP should seek WHO technical advice whenever AIDS projects and programmes are being designed".

The report points out that "the subject of improving coordination of international efforts in development, particularly in the United Nations system, has been a long standing issue...; the concept of coordination has been widely discussed but rarely, if ever, defined; the various governing bodies [of the specialized agencies] tend to emphasize the independent character of the organizations." Also the report points out that among the agencies "there is no agreed understanding of the meaning of the concepts of 'leadership and coordination' or how these are to be feasibly and constructively put into practice." WHO's responsibility for "leadership and coordination" was specified in 1987 in General Assembly resolution 42/8.

The report also points out that the medium-term plan prepared under WHO guidance has been the principal instrument for mobilizing national efforts and donor resources, "particularly in the health sector... But the practical experience from initial programme implementation and the reality of an expanding pandemic, have highlighted the necessity to establish a much broader participation in national action, than is currently the case... there remain significant procedural and structural obstacles at the national level to the development of genuinely multi-sectoral policies and plans, and giving them practical effect... The Resident Coordinator of the United Nations has a key role in initiating and facilitating inter-agency consultations."

It sums up by concluding that "there is a general recognition that HIV/AIDS, a health problem for individuals, is also of wide-ranging developmental significance for society as a whole. Thus, the important social and economic factors associated with the transmission of HIV as well as its prevention and care require that all sectors must be seriously involved in responding to the challenge posed by the pandemic".

4. Conclusions of the Management Committee, GPA

The above conclusions of the Ad Hoc Working Committee were accepted at the Eighth Meeting of the Management Committee, Global Programme on AIDS, Geneva, 10-12 June 1992. It requested GPA "to initiate and carry through a process to propose mechanisms (whether new mechanisms or development of existing mechanisms) for country-level coordination which would:

- (i) Strengthen the host Government's coordination capacity;
- (ii) Increase impact of donor contributions to HIV/AIDS work at the country level, in the health sector and beyond;
- Better enable Governments to request assistance from agencies of the United Nations family that reflects each agency's comparative advantage and capacity;
- Contribute to the development of national public/private sector capacity for HIV/AIDS work.

The Committee, in addition to urging all members to cooperate and participate, recommended the GPA undertake a rapid assessment of existing mechanisms for coordinating assistance at the country level with a few case studies, and report to the GAP meeting in November 1992.

5. Economic and Social Council resolution

In July 1992, the Economic and Social Council adopted a resolution on the prevention and control of AIDS that:

- Endorsed the updated global strategy;
- Endorsed the recommendations of the Management Committee of the WHO/GPA concerning coordination of HIV/AIDS activities at the global and country level;
- Requested the United Nations agencies to take into account the important role of the Resident Coordinator in coordination mechanisms to ensure effective implementation of the strategy.

6. WHO/UNDP Alliance to Combat AIDS

In July 1992, WHO and UNDP signed a "Memorandum of Understanding for the Implementation of the WHO/UNDP Alliance To Combat AIDS", amending the original agreement of 1988. This Memorandum "reflects the urgency with which both organizations view the need to develop effective and timely multi-sectoral responses to this serious threat to human survival, health and development."

The Memorandum emphasizes the joint WHO/UNDP involvement in multi-sectoral policy development and strategic planning and WHO's contributions to the UNDP programme and project cycle. It changes the financial and project approval arrangements for UNDP-financed projects. It specifies national execution for UNDP-financed projects subject to meeting certain criteria. In those instances where national entities are not designated executing agencies, a relevant United Nations organization would be designated, which "in most cases would be WHO." It also spells out the criteria and procedure for selecting implementing agencies. As for execution entities, preference would be given to national organizations to serve as implementing agencies. "WHO will continue to be the main international source for provision of HIV/AIDS-related implementation services to UNDP and Governments."

On the subject of country coordination, the MOU states:

United Nations resident coordinators will be invited to include HIV/AIDS programmes and activities in the agenda of inter-agency meetings at the country level, and to promote systematic coordination of United Nations system operational activities in the fields concerned.

WHO and UNDP will jointly and actively assist countries in the mobilization of national and international human and financial resources required to respond to the consequences of the epidemic. Special attention will be given to strengthen national capacity to ensure that multilateral and bilateral agencies, financial lending institutions and non-governmental organizations coordinate and wherever possible, harmonize their assistance at the country level.

The WHO Representative will, jointly with the UNDP Representative, provide assistance to countries in mobilizing resources for the implementation of national AIDS programmes and in donor coordination.

7. Medium-term plan guidance

The main instrument for developing and implementing national AIDS-control programmes is the medium-term plan designed in 1987. Guidance on the development of these plans is evolving. The original structure for the MTPs, under which most of the country programmes are operating, determined the strategy and programme. It has proved to be overly standardized and rigid. The programmes were largely confined to budget categories of epidemiological surveillance,

- labora"(a) Increase awareness of the development implications of the pandemic...;
"(b) Strengthen and expand the capacity of communities to respond to the pandemic...;
"(c) Promote and assist prevention, care, support and treatment programmes for women...;
"(d) Assist Governments to develop effective multi-sectoral HIV/AIDS strategies and to minimize the devastating consequences of widespread infection."

The programme priorities include advocacy, national policy development, capacity building, women, personnel, strengthening UNDP capacities. Additional guidance statements have been issued on "HIV/AIDS Personnel Policy", "United Nations Volunteers: The role of UNV specialists in HIV/AIDS-related work: a community-oriented programme approach," "Guiding Principles for Policy Development", and "Workshop: The Development Dimensions of the HIV Epidemic."

9. Other relevant UNDP guidance

There are number of other UNDP policies and initiatives that are relevant and affect UNDP's role in the HIV/AIDS programming in the developing country. These include:

- The developing country's primary responsibility for the coordination of external assistance, with UNDP providing support to develop national capacities;
- The use of national execution of UNDP funded activities, including building capacities for project design, appraisal, evaluation, financial accounting, reporting, auditing;
- Assistance to Governments in the formulation and implementation of national capacity-building strategies;
- The application of the "Programme Approach";
- The introduction of National Long-Term Perspective Studies.

Annex III

Bibliography

UN

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UNDP

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- "Uganda HIV/AIDS and Development Programme: UNDP Strategy for Cooperation. 1992-1996: UNDP/Uganda.
- Terms of reference for "Assessment of UNDP Coordination Efforts in Support of WHO Global Programme on AIDS." Global Programme on AIDS. 24 July 1992.
- "The Prevention and Control of HIV/AIDS and Programmes Addressed to the Mitigation of its Negative Socio-Economic Consequences", statement of Ms. Elizabeth Reid, Director, HIV and Development Programme, BPPE, 13 July 1992

- A number of other UNDP policies and initiatives that bear on UNDP's role in HIV/AIDS programming, such as those on capacity building, national execution, support to country external assistance coordination tasks, the programme approach.

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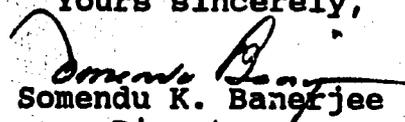
Dear Mr. Eriksson,

The Central Evaluation Office of UNDP, in keeping with its desire and efforts to disseminate findings and recommendations of ... evaluation studies it sponsors, is pleased to enclose herewith a copy of CEO Evaluation Studies No. 2/93 titled UNDP Support for the Global Programme on AIDS: The Country Perspective - An Assessment of the Role of the United Nations Coordinator/UNDP Resident Representative.

The overall purpose of the study was to examine the role played by UNDP in support of the WHO Global Programme on AIDS in the implementation of the Global Strategy as well as in encouraging national leadership to take a multisectoral and multiministry approach to addressing the AIDS threat and the consequences of the pandemic for economic and social development. This report was prepared by four international experts on the basis of consultations with UNDP and WHO Headquarters; analysis of responses to questionnaires received from 66 UNDP country offices and 46 governments out of a total of 70 countries selected to complete the questionnaire; and visits to 12 UNDP country offices and 4 WHO regional offices.

We hope that the study will be found useful.

Yours sincerely,


Somendu K. Banerjee
Director

Central Evaluation Office
Bureau for Programme Policy and Evaluation

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