IOB policy review of the support to and collaboration with UNFPA and UNAIDS

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A case study for the IOB evaluation of the UN for the Dutch development cooperation policy

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TABLE OF CONTENTS

I. Aim of the review, research questions and methodology 7

1.1 Introduction 7

1.2 Background, aim and research questions 7

1.3 Scope, methodology, limitations 8

II. Justification of the policy and the objectives pursued by the policy 10

2.1 Introduction 10

2.2 Grounds for involvement in SRHR 11

2.3 Relevance of UNFPA and UNAIDS for implementing Dutch policy in SRHR 14

2.4 Financial overview and trends 18

2.5 Conclusions 27

III. Effectiveness of the programmes financed 30

3.1 Introduction 30

3.2 Strategic focus of UNFPA and UNAIDS 30

3.3 Achievements of UNFPA and UNAIDS in 2012 – 2015 32

3.4 Contribution of UNFPA and UNAIDS to the Dutch priorities in SRHR 48

3.4 Conclusions 58

IV. Efficiency of UNFPA's and UNAIDS' programmes 62

4.1 Introduction 62

4.2 Organisational performance of UNFPA and UNAIDS 62

4.3 Conclusions 69

V. The quality of the evaluation function of UNFPA and UNAIDS 71

5.1 Introduction 71

5.2 Assessment of the evaluation function of UNFPA and UNAIDS 71

5.3 Conclusions 77

VI. Comparative advantages of UNFPA and UNAIDS 79

6.1 Introduction 79

6.2 Assessment of the comparative advantages of UNFPA and UNAIDS 79

6.3 Conclusions 85

VII. Assessment of policy influence and conclusions 88

7.1 Influence of the Netherlands and collaboration with UN 88

7.2 Overall conclusions 90

Bibliography 93

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral Drugs
ASRH	Adolescent Sexual and Reproductive Health
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CB	Capacity Building
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CCT	Conditional Cash Transfer
CEDAW	Convention on the Elimination of Discrimination Against Women
CEE	Central and Eastern Europe
CHW	Community Health Worker
CIDA	Canadian International Development Agency
CO	Country Office
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization, a collective term implying NGOs, FBOs and CBOs
CSW	Commission on the Status of Women
CTC	Care and Treatment Centre
CU	Contraceptive Use
CYP	Couple Years of Protection
DALY	Disability-Adjusted Life Year
DaO	Delivering as One
DER	Development Effectiveness Review
DFID	Department for International Development
DHS	Demographic and Health Survey
DOS	Division for Oversight Services (DOS) of the Evaluation Branch of UNFPA
DP	Development Partner
ECOSOC	(UN) Economic and Social Council
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
EmONC	Emergency Obstetric and Neonatal Care
eMTCT	eliminating Mother-To-Child Transmission
EP	Evaluation Policy
EQA	Evaluation Quality Assessment
FBO	Faith Based Organisation
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FP	Family Planning
GAT	Gender Assessment Tool
GBV	Gender Based Violence

GE	Gender Equality
GFATM	Global Fund to fight AIDS, TB and Malaria
GNP+	Global Network of People living with HIV/AIDS
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
HAART	Highly Active Antiretroviral Treatment
HACT	Harmonised Approach to Cash Transfers
HIC	High Income Country
HIV	Human Immunodeficiency Virus
HQ	Head Quarter
HRP	Human Reproduction Programme (UNDP/UNFPA/WHO/World Bank Special Programme of research, Development and Training in Human Reproduction)
HSS	Health System Strengthening
IAEG	Interagency and Expert Group
IATI	International Aid Transparency Initiative
IATT	Interagency Task Team
IAWG	Inter Agency Working Group
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
ICW	International Community of Women living with HIV/AIDS
IDP	Internally Displaced Person
IDU	Injecting Drug User
IEC	Information Education and Communication
IHAA	International HIV/AIDS Alliance
IHP	International Health Partnership
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illnesses
IOB	Policy and Operations Evaluation Department
IOM	International Organization for Migration
IP	Implementing Partner
IUD	Intra-Uterine Device
JIU	Joint Inspection Unit
JPMS	Joint Programme Monitoring System
LEA	Legal Environment Assessment
LMIC	Low- and Middle Income Country
LMIS	Logistics Management and Information System
M&E	Monitoring and Evaluation
MAR	Multilateral Aid Review (DFID)
MARA	Most At Risk Adolescents
MARP	Most At Risk Population
MCH	Maternal and Child Health
MCWC	Maternal and Child Welfare Centre
MDG	Millennium Development Goal
MDTF	Multi-donor trust fund
MERG	Monitoring and Evaluation Reference Group
MFA	(Netherlands) Ministry of Foreign Affairs

mhealth	Mobile Health
MHTF	Maternal Health Thematic Fund
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MNH	Maternal and Newborn Health
MOPAN	Multilateral Organisation Performance Assessment Network
MRTS	Management Response Tracking System
MSI	Marie Stopes International
MSM	Men having Sex with Men
MTCT	Mother to Child Transmission
MTDF	Medium Term Development Framework
MTSP	Medium-Term Strategic Plan
NCSW	National Commission on the Status of Women
NEPAD	New Partnership for Africa's Development
NGO	Non Governmental Organization
OAS	Office of Audit and Investigating Services (UNFPA)
OECD	Organisation for Economic Co-operation and Development
OF	Obstetric Fistula
OHCHR	Office of the High Commissioner on Human Rights
P&D	Population and Development
P&H	Population and Housing
PAC	Post Abortion Care
PCB	Programme Coordinating Board of UNAIDS
PCO	Population Census Organisation
PEP	Post-Exposure Prophylaxis
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PID	People who Inject Drugs
PLWHA	People Living With HIV/AIDS
PMNCH	Partnership for Maternal, Newborn and Child Health
PMTCT	Prevention Mother To Child Transmission
POA	(ICPD) Programme Of Action
PPP	Public Private Partnership
PWID	People Who Inject Drugs
QCPR	Quadrennial Comprehensive Policy Reviews
RBM	Results Based Management
RC	Resident Coordinator
RH	Reproductive Health
RHC	Reproductive Health Commodity
RHCS	Reproductive Health Commodity Security
RHR	Reproductive Health and Research (WHO)
SDG	Social Development Goal
SERAT	Sexual Education Review and Assessment Tool
SGBV	Sexual and Gender Based Violence
SIE	Second Independent Evaluation

SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
SRHC	Sexual and Reproductive Health Commodity
SRHR	Sexual and Reproductive Health and Rights
SSA	sub-Saharan Africa
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
ToC	Theory of Change
TSF	Technical Support Facilities
UBRAF	United Budget, Results and Accountability Framework
UCC	UNAIDS Country Coordinator
UCO	UNAIDS Country Officer
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNDS	United Nations Development System
UNEG	United Nations Evaluation Group
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNH4+	Partnership between UNAIDS, UNFPA, UNICEF, UN Women, WHO and World Bank (now H6)
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
UNSC	UN Statistical Commission
UNSG	United Nations Secretary-General
USAID	United States Agency for International Development
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WB	World Bank
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WHS	World Health Statistics
YAP	Youth Advisory Panel
YFC	Youth Friendly Centre
YFHS	Youth Friendly Health Services

I. Aim of the review, research questions and methodology

1.1 Introduction

In 2016, the Policy and Evaluations Department (IOB) of the Ministry of Foreign Affairs (MFA) is carrying out a review on the Dutch efforts at the United Nations (UN) to achieve the objectives set for the priorities of Dutch development policy. For each of the four key themes of the Dutch development policy a separate review study is conducted.

This report presents the findings of the review related to the domain of sexual and reproductive health and rights (SRHR), focusing on the United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).[1]

1.2 Background, aim and research questions

The Netherlands attaches great importance to working with the United Nations to meet its development policy goals. At the same time, the Netherlands is pushing for UN reform and a greater focus on coherence and efficiency in the organisation's work. Between 2012 and 2015 the Netherlands contributed a total of EUR 1571.7 million to SRHR through all channels, of which EUR 486 million is channelled through (31%) the UN. This amount includes both core (not earmarked) and non-core (earmarked) funding.

On the instructions of the Ministry of Finance all ministries must conduct a policy review at least once every seven years of their most important policy areas, in order to account for their main budgetary expenditures. In line with this, the evaluation department of the Ministry of Foreign Affairs is conducting a policy review in 2016 of its development work with the United Nations Development System (UNDS). The aim of the overall policy review is:

- Rendering account for the effectiveness and efficiency of the Dutch government's policy on cooperation with relevant UN organisations in the area of development cooperation.
- Identifying specific ways of improving policy in the future.

Evaluation questions for this review of the Dutch cooperation with the UNFPA and UNAIDS on SRHR are:

- What is the justification for the policy of the Netherlands MFA, the objectives pursued by the policy, and what is the structure of the financial commitments to the UNFPA and UNAIDS? ***(chapter 2)***
- How effective and efficient are UNFPA and UNAIDS in achieving development objectives in SRHR? ***(chapter 3 and 4)***
- What is the quality of the evaluation functions of UNFPA and UNAIDS? ***(chapter 5)***
- What are the comparative advantages for the Netherlands MFA for working with UNFPA and UNAIDS in SRHR? ***(chapter 6)***

[1] Other areas are: food security; water, sanitation and hygiene; peace building and conflict management

- What conclusions can be drawn regarding achievement of development objectives (effectiveness), efficiency of the UNFPA and UNAIDS, and on comparative advantages of the UN?[2] ***(chapter 7)***

1.3 Scope, methodology, limitations

Scope

The period evaluated was 2012 – 2015. The policy review on cooperation with SRHR evaluation covers core components of SRHR, including HIV/AIDS.[3] The review of SRHR covers two United Nations (UN) organisations which are significant for the Netherlands development assistance in the domain of SRHR: the United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The mandate of both UN organisations is closely tied to SRHR, making them important stakeholders for the Netherlands MFA. Other UN organisations active in SRHR – United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO) – are excluded from this study because of their relatively limited share of the Netherlands funds allocated to SRHR; also, the WHO was reviewed by the IOB in 2015.[4] As the review focuses on the UN only, Dutch support to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) as part of the multilateral channel is not included. Support to SRHR through other channels including bilateral, Non Governmental Organisations (NGOs) and civil society, and public-private partnerships is not included either.

Methodology

The evaluation was based on secondary materials obtained from MFA, UN organisations, and public websites. In addition interviews were held with key informants from within and outside the UN, by Skype/phone, or in person during field visits to New York and Geneva. Methodological triangulation in this review included:

- The conduct of a desk review to reconstruct Dutch policy in Sexual and Reproductive Health and Rights (SRHR), to analyse the financial contours of Dutch support in this domain, and to assess how programmes are being monitored. For this documents from the Ministry of Foreign Affairs were used such as formal policy documents; letters to the parliament; internal memos; instructions and correspondence.

- A systematic review of relevant evaluations, as the aim of the review was to assess and find evidence of the extent to which UNFPA and UNAIDS were able to meet expectations and assumptions formulated for the domain of SRHR. Evaluations were reviewed following an evaluation frame (see annex 2). Inclusion of the evaluations was based on whether they met the quality criteria set by the IOB, or by the organisations themselves, and their relevance to the period under review. In a few cases evaluations before 2012 were included, as they provided relevant contextual or information regarding the evolution of a programme.

[2] See annex 1 for the Terms of References

[3] The core components of SRH as outlined in the 2004 WHO Global Strategy on Reproductive Health include: Improving maternal and new-born health; Ensuring contraceptive choice and safety, and fertility services; Eliminating unsafe abortion and providing post-abortion care; Reducing STIs, including HIV, and other reproductive morbidities; Promoting health sexuality, including adolescent health and reducing harmful practices.

[4] IOB (2016). *Voorkomen is beter dan genezen. Evaluatie over Nederland en de WHO (2011-2015)*. IOB Evaluatie nr. 414

- Interviews were held with key informants from the Netherlands Ministry of Foreign Affairs (MFA), relevant staff from the Permanent Representation in New York and Geneva dealing with UNFPA and UNAIDS, key staff from UNFPA and UNAIDS, key persons from donor agencies, non-governmental organisations, and other experts in the domain. The interviews served to collect more detailed information on particular topics and to validate findings from the desk review. A semi-structured questionnaire was used to guide the interviews.[5]

Throughout the review the evaluator systematically triangulated data and information sources. The use of the evaluation matrix was key for the formulation of evidence-based findings; it outlined the assumptions underlying each research question, and served as a framework to systematise and report the findings.

Limitations

- Data availability. Evidence related to 'soft aid' activities such as advocacy and policy dialogue are often not documented, or hard to attribute to the efforts of a single organisation.
- Quality of the evaluations. Regular programme evaluations do not usually report beyond output level, therefore effects at outcome levels are quite difficult to substantiate. In addition, as UNFPA notes in an assessment of Country Programme Evaluations, there was a general difficulty in defining what was effective within many of the programmes, which, together with a lack of consistent, robust data, meant that it was difficult to trace UNFPA contributions. [6] This limitation is not particular to UNFPA evaluations, as it is often reported as a constraint in analysis of development effectiveness.
- Retrospective aspects. Evaluations referring to a period before 2012 – 2015 were included in case they were considered relevant for this review.

To overcome these limitations, additional interviews were held with key informants and other sources were consulted.

[5] See annex 3 for a list of key informants
[6] UNFPA (2016b). Lessons learned from UNFPA Country Programme Evaluations

II. Justification of the policy and the objectives pursued by the policy

Guiding questions to be answered in this chapter

- What are the grounds for involvement in SRHR for the Netherlands MFA?
- For the Netherlands, what is the specific relevance of the collaboration with UNFPA and UNAIDS in achieving the policy priorities of the Netherlands in SRHR?
- What is the proportion of SRHR expenditure for UNFPA and UNAIDs, and what are the financial trends and outlook of these organisations?
- Which monitoring instruments are available to the Netherlands for progress monitoring and accountability?
- What conclusions can be drawn on the choice of the Netherlands MFA for UNFPA and UNAIDs, in terms of justification of policy and financial allocations?

2.1 Introduction

Sexual and reproductive health and rights (SRHR) are grounded in international human rights instruments ratified by the Netherlands.[7] The prioritization of SRHR in its policy can be seen as a reiteration and underlining of the commitments world leaders made at the ground-breaking conference in 1994 in Cairo: the International Conference on Population and Development (ICPD) and its Programme of Action (POA). Compared to previous conferences on population and development, in Cairo the focus was placed on the role of women's empowerment and a human rights approach to reproductive health including the right to be informed and to make free choices, the recognition of sexual rights, and SRHR of young people. The comprehensive reviews of the progress and achievements of ICPD in 2004 and 2014 showed the advances, and mapped remaining challenges.

The United Nations Development Summits in 2000 and 2015[8] proved important advocacy events for development goals including Sexual and Reproductive Health and Rights. The 2015 Sustainable Development Goals (SDG Summit) marked a shift from the 2000 Summit on the MDGs as it allowed for active participation of all countries in defining a *universal agenda* applicable to all countries. With this, the traditional North-South divide was left behind. Countries were urged to address economical, social and ecological dimensions of sustainable development, and to take *responsibility* for mobilizing their own domestic resources, aiming to reduce their dependence on Overseas Development Aid (ODA). The domain of SRHR, which is critical to the full achievement of all shared global development

[7] IOB (2013a). *Balancing ideals with practice*. *Policy evaluation of Dutch involvement in sexual and reproductive health and rights 2007 – 2012*

[8] The United Nations Millennium Development Goals Summit in 2000, and the United Nations Sustainable Development Goals Summit in 2015

goals[9], it is included in three of the seventeen sustainable development goals: health (SDG 3)[10], education (SDG 4)[11], and gender equality (SDG 5).[12] An important achievement, though SRHR proved to be a an area of dispute and sensitivities among Member States in the negotiations.[13] Important instrument in combatting HIV/AIDS is the Declaration of Commitment (DoC) on HIV/AIDS adopted at the 2001 United Nations General Assembly Special Session on HIV/AIDS. The Special Session marked HIV/AIDS as a *"matter of urgency, and called for global commitment to enhance coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner."*[14] The UN Special Sessions on HIV/AIDS are important podia to review progress, renew commitment, and for the formulation of political declarations and moral agenda's. In addition, the UNGASS Country Progress Reports serve to measure and report on progress to the commitments made at national level. The International AIDS conferences, organised since 1985, provide a stimulating stage for presenting evidence, and maintaining a dialogue on useful approaches in prevention, treatment and care.[15]

This chapter outlines in more detail the grounds for involvement in SRHR, the Netherlands policy, and the financial contribution to the two principal UN agencies dealing with these thematic areas: the United Nations Population Fund (UNFPA) and the United Nations Joint Programme on HIV/AIDS (UNAIDS).

2.2 Grounds for involvement in SRHR

The Netherlands has a long history in promoting and supporting interventions in sexual and reproductive health and rights (SRHR), including the prevention of HIV and providing treatment and care for people living with HIV. Over the years the Netherlands has positioned SRHR more prominently in its foreign affairs policy thereby underlining the link between SRHR and human rights, and the links between SRHR and HIV/AIDS.[16]

In 2010 the Netherlands underlined its specific policy focus on addressing SRHR, rather than

[9] Education, economic benefits, broader health agenda, gender equality and the environment. See also the Briefing Cards SRHR and the Post-2015 Development Agenda of the Universal Access Project (undated)
[10] With target 3.7 specifically referring to SRHR: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. Other targets are related to maternal health (3.1), newborn and child health (3.2), ending AIDS epidemic (3.3), and achieving universal health coverage (3.8). See: https://sustainabledevelopment.un.org/sdg3
[11] With target 4.7 referring to healthy lifestyle education, gender equality and human rights: By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development. See: https://sustainabledevelopment.un.org/sdg4
[12] With target 5.6 specifically referring to SRHR: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences. See: https://sustainabledevelopment.un.org/sdg5
[13] Representatives of regional SRHR networks from around the world, together with UNFPA, advocated tirelessly at these negotiations to ensure that the post-2015 agenda guarantees human rights, particularly the SRHR of all people everywhere; brings gender equality to the forefront; recognizes young people's role as key agents of change; and includes the active participation of civil society in shaping global development, both at country and global levels. Comments from key informants, and http://www.twn.my/title2/unsd/2014/unsd140801.htm
[14] Declaration of Commitment on HIV/aids "Global Crisis – Global Action"
[15] Organised every year in the period 1985 – 1994; from 1996 onwards every two years
[16] IOB (2013). Balancing ideals with practice

supporting the wider health sector. This specific focus however did not imply that a health system strengthening focus was left, more specifically it meant strengthening the health sector taking SRHR as an entry point.[17] Grounds for involvement are rooted in the Netherlands' commitment to advancing the Cairo, Beijing[18] and Millennium Development agendas, as well as other international human rights covenants and soft law.[19] The Netherlands' position on SRHR is a reflection of its domestic policies on SRHR which continue to have positive results in relevant areas like low abortion rates and low numbers of teenage pregnancies. It is also a reflection of its leading role in the international debate on the promotion of the ICPD Programme of Action, on human rights and SRHR, gender equality, women's rights, reproductive rights, sexual rights of all; and on sensitive issues such as abortion, adolescent SRHR, and SRH rights of LGBTI[20] and other key populations (sex workers, drug users).

The underlying vision of the Netherlands is that health, including reproductive health, is a human right and that sexual and reproductive rights are implicitly included in a number of other human rights.[21] This vision implies a focus on the individual's free choice regarding sexuality and reproduction. It also implies that special attention will be given to key populations, because these groups are at risk of HIV infection and vulnerable to human rights violations related to SRHR. In addition, they may have less access to SRHR and HIV/AIDS services.[22]

Advancing the Cairo agenda remains a priority for the Netherlands. Despite progress made in the area of maternal health and access to family planning, universal access to SRHR is still not guaranteed in all countries, and within countries inequities remain among pockets of the populations and among key or marginalised populations. More than 60% of married or in-union women of reproductive age worldwide use some form of contraception, however there are large differences by region and across countries. Worldwide in 2015 12% of married or in-union women are estimated to have unmet need for family planning (wanting to stop or delay childbearing but not using any method of contraception); with 22% in the least developed countries.[23] One third of pregnant women still have no skilled assistance for delivery, and the unmet need for family planning remains high with more than 225 million women having unmet need for modern family planning in 2014.[24] Maternal deaths are more prevalent in countries with a severe HIV epidemic, and in countries dealing with conflict. Even though new HIV infections have dropped by 38% since 2001, at the end of 2015 there were 36.7 million people globally living with HIV, 2.1 million people newly infected.[25] Since the start of the epidemic, 78 million people have become infected with HIV and 35 million people have died from AIDS-related illnesses (data from end 2015).[26] As of June 2016, some 18.2 million people are accessing antiretroviral therapy. Notwithstanding commendable achievements in access to ARVs, more than half of the people needing treatment in low- and middle-income countries do not have

[17] Interview with key informant from the Ministry
[18] Fourth World Conference on Women in 1995 organised by the Commission on the Status of Women (CSW)
[19] Referring to resolutions and declarations of the UN General Assembly; statements, principles, codes of practice; actions plan; and other non-treaty obligations
[20] LGBTIs is an abbreviation that covers lesbian, gay, bisexual, transgender, transvestite and intersex people
[21] Art. 12, Covenant Economic Social and Cultural Rights. http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx
[22] IOB (2013). Balancing ideals with practice
[23] United Nations (2015). Trends in Contraceptive Use Worldwide 2015
[24] Singh S, et al. (2014). *Adding It Up:The Costs and Benefits of Investing in Sexual and Reproductive Health 2014*
[25] UNAIDS Fact Sheet, November 2016. http://www.unaids.org/en/resources/fact-sheet
[26] Ibid

access to such services. An estimated half of the people with HIV are ignorant of their status. Adolescent girls and young women account for one in four new HIV infections in sub-Saharan Africa (SSA). Stigma, discrimination and taboos continue to hinder key populations (drug users, gay men, transgenders and sex workers) accessing information and prevention and treatment services.

In addition, other political challenges have emerged as the international consensus on equal rights for men and women is under severe pressure, with conservative voices opposing elements of the Cairo agenda, such as abortion services, adolescent SRH, sexuality education, contraception, and same sex unions.[27] It remains therefore important to keep SRHR issues and the attainment of international commitments high on the agenda. For this, investments in partners and in building alliances with other progressive countries is vital. In box 1 the key elements of the Dutch SRHR policy are described.

Box 1: Key elements of the Dutch SRHR policy

The 2011 MFA Focus Letter on development aid mentions 'reduction in unwanted pregnancies', 'reduction in maternal mortality' and 'reduction in HIV infections' as impact indicators, and formulates as outcomes:

- Young people have increased knowledge of sexuality, pregnancy, and HIV, and are free and able to make choices in their sexual relationships, safe sex, and the use of contraceptives;
- Improved access to and choice of good quality family planning, male and female condoms, drugs, vaccinations and other SRHR commodities, and improved HIV prevention;
- Improved access to, and quality of public and private services in SRHR, including safe abortion and HIV/AIDS;
- Improved access to health services among key populations;
- Universal reproductive rights worldwide, in particular of women and youth, are brought to the attention of policy makers and the public within the focus countries of the Netherlands, and are included in policies and laws.

Source: MFA (2011) Focus Letter on Development Aid

The Ministry recognised that in order to achieve tangible results in SRHR, actions require collaboration within the Ministry, and should be embedded in a wider foreign policy agenda, in particular on human rights.[28] SRHR was the only priority area exempt from budgetary cuts, on the contrary, there was a budget increase for the sector from 396 million in 2011 to 427 million Euro in 2015.[29] The objectives were to be met through partnering with multilateral organisations and private organisations (national and international NGOs, private companies) and through bilateral work with

[27] Including: Glob Public Health. 2014;9(6):607-19. doi: 10.1080/17441692.2014.917381. Epub 2014 Jun 3. Taking ICPD beyond 2015: negotiating sexual and reproductive rights in the next development agenda; Girard F1. / http://www.youthcoalition.org/wp-content/uploads/YC@CPD44_external-report.pdf

[28] See: TK 2010 – 2011, 32 605, nr. 3. Beleid ten aanzien van ontwikkelingssamenwerking. (SRGR); TK 2011 – 2012, 32 605 nr. 93. Beleid ten aanzien van ontwikkelingssamenwerking; MFA (2011). *Focus Letter on Development Aid;* TK 2011. Focusbrief ontwikkelingssamenwerking. TK 2011. Kamerbrief. Multilateraal OS-beleid; TK 2012 – 2013, 32 735, nr. 78. Mensenrechten in het buitenlands beleid. 'Respect en recht voor ieder mens'; TK 2012 – 2013, 33 625, nr.1. Hulp, handel en investeringen; MFA (2013b). *A World to Gain. A New Agenda for Aid, Trade and Investment*

[29] TK 2011 – 2012, 32 605 nr. 93. Beleid ten aanzien van ontwikkelingssamenwerking

governments in partner countries.

The overview in annex 4 illustrates Dutch policy intentions in the area of SRHR, and annex 5 details the key issues in SRHR in the four thematic areas. The overview of the policies clearly shows the consistency of the Ministry in promoting the Cairo Agenda, in linking SRHR with human rights, and in focusing on the need to address SRHR of key populations. The 2008 *Choices and Opportunities* document (in Dutch *Keuzes en kansen*) is the first policy paper specifically focusing on SRHR and addressing both SRHR and HIV/AIDS. It describes the challenges of human rights violations, insufficient investments in the health sector, insufficient efforts in other non-health sectors and insufficient cooperation between various partners. In terms of priorities, the report *Balancing ideals with practice* (IOB, 2013a) analysed Dutch priorities in SRHR regarding the type of intervention, topic, approach and target population.[30] In terms of type of intervention, one of the chief priorities in Dutch priorities has always been prevention, in the case of SRHR this includes prevention of unintended pregnancies, of unsafe abortion and of HIV infections and other STIs. Whereas prevention is seen as a two-sided approach: prevention of a problem (HIV infection), as well as prevention of the adverse effects of a problem (discrimination against people living with HIV). Regarding the topic, priority is given to those areas that are considered sensitive themes of the Cairo agenda, with the prevention of unsafe abortion as the most prominent example. In terms of priorities in the approach, the need for a multi-sectored approach is consistently mentioned in the policy documents of the MFA. Linking education for example to the reduction of maternal mortality, thereby emphasising that the causes and consequences of SRHR-related problems, as well as the solutions for these problems are strongly linked to other sectors. The choice for a multi-sectored approach is also visible in the inter-linkages between the sectors, but also in the selection of funding modalities (involving actors who can complement each others actions). Consistent in Dutch policy documents on SRHR is the need to address adolescents and young people, and key populations (for example sex workers and men having sex with men).

The report *A World to Gain* marked a shift towards a thematic approach to facing development issues, resulting in the choice of four thematic areas, and a reduction in partner countries.[31] The Letters to Parliament (2010, 2011 and 2012) further specify Dutch policy intentions in SRHR.[32] The commitment to SRHR overcame political differences as, despite changes in government, the new Cabinet-Rutte II, installed at the end of 2012, continued the policy intentions that were formulated under Cabinet-Rutte I (2010-2012) including a reduction in thematic areas, and in the number of focus / partner countries.[33]

2.3 Relevance of UNFPA and UNAIDS for implementing Dutch policy in SRHR

2.3.1 UNFPA

[30] Policy evaluation of Dutch involvement in SRHR 2007 - 2012
[31] MFA (2013b). *A World to Gain. A New Agenda for Aid, Trade and Investment.* The Hague: Ministry of Foreign Affairs
[32] The 2010 Basic letter international affairs (*in Dutch: Basisletter Internationale Samenwerking*); MFA (2011). *Focus Letter on Development Aid*; 2011 Focusletter; TK 2011 – 2012, 32 605 nr. 93. Beleid ten aanzien van ontwikkelingssamenwerking
[33] Focusletter 2011, and the 2012 Policy letter 2012 TK 32605. 7 partner countries: Afghanistan, Burundi, Mali, Rwanda, South Sudan, Palestinian Territories and Yemen; 8 countries are labelled as transition countries: Bangladesh, Benin, Ethiopia, Ghana, Indonesia, Kenya, Mozambique and Uganda

"The Netherlands appreciates UNFPA for its unique mandate and strategic focus and for being our partner in securing Sexual and Reproductive Health and Rights for all."[34] According to the Netherlands UNFPA is relevant for implementing its policy in SRHR because of its role:[35]

- In the promotion of all aspects of SRHR (complete Cairo agenda), including Comprehensive Sexuality Education (CSE), Gender Based Violence (GBV), Female Genital Mutilation/Cutting (FMG/C) and SRH rights for key populations.
- As a strong advocate for promoting SRHR as human rights, and for the inclusion of gender equality, HIV/AIDS and human rights as cross cutting thematic areas in its work.
- As an active participant at global level in the negotiations on the post-2015 agenda; in the Commission on the Status of Women (CSW); and in the Commission on Population and Development (CPD).
- At the regional level in facilitation / participation in regional conferences.
- As a technical advisor to national governments.

Specifically, for the period under review, the Netherlands formulated its expectations for UNFPA: (a) to work in close collaboration with other UN areas; (b) to complement other UN Agencies on cross-cutting areas such as gender (UN-Women and UNICEF); HIV/AIDS (UNAIDS)[36] and human rights; (d) to contribute to UN conferences, harmonisation of laws and policy development in the area of international development and humanitarian affairs, and actively participate in the UN country teams; (e) to improve its collaboration with governments, NGOs, the private sector and other parties (multistakeholder partnerships). Furthermore, short and medium term expectations for UNFPA included advocacy work for inclusion of the 2014 ICPD review process in the post 2015-framework. Areas of specific importance included combatting violence against women, preventing child marriages, and the optimal implementation of the *Road Map for the Call of Action on Protection from GBV in Emergencies*.[37]

In the period under review the Netherlands continued its support to the WHO Human Reproduction Programme (HRP), the WHO Special Programme of Research, Development and Research Training in Human Reproduction.[38] The HRP governance is structured on the basis of co-sponsorship by UNFPA, UNDP, UNICEF, WHO and the World Bank. The Netherlands is member of the Policy and Coordination Committee (PCC), the governing body of the Special Programme.[39] The HRP Programme is the main instrument within the United Nations system for research in human reproduction which brings together policy-makers, scientists, health care providers, clinicians, consumers and community representatives to identify and address priorities for research to improve sexual and reproductive health. The Netherlands sustained its support to HRP, among others for its normative role (producing

[34] Statement of the Netherlands at the UNFPA Annual Executive Board meeting in June 2016
[35] MFA: Scorecards 2013, 2015 and *Kadersinstructies* 2012 – 2015
[36] UNFPA is one of the 11 co-sponsors of UNAIDS, since its establishment in 1996
[37] Ibid
[38] The Netherlands considers the WHO as an important partner in the implementation of the thematic areas, in particular SRHR and water and sanitation. The added value is the work on normsetting, and developing an evidence base on key issues in SRHR. See: IOB (2016). *Voorkomen is beter dan genezen. Evaluatie over Nederland en de WHO (2011-2015)*. IOB Evaluatie nr. 414 *(in Dutch*). This IOB evaluation details the relation between the Netherlands and the WHO, with a particular focus on the role of the WHO during the Ebola crisis
[39] The PCC consists of 34 members among which representatives of the largest financial contributors. Other members include the permanent members (co-sponsors, UNAIDS, IPPF), countries elected by the WHO regional committees, and other interested cooperating partners.

guidelines and tools), technical support to countries and institutions on issues in SRHR and its convening role among others with NGOs. According to key respondents the establishment of the Special Programme *"was a master stroke"*, as HRP is able to do provide evidence and work on sensitive issues. The WHO is less inclined to play this role because of its Member-State-structure, however the fact that HRP is a Special Programme within the WHO is useful in the publication of guidelines and tools. For the Netherlands, of particular importance in the period under review (in 2012) the publication of the revised edition of the technical guidelines on abortion.[40]

In box 2 key features of UNFPA are presented.

2.3.2 UNAIDS

The mandate of UNAIDS is built on the fight against HIV/AIDS. For the Netherlands UNAIDS is considered an important partner in the fight against HIV/AIDS, and the achievement of the Millennium Development Goals (MDGs), in particular MDG 6 (combat of AIDS). The implementation of UNAIDS' mandate requires a broad approach which includes influencing policy, coordination of partnerships within and outside the UN, fundraising and performing a leadership role in the fight against HIV/AIDS at the global level.

UNAIDS is the only joint programme in the UN system and the UNAIDS Secretariat in Geneva is, as such, not an implementing organisation, but it provides the political leadership, advocacy, coordination, coherence and accountability to the work and activities of its co-sponsors: ILO, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UN-Women, WFP, WHO, and the World Bank. The Joint Programme aims to position its support in places with the highest potential to make a difference, the so-called high impact countries (HIC).[41, 42] The UNAIDS Secretariat leads the mobilization of worldwide support for the fight, and enhance global solidarity while insisting on shared responsibility. Low- and middle-income countries already provide the majority of funds for combatting the disease in their own countries. UNAIDS embodies *Delivering as One* (DAO) and *systemwide coherence*. The organisation works closely with the multilateral financing mechanism for the response, the Global Fund to fight Aids, Tuberculosis, and Malaria (GFATM), and has instigated private sector initiatives such as the 2011 initiated Global Plan to end new HIV infections among children by 2015 and keep their mothers alive.[43] UNAIDS Strategy is adopted by the UNAIDS Board and sets direction for the global response. In the reporting period, UNAIDS Board adopted the new 2016-2021 Strategy. Uniquely, it sets out the role of SRHR for the AIDS response, including sexual rights and the critical role of comprehensive sexuality education, following long member state

[40] WHO (2012). Safe abortion: technical and policy guidance for health systems. Second edition
[41] In addition to those with the most significant (14) and severe (4) HIV epidemics, High Impact Countries also include the rapidly emerging economies (including the BRICS1 countries) that will help lead the AIDS response into the future. In addition, the 30+ priority countries include those of compelling geopolitical relevance that also have high levels of infection among risk populations,2 or other key geopolitical relevance, such as acute humanitarian situations (11 countries)
[42] The Strategy 2016-2021, adopted October 2015, introduces focus on the fast-track countries that together account for more than 90% of people acquiring HIV infection and 90% of people dying from AIDS-related causes worldwide. http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf
[43] The Global Plan provides the foundation for country-led movements towards the elimination of new HIV infections among children and keeping their mothers alive. http://www.unaids.org/believeitdoit/the-global-plan.html

negotiations. This represents a critical SRHR 'upgrade' over the SDG language. It is noteworthy that the progressive Strategy was adopted under the chairmanship of Zimbabwe.

For the Netherlands key goals in the period under review were the integration of SRHR and HIV/AIDS, and successful embedding of HIV/AIDS, human rights and SRHR in the UN, and in country programmes.[44] Furthermore, the Netherlands considered it important that UNAIDS maintained its profile in support of a human rights approach, and its involvement in the post-2015 agenda. In its advocacy UNAIDS was expected to position HIV/AIDS prominently on the agenda, and taking a multi-sectoral approach focusing on prevention, health care, human rights and gender equality. Specific expectations for the collaboration with the Netherlands included:[45]

- Continuation of the reforms based on the 2011 – 2015 Strategy *Getting to Zero*.
- Active collaboration / partnering in the context of Delivering as One.
- Alignment of the activities of UNAIDS (implemented through its co-sponsors) with national structures and capacities of national government.
- Further development of the Unified Budget, Results and Accountability Framework (UBRAF), with attention to (financial) monitoring and reporting of results at country level.
- Follow up of the recommendations of the QCPR and MOPAN (2012).
- Increase attention to the collaboration with the GFATM and increased attention to the AIDS epidemic in Eastern Europe and Central Asia.
- Further development of the initiative 'NL-UNAIDS cooperation on key populations in selected countries'.[46]

As a key donor to the GFATM the Netherlands promotes the synergy between the two organisations.[47] In 2014 UNAIDS signed a memorandum of understanding with GFATM, an update from the first Memorandum of Understanding in 2008. The new agreement – up for revision in 2016 – leverages the strengths of both organizations in providing technical support to countries and coordination throughout the grant cycle. Special emphasis is placed on data collection, analysis and identification of gaps in the epidemic and the response, including on countries' enabling environments, equity in access to services, human rights, gender and key populations at higher risk. At the core of the agreement is an improved way of collaborating that strengthens coordination mechanisms, information-sharing at all levels and mutual accountability.[48]

See box 2 for the key features of UNAIDS.

Box 2: Key features of UNFPA and UNAIDS (as of November 2016)		
Key features	***UNFPA***	***UNAIDS***
Established	1969	1996 (as a multisectoral joint programme evolution of the WHO Global Programme on AIDS)
HQ	New York	Geneva

[44] Scorecards, *Kaderinstructies* 2012 – 2015
[45] Scorecards, *Kaderinstructies* 2012 – 2015
[46] Ukraine, Kenya and Indonesia, see case study on the Tripartite programme on key populations in chapter 3
[47] Total of 236 million for the period 2012 – 2015 (DSO and DSI)?? DMM??)
[48] http://www.unaids.org/en/resources/presscentre/featurestories/2014/december/20141209_GFATM_cooperation

Box 2: Key features of UNFPA and UNAIDS (as of November 2016)		
Key features	***UNFPA***	***UNAIDS***
Offices	Country: 129 Regional: 10 Liaison offices in Brussels, Copenhagen, Geneva	Country: 84 Regional: 7 Liaison offices in Addis Ababa , Washington and New York
Staff	2015: 2,697 regular staff (all offices)	2015: 832, of which 595 at field offices and 237 at headquarters
Executive Director	Dr Babatunde Osotimehin (Nigeria) since 2011, fourth Executive Director	Dr Michel Sidibé (Mali) since 2009, second Executive Director
Financial contours	Contributions to UNFPA totaled $979 million in 2015: $398 million core resources and $581 million earmarked for specific programmes or initiatives	Board approved annual budget of $ 242 million. Revenue of UNAIDS in 2015 totalled to $226 million: $201 million UBRAF core funds and $25 million earmarked funds
Board	Executive Board (for UNDP/UNFPA/UNOPS) – 36 members states (12 donor countries and 24 programme countries). NL is a member of the Board: 2007 – 2021 (with exception of 2018) and is a member of the Steering Committee for GPRHCS / Supplies	Programme Coordinating Board – 22 member state members elected in ECOSOC. NL is part of the West-European/Other Group (WEOG, 7 members) in constituency with Belgium, Portugal and Luxembourg. Co-sponsors have 6 seats at the PCB (without voting rights). UNAIDS is the only UN programme with NGO representation on the Board (without voting rights)

2.4 Financial overview and trends

In the period under review, the Netherlands' financial commitment to SRHR (including HIV/AIDS) increased from almost 377million in 2012 to more than 383 million Euro in 2015 (table 1 below), despite overall development assistance budget cuts. Throughout the period evaluated the lion's share of the funding was channelled through multilaterals and NGOs, with smaller contributions to public private partnerships (PPPs), bilaterals and others, with no clear funding trend for these smaller donations. Decisions to spread the funds for SRHR over the different channels is a consequence of the policy choices made and the understanding that a multifaceted approach is needed to achieve results in SRHR, which will involve all channels. According to a key informant from the Ministry, "*the rationale behind providing support through multiple channels is that they are complementary. It is imperative therefore to involve different types of partners, at all levels, as they play different, yet complementary roles. The UN works in a different way as compared to implementing organisations, such as NGOs. In health the UN plays an important role in norm setting, in particular the WHO. The UN is in a convening role with governments – this is where NGOs are generally not equipped for, or do not have this position. Research institutes are vital in developing and testing new or innovative approaches, which in many cases are being piloted in collaboration with NGOs. The UN in turn can assist with, or encourage governments to scale up successful approaches."* In its letter to Parliament in 2011 the MFA underlines the complementarity of the channels (multilateral, bilateral and NGOs)

as an added value. As bilateral aid is limited, additional support through the multilateral channel is important because of its outreach and the coordination capacity of the multilateral organisations. Also, the active engagement with (through various roles in Executive Board, PCB and Steering Committees) and strategic posting of Dutch experts in multilateral channels is an advantage. As the letter underlines: *"In practice the channels complement each other. This complementarity makes a simple comparison based on effectiveness not useful. Each of the channels has its own strength".*[49] See 3.3 for more background on the interplay between the different partners, and how the MFA appreciates the different partners of the Ministry and their expected contribution to the development results in SRHR. Figure 1 shows the funding allocations to the various channels during the period under review. Funding of the multilateral channel shows a steady upward trend in the period 2012 – 2015 (with the exception of 2015).

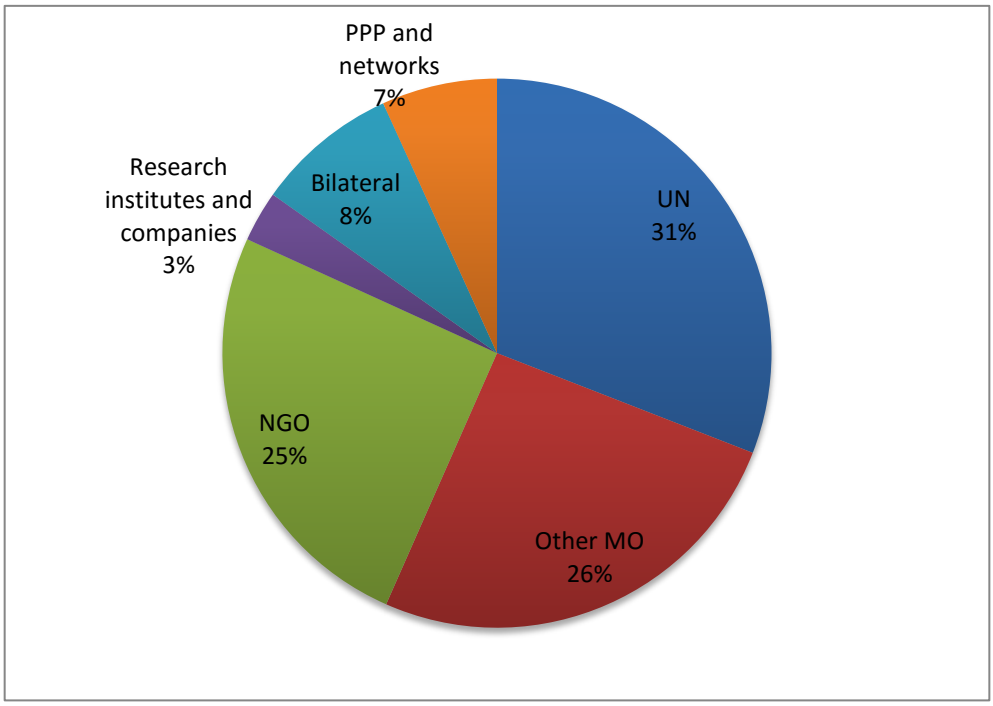
Table 1: Netherlands development cooperation expenditure (EUR million) on SRHR in 2012-2015 per channel

Channel	2012	2013	2014	2015	Total
Multilateral	184.5	237.5	250.5	217.5	890
UN	*117*	*129*	*126*	*114*	*486*
Other multilateral organisations	*67.5*	*108.5*	*124.5*	*103.5*	*404*
NGOs	88.5	110.7	102.7	94	395.9
PPP and networks	35.4	18.8	21.9	31	107.1
Bilateral	58.2	21	23.1	29.9	132.2
Research institutes and private sector	10	9.7	15.9	10.9	46.5
Total SRHR	376.6	397.7	414.1	383.3	1 571.7

Source: IOB / (OECD DAC Channel Codes, and Piramide (MFA information system)

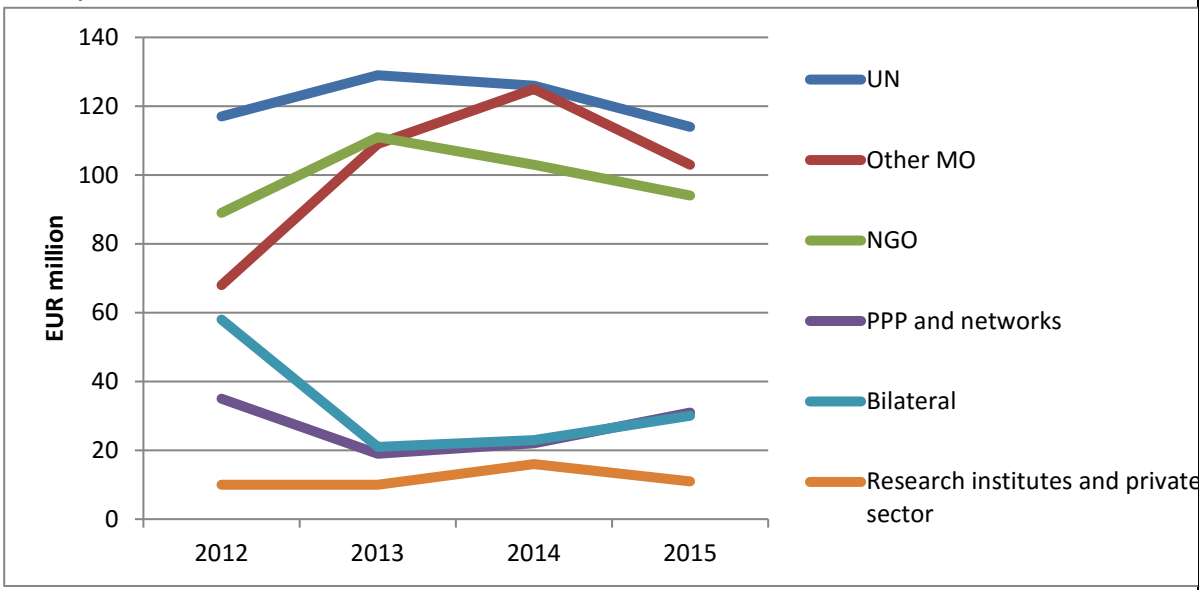
[49] Kamerbrief 7 – 10 – 2011. Multilateraal OS-beleid, Directie Verenigde Naties en Internationale Financiële Instellingen

Figure 1: Breakdown of the expenditure on SRHR in 2012-2015 (in %)



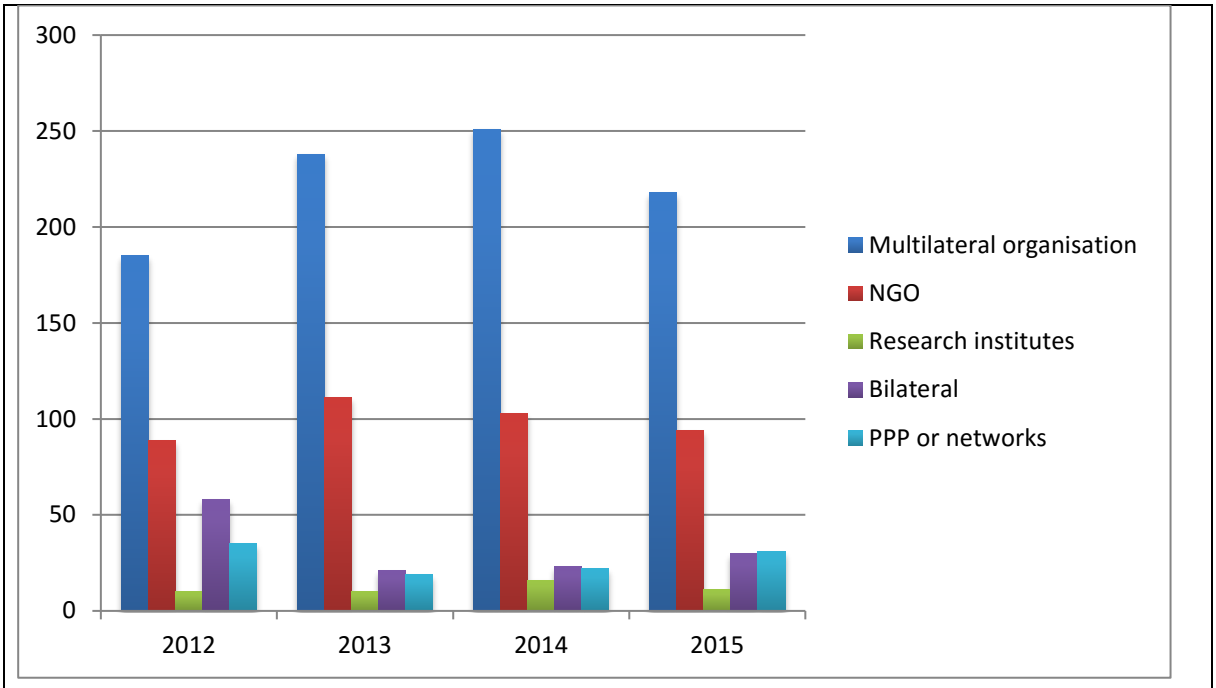
Source: Piramide and DASH (MFA information system)

Figure 2: Trend in Netherlands development cooperation budget allocation to SRHR 2012 – 2015 (EUR million)



Source: Piramide and DASH (MFA information system)

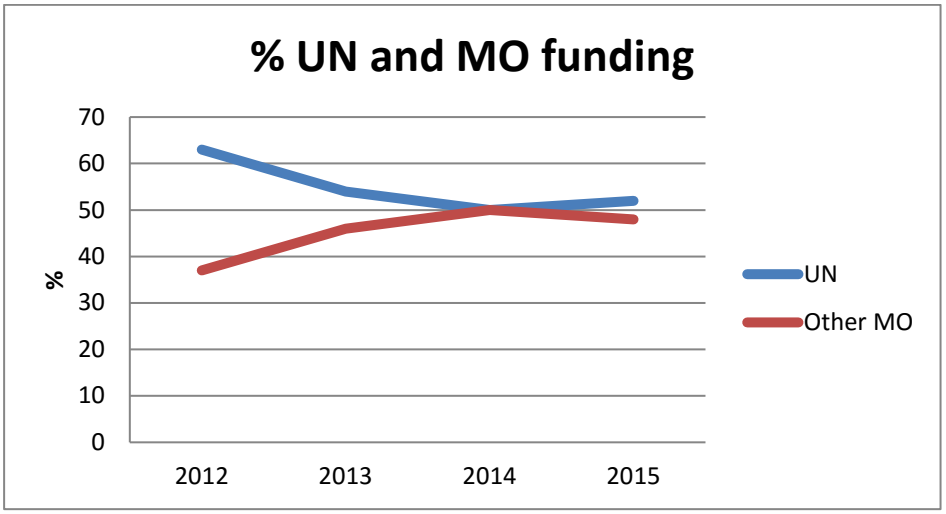
Figure 3: Trend in Netherlands development cooperation budget allocation to SRHR 2012 – 2015 (EUR million)



Source: Piramide and DASH (MFA information system)

Over the period evaluated, the proportion of multilateral funding allocated to the UN declined, whereas the contribution to other multilateral organisations such as GAVI and GFATM increased. The allocation of funding to NGOs showed some fluctuations, averaging around 100 million. Contribution to NGOs is predominantly based on the granting of subsidy proposals, differing vastly from the funding principles used for the other channels. As respondents from the Ministry indicate, contributions to the different channels are based on the assumptions of their complementarity. The UN is supported among others because of their geographical outreach which is larger than any of the NGOs, their relationship to national governments and agenda setting role at national and international levels.

Figure 4: Breakdown of Netherlands development cooperation budget allocation to SRHR 2012 – 2015 for the multilateral channel (in %)



Source: Piramide (MFA information system) and OECD DAC Channel Codes

Following a trend away from UN funding by the Netherlands, UNFPA funding has been steadily decreasing throughout the period under review, and was 10% lower in 2015 than in 2012. UNAIDS funding has remained static during the reporting period but at a significantly lower level than the € 36 million provided before 2010. Others are smaller sporadic amounts with no clear trends. See table 2.

Table 2: Distribution of funds in the area of SRHR in 2012-2015 by UN organisation (EUR million)

	2012	2013	2014	2015	Total
UNOFFICE at Geneva	-	-	0.29	-	**0.29**
UNAIDS	20.00	20.00	20.00	20.10	80.10
UNDP		3.7	5.3		9
UNFPA	72.55	79.04	66.66	65.11	283.36
UNICEF	10.26	5.72	16.72	12.34	45.04
UNODC	0.51	-	0.99	2.12	3.62
UNWOMEN	1.02	1.13	0.94	-	3.09
WHO-Assessed[50]	12.92-	18.91	15.03	14.87	61.73
Total	117.26	128.5	125.93	114.54	486.23

Source: Piramide and DASH (MFA information system)

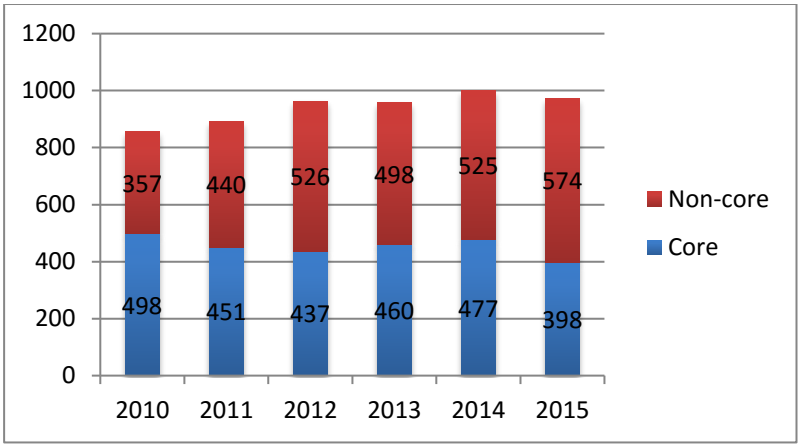
UNFPA's financial outlook

UNFPA's income base consists of voluntary contributions in the form of core and non-core contributions. Over the past 5 years the share of non-core is growing but there are no clear trends in core funding. Overall UNFPA donor support from member states is not completely predictable, therefore increasingly UNFPA is seeking to broaden its donor base, through attracting non-traditional donors such the private companies. The downside is that the support from private sector is still relatively small and also is not predictable. Overall, the total income has reached one billion in 2014 which is slightly less in 2015. The predictability of contributions is affected by political changes and, for sources outside the USA, changes in exchange rates which have been particularly volatile in the last 2 to 3 years. Despite having a strong mandate – which is useful in fundraising – there are other challenges such as the fact that a number of key donors have reduced their funding to the UN (including UNFPA) because of political choices in their home countries.[51] To counterbalance these trends, UNFPA is working on refining its local fundraising strategies, and a more focused approach in programming (see chapter 3). Figure 5 shows the overall funding base of UNFPA.

[50] Assessed is Member States contribution to UN

[51] Because they need resources to deal the influx of refugees in their country which affects the funding base for development assistance, hence contributions to the UN

Figure 5: UNFPA core and non-core contributions in 2010-2015 (in US$, millions)



Source: UNFPA

The Netherlands provides both core and non-core funding to UNFPA. Core funding decreased slightly from 40 million Euro in 2012 and 2013, to 35 million Euro in 2014 and 2015. Non-core funding increased vastly in the same period; most of it channelled to contraceptives and RH commodity security programmes.[52] In the period under review the Netherlands ranked high as one of the top 5 donors to the organisation. In 2013 the Netherlands ranked as second largest donor overall (core and non-core combined), and third donor for core funding only. This pattern was fairly stable during the evaluation period; in 2015 the Netherlands was also the third largest donor, contributing some 10% of the total donor core funding. For non-core funding, the United Kingdom is the largest donor contributing around 185 million US$.

Table 3: Netherlands core and non-core contributions to UNFPA in 2012-2015 (in Euro)

	2012	2013	2014	2015	Total
Non-core					
ICPD Beyond review	910.000	1.141.213	6,84		2.051.220
UNFPA Programme Support	200.000				200.000
Global Programme ERHCS	31.000.000	33.000.000	8.000.000		72.000.000
Global Programme Reproductive Health Commodity Security (2015-2018)			19.500.000	26.500.000	46.000.000
Bangladesh: Generation Breakthrough (2012), ASRHR (2013)	400.001	1.003.200		1.801.324	3.204.525
Burundi: Contraceptive CS		1.499.971	1.900.000		3.399.971
Mozambique: Geracaobiz		600.000	548.559	547.255	1.695.814

[52] A commitment until 2018

Table 3: Netherlands core and non-core contributions to UNFPA in 2012-2015 (in Euro)					
	2012	**2013**	**2014**	**2015**	**Total**
Yemen: census 2014		800.000			800.000
Yemen: RHCS		1.000.000	1.700.000	1.265.789	3.965.789
Subtotal non-core	32.510.001	39.044.384	31.648.566	30.114.368	133.317.319
Core	40.000.000	40.000.000	35.000.000	35.000.000	150.000.000
Total core and non-core	72.510.001	79.044.384	66.648.566	65.114.368	**283.317.319**

Source: Piramide (MFA information system)

The Netherlands is among the donors that have provided predominantly core funding to UNFPA. Interviews with key informants substantiate the rationale for this, as core funding remains important for the implementation of the full mandate, whereas non-core funding is directed at specific activities and may create silos as well as adding to the administrative burden. The relatively substantial *non-core support* to the Global Programme ERHCS which totalled 72 million and Global Programme Reproductive Health Commodity Security, which reached to an overall 46 million in 2014 and 2015, could be considered as an exception rather than a reversal of this trend, as the GPRHCS funding was a financial commitment the Netherlands made to deliver on their promise made at the Family Planning Summit in 2012 to accelerate support to family planning. Reproductive health commodities are considered the backbone in SRHR, as commented by one of the interviewees: "*without SRH commodities, no SRHR*".[53]

The scorecards[54] and information from informants[55] clearly state the downside of increasing non-core funding, acknowledging the danger that the broader vision of what UNFPA stands for can get lost if funding is focused on projects, as *"the non-core funds cannibalize on the core funds, and too many specialised programmes hollow out basic infrastructure of the organisation."*[56] Also, the management costs not only increase on the donor side but also for UNFPA, and the organisation is more burdened with administrative issues. Another downside is the fact that a decrease in core funding can have a detrimental effect on the technical branches of the organisation, which in the case of UNFPA are predominantly financed through core funding. The same applies to other important areas of UNFPA work such as advocacy at the global level, and policy influencing work

[53] Another exception, albeit before the period under review, was the earmarked support to UNFPA Maternal Health Thematic Fund (MHTF, during the initial years of the Fund from 2008 onwards). According to the Ministry the support to MHTF was considered strategic support, as it was a cognizant move to spur progress on MDG5, by jumpstarting safe motherhood programmes in the least developed countries. For the Netherlands non-core support was important to underline the role of midwives, emergency neonatal and obstetric care in safe motherhood, and to support other crucial areas in maternal health like fistula

[54] Scorecards are assessments of the organisations prepared by the MFA every 2 years, covering institutional aspects of the organisation, its functioning and policy relevance

[55] From within the Ministry and UNFPA

[56] For example, for an earmarked project in South-Sudan 8% overhead is charged which does not cover the actual costs of implementing a programme in such a country

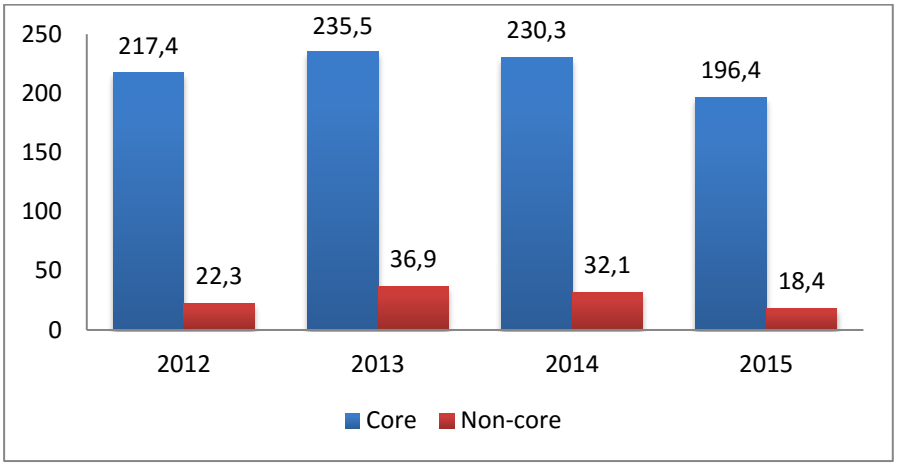
UNFPA is doing: work that is highly appreciated by the NL, and instrumental in furthering the POA of the Cairo agenda.

UNAIDS' financial outlook

UNAIDS's income base consists of voluntary contributions – the vast majority from governments, in the form of core and non-core contributions. The annual PCB approved core budget in the period 2012 – 2015 was zero growth at $ 242 million. This budget supports the work of co-sponsors and the Secretariat (presence at country, regional and HQ levels). Initially, the core budget of UNAIDS only covered the work of UNAIDS Secretariat. This was based on the founding resolution of UNAIDS (ECOSOC 1994/24) according to which *"The co-sponsors will contribute to the resource needs of the programme"* and *"Funding for country-level activities will be obtained primarily through the existing fund-raising mechanisms of the co-sponsors."* This changed with a rapidly changing epidemic and response, and a part of the core budget, mobilized by UNAIDS Secretariat is now allocated for the work of the co-sponsors. The core UBRAF funds support cosponsor mobilizing further funds for HIV and leveraging of their organizations' own resources. While the core budget of UNAIDS has remained constant in nominal terms since 2008, the share of the co-sponsors of the budget has increased over the years.[57] In terms of distribution of funds over the strategic goals, for the period 2014 – 2016 close to 50% is reserved for HIV-prevention; almost 30% for treatment, care and support; and 23% for human rights and gender.

UNAIDS receives most of its funds through core funding (figure 6). Compared to other UN organisations UNAIDS is in a relative fortunate position as core funding provides independence, enhances flexibility and allows the organisation to more effectively respond to development needs.[58]

Figure 6: Breakdown UNAIDS funding in 2012 – 2015 (USD million)



Source: UNAIDS[59]

The majority of the funds of UNAIDS comes from a group of seven large donors (Finland, Norway, the Netherlands, Sweden, Switzerland, United Kingdom and the United States), with the USA as the

[57] https://results.unaids.org/resources/ubraf-funding
[58] Scorecard 2015, and interviews with key informants
[59] Information from UNAIDS' webportal (https://results.unaids.org/resources/contributions). Assessed January 2017

highest contributor (around 45 million USD annually), followed by Sweden and Norway. Notably is the steep decline of contributions from Sweden in the period under review: from 41 million USD in 2012 to 24.9 million USD 2015; whereas the contributions from the Netherlands remained relatively stable during the same period (see table 4). Overall, the Netherlands is an important donor to UNAIDS, ranking the 4th position among the main donors (2012 – 2015). For UNAIDS the principles of shared responsibility and global solidarity are pivotal in ending the epidemic. Therefore contributions from low- and middle-income countries are encouraged and welcomed, such as the recent core contributions of Russia, Congo, Ivory Coast and Senegal.

Table 4: Netherlands contributions to UNAIDS (core and non-core)

Year	*Type of funding*	*Amount (in USD)*
2012	Core	24.9
	Non-core	-
2013	Core	26.2
	Non-core	-
2014	Core	27.2
	Non-core	0.4
2015	Core	22.7
	Non-core	0.1

Source: UNAIDS.[60]

An important element of UNAIDS's work is mobilizing resources for the response to AIDS at large and not only the UNAIDS budget. Increasingly this is done in capitals in low- and middle-income countries as well. The results are significant with 57% of the 19 billion dollar annual investment in the response, coming from low- and middle-income countries and some 8 to 9 billion USD as international resources. To continue the HIV/AIDS response, UNAIDS recognised the need to broaden its donor base given budget cuts from major (traditional) donors, and the need – in light of the post-2015 agenda – to maintain the momentum. According to the Executive Director of UNAIDS: *"The post-2015 debate provides a not-to-be-missed opportunity to emphasize HIV as an entry point for social transformation in the broader health and development agenda, including through tangible impact on human rights and gender equality".*[61] As other UN organisations UNAIDS is experiencing the consequences of exchange rate fluctuations, and reduced financial support of key donors.[62] Interestingly however, a significant amount of African countries are providing funding to UNAIDS, including, Cote d'Ivoire, Mali, Niger, Senegal and Zimbabwe.

Monitoring contributions and support to the UN

UNFPA and UNAIDS are not comparable in terms of organisational structure, some monitoring instruments and agents however are of the same nature:

- In the case of both organisations the Netherlands is represented at the Board: UNFPA at the level of the Executive Board; and UNAIDS at the level of the Programme Coordination Board.

[60] Information from UNAIDS' webportal (https://results.unaids.org/resources/contributions). Assessed January 2017
[61] UNAIDS (2014i). Report of the UNAIDS Financing Dialogue
[62] Some 30% of the 2017 budget is unfunded which in part can be seen as a direct result of ODA cuts in some European donor countries – funds which are needed to respond to the consequences of the Syrian conflict – and other political decisions

The representation at the PCB offers many opportunities for dialogue and discussion on programme plans, for example through its thematic sessions organised during the PCB meetings.

- UNFPA Reports, such as annual reports of the organisations and financial statements.
- For UNFPA, the Integrated Results Framework; and for UNAIDS, United Budget Results and Accountability Framework (UBRAF).
- UNFPA reports to the Executive Board and UNAIDS reports to the PCB.
- Active engagement in policy dialogue and in board meetings and similar governance processes, including consultative processes for developing strategies and budgets.
- Board of Auditors' reports. Since 2015 also – at the request of the donors[63] – an audit opinion is included, including an assessment of whether risk management and internal control processes are adequate and effective.[64]
- Evaluation reports, such as MOPAN, Development Effectiveness Review (DER), and others.
- Policy meetings (bilateral) between Netherlands and the organisations and or other progress meetings at HQ level (between the Permanent Mission to the UN in New York and Geneva). On an *ad hoc* basis representatives from the Netherlands MFA arrange meetings with staff from both organisations.
- In the case of UNAIDS, the Friends of UNAIDS (co-chaired by the Netherlands) provides a platform for exchange of information and collaboration between large donors and senior management of UNAIDS.
- Through Embassies and Permanent Missions to the UN.
- Since 2013 UNFPA has published data on the International Aid Transparency Initiative (IATI), the international standard for publishing data on development activities. UNAIDS published data on IATI for the first time at the end of 2016.[65]
- Since 2014 the internal audit department Office of Audit and Investigation Services (OAIS) has assessed UNFPA and its partners. Also UNFPA has an Audit Monitoring Committee.

All these instruments provide monitoring and accountability information; some are more relevant than others when it comes to deciding on the allocation of funds to a particular organisation. For these decisions other considerations come into play, such as political discussions, scorecards of the organisations, multilateral and external reviews of the organisation (regarding effectiveness and efficiency) and the closeness of fit of the mandate and strategy of the organisation with the Netherlands policy goals in the domain of SRHR.

2.5 Conclusions

What are the grounds for involvement in SRHR for the Netherlands MFA?

[63] Statement for UNFPA Executive Board. Agenda Item 14: Internal Audit and Oversight. June 10, 2016 (Joint statement of Canada, Denmark, Germany, Italy (TBC), the Netherlands, New Zealand, Sweden, Switzerland, the United Kingdom, and the United States)

[64] Report of MFA DMM (Rijks-Intern VN-UNFPA – SRGR Jaarlijkse Uitvoerende raad UNFPA juni 2016 New York; 16 juni 2016)

[65] Launched at the High level Forum on Aid Effectiveness in Accra (2008), IATI increasingly is the standard which is being used by partners (including the UN) to report on progress and results. https://www.iatiregistry.org/ UNFPA's June 2015 Release contains 2012, 2013 and 2014 data. An additional 'real-time' dataset is available as of September, 2015 highlighting current project budgets, commitments and expenditures monthly

Historically the Netherlands has positioned SRHR as a central theme in its development agenda, underlying the human rights connotations of SRHR, and living up to its commitments to support the Programme of Action of the Cairo agenda. The Netherlands' SRHR policy remained consistent in terms of promoting reproductive and sexual rights, human rights – in particular of women, youth, and key populations – and giving attention to sensitive areas such as abortion and adolescent SRH. The focus on SRHR was intensified in 2012, when the development agenda was tied to four key areas one of which is SRHR. The policy of MFA is in line with the global MDG agenda, thereby recognising the crucial role of SRHR in also achieving the other development goals, and illustrating that lack of progress on SRHR has hampered improvement of maternal health, achievement of universal access to SRH and reduction in the unmet need for family planning, among others.

For the Netherlands, what is the specific relevance of the collaboration with UNFPA and UNAIDS in achieving the policy priorities of the Netherlands in SRHR?

UNFPA and UNAIDS are relevant in the development agenda of the Netherlands, as both are key UN actors in SRHR. UNFPA is the only organisation of the UN with a specific mandate for SRHR. The work of the organisation is based on the Programme of Action of the Cairo and Beijing Conferences, and therefore relevant and important for achieving policy priorities of the Netherlands. Other specific aspects include UNFPA's work on comprehensive sexuality education, the (joint) efforts in combating gender based violence, and in preventing child marriages. UNAIDS is relevant for its clear focus on intensifying the fight against HIV/AIDS – closely tied to MDG 6 and SDG 3.3 – and coordinating the contribution of multilateral organisations. UNAIDS is not an implementing organisation, therefore its relation to the Global Fund is important, as well as the strength of the organisation in positioning the fight against HIV/AIDS on the global and national agenda. Both organisations are seen as relevant partners in facing growing conservative voices, threatening the implementation of the SRHR agenda.

What is the proportion of SRHR expenditure for UNFPA and UNAIDs, and what are the financial trends and outlook of these organisations? And, which monitoring instruments are available to the Netherlands for progress monitoring and accountability? What conclusions can be drawn on the choice of the Netherlands MFA for UNFPA and UNAIDS, in terms of justification of policy and financial allocations?

The proportion of the 2012 – 2015 budget for SRHR allocated to the UN averages 569 million Euros, which is about one third of the overall total 1.6 billion Euros of Dutch support to SRHR. UNFPA and UNAIDS are the largest UN recipients with UNFPA receiving an average 50 million Euro (core and non-core funds), and UNAIDS more than average 20 million Euro (predominantly core funding). The Netherlands is an important donor for both UNFPA and UNAIDS, in both cases featuring among the top 5 donors. The trend of providing funds in the form of core funds remained relatively stable in the period under review, with the exception of non-core funds for UNFPA's flagship programme, the Global Programme on Reproductive Health Commodity Security (GPRHCS, in 2014 renamed as UNFPA Supplies). Making exceptions to this general rule were justified because certain areas required additional strengthening (such as RH commodities, or the support to the ICPD review process), and in the past for strategic reasons such as in the case of support to the Maternal Health Thematic Fund.

The Netherlands' support for SRHR via the UN is complementarity to other channels, including NGOs, research institutes and the private sector, bilateral and multilateral organisations. Seeking

complementarity between the channels is seen as beneficial to achieving results, as all are foreseen to work on the same agenda and played a specific role in achieving the goals for the period 2012 – 2015, yet through different modes. For the UN this includes their geographical reach, convening power, partnering with governments, and agenda-setting capacity.

In order to monitor progress and to account for expenditure the Netherlands applied a varied mixture of instruments. It is concluded that the instruments combined provide the necessary level of information on progress.

In conclusion, based on the assessment of strategic and policy intentions of UNFPA and UNAIDS in the period under review, the choice of these organisations is justified, as they are well aligned with the priorities of the Netherlands development agenda in SRHR – and considering the role of SRHR in achieving the broader development agenda. Regarding the form of allocations, it is concluded that the Netherlands – giving its appreciation of the benefits of core funding – remained relatively true to this belief, with the support to reproductive health supplies as an exception.

III. Effectiveness of the programmes financed

Guiding questions to be answered in this chapter:

- To what extent have UNFPA and UNAIDS achieved the development objectives and expected results:
  - Performance regarding organisation-wide and country-wide results.
  - Contribution to national goals and priorities, including MDGs, and shaping of the post-2015 agenda.
- To what extent did UNFPA and UNAIDS supported activities effectively address the cross-cutting issue of gender equality?
- To what extent are UNFPA's and UNAIDS's programmes sustainable?
- To what extent were UNFPA and UNAIDS able to meet the expectations of the Netherlands considering the priority areas of the Netherlands in SRHR?
- What conclusions can be drawn on the effectiveness of UNFPA and UNAIDS for achieving development objectives in SRHR?

3.1 Introduction

Effectiveness means the extent to which the objectives are met.[66] In this review the effectiveness of UNFPA and UNAIDS is assessed, presenting evidence regarding UNFPA's and UNAIDS' relevance and effectiveness, looking at progress towards organisation-wide and country level results. In this section progress towards achievements of the goals of the four MFA's thematic priorities in Sexual and Reproductive Health and Rights is presented. In annex 6 the strategic frameworks that have guided UNFPA and UNAIDS in the period under review are outlined.

3.2 Strategic focus of UNFPA and UNAIDS

The MOPAN 2014 report on **UNFPA**[67] rates the organisation 'strong overall on relevance'; evidence is presented on how UNFPA is *"pursuing results relevant to its mandate that are aligned with development trends and priorities and that respond to the needs and priorities of beneficiaries, and that UNFPA adapts to changing country circumstances."*[68] Other reviews and interviews with key informants confirm the relevance of UNFPA's mandate which is tied to the Programme of Action of

[66] https://stats.oecd.org/glossary/detail.asp?ID=4775
[67] MOPAN (2014). *Organisational Effectiveness Assessment UNFPA 2014.* Synthesis and technical reports (Volume I and II)
[68] Ibid

the unfinished Cairo agenda.[69] There is similar commendation for UNAIDS as an organisation with a clear and strong mandate.[70]

The strategic focus of both organisations is in concurrence with the priorities of the Netherlands. Key in the strategic frameworks that guided **UNFPA i**n the period under review is the focus on family planning, gender, and work related to improving data availability and analysis around populations dynamics, sexual and reproductive health, and gender equality.[71] UNFPA is also one of the co-sponsors of UNAIDS, and it that regard focuses on promoting SRH rights of key minorities, in particular sex workers. The UNFPA Mid-Term review in 2011 resulted in the development of Theories of Change (ToC) for each outcome area, and a revision of UNFPA's Business Model to better adapt to the different needs and shifting nature of support requested by countries in which UNFPA operates.[72] This revised focus was expected to affect the way the organisation operates and distributes funds, and also to affect the skills sets required to respond to countries' specific and changing needs. For the Netherlands UNFPA is considered a key player in moving the family planning agenda, and is instrumental in ensuring inclusion of the outcomes of the ICPD+20 review into the sustainable development goals (SDGs) and the post-2015 agenda.[73] Some key informants are critical though on how UNFPA withholds from taking a prominent position in the debate on sensitive issues in SRHR, such as abortion. Interviews with key informants are not conclusive on how UNFPA should position itself in this, as the organisation is constrained by its governance structure.

The MOPAN report (2012) rates the strategic focus of **UNAIDS** as 'strong' concluding that the organisation consistently showed *"strategic leadership and a commitment to organisational renewal while also continuing to track the epidemic and provide critical evidence based guidance"*. More recent reviews and interviews with key informants value UNAIDS as a key player in providing up-to-date evidence and as a leader in positioning HIV/AIDS on the global agenda: *"UNAIDS is at the forefront of the struggle for human rights, and increasingly influences other UN organisations' thinking in this field."*[74] UNAIDS is an important partner for the Netherlands in the promotion of an effective and inclusive HIV/AIDS policy at national and international levels. For many development partners, including the Netherlands, UNAIDS is an important advocate for HIV/AIDS and a catalyst for combating discrimination.[75] For the Netherlands UNAIDS is an important ally in the fight against AIDS, not only from a bio-medical perspective, but also for its work on prevention, stopping the feminisation of the epidemic, and improving access to information, care and treatment for women and girls and key populations.[76] Also, UNAIDS is considered to play a role in establishing linkages between SRHR and HIV/AIDS (and the integration of HIV in SRHR) by (a) ensuring access to information (especially for young people); (b) the protection of rights, and access to treatment and care for sexual minorities; (c) self determination for women and girls; (d) prevention of mother to child transmission; and (e) decrease HIV/AIDS related deaths in pregnancy and delivery. Key

[69] DER 2016: Global Affairs Canada (2016). *Development Effectiveness Review of UNFPA 2008 – 2014;* and key informants from the MFA
[70] UNAIDS (2014a). *Key findings from external reviews and assessments of UNAIDS 2012- 2013. Overview and summary*
[71] All of which were rated strong by MOPAN donors at headquarters. MOPAN UNFPA 2014
[72] This approach is referred to as 'Bulls Eye"
[73] According to key informants of the MFA. See the Case Studies on UNFPA Supplies in Chapter 3
[74] DANIDA (2014). *Danish Organisation Strategy for UNAIDS 2014-2016*
[75] Interviews with key informants and reports: DANIDA 2014, UNAIDS key findings from external reviews
[76] Scorecards 2013 and 2015

informants from the Ministry confirm that UNAIDS consistently confronts sensitive issues such as rights of the most vulnerable groups, discrimination and the SRH rights of adolescents and youth. UNAIDS is also a strong partner in conducting high level advocacy for equal access to health care, and the rights of vulnerable populations and LGBTI.[77] The IOB report 2013 'Achieving universal access to Sexual and Reproductive Health and Rights' concludes that UNAIDS plays a *"crucial role in the involvement of PLWH and strengthening of their capacity and leadership"* and that "*UNAIDS is instrumental in the positioning of HIV/AIDS as a human rights issue".*[78] Interviews with staff from UNAIDS substantiate the organisations involvement in defending the rights of key populations with many current examples of how UNAIDS operated at various levels and responses. For example in the case of the anti-gay laws in a number of African countries where the organisation played a role in managing the crisis and acting as 'friends of the court', giving technical advice on health and human rights.

The Netherlands AIDS and SRHR policy is partly developed on the data and insights collected and distributed by UNAIDS. UNAIDS data encouraged the Netherlands to support specific interventions, such as increased attention to marginalised populations. Interviews with key informants commend UNAIDS for its expertise and central role in providing quality data on HIV/AIDS; overall, the organisation is considered *the* reference base for up-to-date data on trends and developments in the domain of AIDS.

3.3 Achievements of UNFPA and UNAIDS in 2012 – 2015

This section in the document summarises the performance regarding organisation-wide and country-wide results, outlining the contribution of UNFPA and UNAIDS to national goals and priorities, including MDGs, and shaping of the post-2015 agenda. In addition, cross-cutting issues of gender equality and sustainability are addressed.

3.3.1 UNFPA

Box 3: UNFPA outcome areas	
Outcome areas under the SP 2008 - 2013	**Outcome areas under the SP 2014 - 2017**
(1) Population dynamics (2) Access and use of MNH services (3) Access to FP (4) Access to HIV and STI prevention services (5) Gender equality and RR through advocacy and laws and policy (6) Improved access to SRH services and SE for young people and adolescents (7) Improved data availability and analysis around population dynamics, SRH (including family planning) and gender equality	(1) Increased availability and use of SRH services (including FP, maternal health and HIV) (2) Increased priority on adolescents, especially on very young girls (3) Advanced gender equality, women and girls' empowerment and RR for the most vulnerable and marginalized women, adolescents and youth (4) Strengthened national policies and international agendas through the integration of evidence-based analysis on population dynamics and their links to sustainable development, SRH health and reproductive rights.

[77] LGBTI is abbreviation that covers lesbian, gay, bisexual, transgender, transvestite and intersex people
[78] IOB (2013). *Achieving universal access to Sexual and Reproductive Health and Rights. Synthesis of multilateral contribution to SRHR during the period 2006-2012*

Below an overview of results are presented on the main areas of work of UNFPA.[79]

Sexual and reproductive health[80]

The assessment of the effectiveness of the work of UNFPA draws upon (external) reference material available, including the MOPAN 2014 and the DER 2016. The first, the extensive review (MOPAN 2014) of UNFPA's performance during 2008 – 2013 SP sees UNFPA's largest contributions in that period in the areas of family planning, (advocacy for) gender equality, and work related to improving data availability and analysis around population dynamics, SRH and gender equality. DER 2016 mentions as overall conclusion on UNFPA effectiveness: "*UNFPA programmes produced positive benefits for target group members. Their ability to identify and engage with key policy actors in the development of strategic policies/frameworks in, for example, family planning, gender-based violence, and sexual and reproductive health, facilitated the achievement of objectives. This was also supported by UNFPA's role in building coalitions and advocating for the targeting of vulnerable populations. When programme objectives were not achieved this often related to: weak project design; fragmentation of UNFPA support; and, weaknesses in the technical capacity of UNFPA staff sometimes associated with high rates of attrition and staff turnover.*" In addition the DER reports that overall *"UNFPA has been effective in achieving the development objectives of its programmes and in contributing to significant changes in national development policies and programmes*".

The 2016 synthesis of lessons learned from UNFPA Country Programme Evaluations (CPEs) looked at the reported effectiveness in the country programme evaluations. Actions under this outcome area vary from the provision of vital services like family planning and maternal health, and also includes the promotion of demand for these services. The synthesis notes that whenever SRH interventions were made available they were widely and effectively used. However the effectiveness of SRH services was dependent on factors such as how the information was disseminated, the policy framework, the competence and capacity of the service providers and government departments and how health services were financed. Below some examples of results under this outcome area.

Box 4: Sexual and reproductive health [81]	
A snap shot of the results under SRH	
Training and capacity building	**Sudan**: An increase in young women training as midwives was the result of work with religious and community leaders **Cambodia:** Supporting recruitment and training of midwives resulted in greater availability of trained staff

[79] This review does not detail UNFPA's work in humanitarian emergencies (conflicts, natural disasters and other emergencies). In brief, UNFPA works on ensuring access to SRH services and that RH needs are integrated in emergency responses and in the reconstruction phase. Part of the work includes the prevention and responding to GBV; empowering women, adolescent girls and young people; and raising awareness on the specific needs of young people in emergencies. The organisation plays a critical role in collecting data during emergencies. Some results reported for 2015 are the publication of the (toolkit) Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies; the deployment of more than 100 trained and skilled staff in emergencies; the distribution of reproductive health kits; the revision and global roll out of the revised Minimum Initial Service Package (MISP); disbursement of emergency funds (5 million USD); and the publication of a toolkit on SRH for urban refugees and strengthened the risk analysis.

[80] Outcome 2 under the SP 2008 – 2013 and outcome 1 under the new SP 2014 – 2017

[81] Summary of results presented in: UNFPA (2016b). *Lessons learned from UNFPA Country Programme Evaluations*

Box 4: Sexual and reproductive health [81]	
Research, education and policy development	**Gambia:** Working with religious and political leaders raised awareness of the effects of GBV, FGM and early marriage **Namibia:** Work with community leaders and men led to improvements in referrals to primary healthcare facilities **Thailand:** Multiple communication channels increased the availability of information and services for vulnerable groups
Commodity security	**Gambia**: UNFPA was the sole supplier of condoms to the Ministry of Health and Social Welfare **Niger:** The procurement and availability of contraceptives and laboratory consumables significantly reduced the problem of stockouts **Pacific Islands:** A regional warehouse improved national access to commodities
Emergency preparation and response	**Haiti:** Rapid response after the earthquake resulted in a newly restored surgical unit, a rise in Caesarean sections and a reduction in maternal deaths **Madagascar:** Improvements in emergency obstetric care, as well as the provision of equipment and training led to greater use of obstetric services **Myanmar:** Support given to reproductive health services increased the use of these services by mothers and reduced emergencies, which in turn reduced child and maternal mortality rates

Maternal health [82]

The most recent evaluations of UNFPA's contribution to maternal health are the 2012 Midterm evaluation of the Maternal Health Thematic Fund (MHTF)[83] and the organisation-wide evaluation of UNFPA's support in this area covering 2001 – 2011.[84] The thematic fund evaluation concluded that the Fund acted positively as a catalyst in specific areas, among others in the emergency obstetric and newborn care (EmONC) improvement plans that governments endorsed and to which DPs contributed. However, increasing complementarity and synergies at country levels was not optimally achieved. Also the Mid-Term evaluation concluded that more synergy was needed between programmes, such as the GPRHCS, the Campaign to End Fistula, the UNFPA-International Confederation of Midwives (ICM) Midwifery Programme and the UNFPA HIV-PMTCT Programme. The evaluation notes the focus on midwifery and EmONC as relevant and appropriate; though sustainability prospects were at times compromised by a lack of strategic long-term planning and exit strategies. The global context of midwife shortage seemed effectively addressed; to a lesser extent attention was given to strategies ensuring their retainment. The evaluation concludes that there was due attention to policy dialogue and a focus on maternal health priorities, but demand creation was

[82] Outcome 2 SP 2008 - 2014

[83] The Netherlands supported the MHTF in the first years of the thematic programme (from 2009 onwards), specifically focusing on the role of the midwife

[84] Both evaluations are included in this review – despite the fact that they refer to the period 2008 - 2011 – because of their relevance to demonstrate the work, trends, and the challenges UNFPA is facing in maternal health, a key area for the organisation. The updated management responses and the annual reports provided information on how UNFPA responded to the recommendations

not prioritised sufficiently.[85] The thematic fund evaluation complemented the organisation-wide evaluation on maternal health. This evaluation acknowledged the contribution of UNFPA to improved harmonisation of maternal health support (in particular through partnerships); stronger involvement of communities and increased demand for RH services; and increased human resources for maternal health. Areas identified for improvement included the staff capacity and gaps in the skills available in country offices. Result-based monitoring systems require strengthening, as does knowledge generation. The evaluators recommend focusing on countries with the greatest needs and on the most vulnerable groups. The updated 2014 Management Response on the UNFPA Support to Maternal Health (2000 – 2011) reports on the actions taken to address the recommendations. With regard to 'improving capacity of UNFPA COs' actions included: staff meetings regional level, revising terms of references of senior managers, forming partnerships on adolescents and FP (once these strategies are rolled out). The recommendation to better address the needs of marginalised or vulnerable populations was taken further in the UNH4+ partnership, among others, through supporting evidence-based innovations to reach out to such populations.[86]

Family planning [87]

The 2016 UNFPA Family Planning Evaluation, covering two Strategic Plan periods, underlined the holistic approach that is required to address the multifaceted determinants of access and use at the policy, service system and community levels.[88] Programming for FP therefore must be collaborative, making strategic use of the comparative advantages of UNFPA and building on a shared understanding of the position of family planning within an integrated sexual and reproductive health rights framework. The evaluators applaud the leadership role UNFPA performed as an advocate for integrating FP into broader sexual and reproductive health services, adopting a human rights based approach and committing to reaching vulnerable and marginalised groups (VMG), however they note that not all of the potential of its broker role is fully utilized, as there is a critical gap between the commitment to FP and the extent to which this is operationalised within its programmes of support. Although the 2008 – 2013 evaluation covers a period that ended in the middle of the period of this review, the findings are relevant, as issues identified were not unique to family planning, or had been raised in prior evaluations. These include the difficulties of managing across silos; vertical vs

[85] UNFPA/Evaluation Branch/Division for Oversight Services (2012). *UNFPA Support To Maternal Health. Thematic Evaluation /Volume 1 and II*; and UNFPA/Evaluation Branch/Division for Oversight Services (2012a). *Thematic Evaluation. UNFPA support to maternal health 2000-2011.* Final report + VOLUME 2 Annexes

[86] Partnership of UNAIDS, UNFPA, UNICEF, UN Women, WHO, and the World Bank working together as "H4+", to intensify their collective, coordinated and harmonized support to the countries with a high burden of maternal, newborn and child mortality and morbidity (the technical arm of the UN Global Strategy for Women's and Children's Health. See: UNFPA (2014). The H4+ partnership Joint support to improve women's and children's health

[87] Outcome 3 SP 2008 – 2013

[88] The objective of the FP evaluation was to assess how the framework as set out in UNFPA Strategic Plan 2008-2013 and further specified in the Reproductive rights and sexual and reproductive health framework (2008-2011) as well as in the GPRHCS (2007-2012) and the HIV/Unintended Pregnancies framework (2011- 2015), has guided the programming and implementation of UNFPA interventions in the field of family planning. Also, to facilitate learning and capture good practices from UNFPA experience across a range of key programmatic interventions in the field of family planning during the 2008-2013 period. The evaluation which took place between 2014 and 2016 was thorough in its design, combined quantitative and qualitative methods and included: a desk study and financial review at global level; document review, global and regional interviews, CO survey and stakeholder survey (online survey in 64 countries), 12 country case studies (5 field and 7 desk-case) and FGDs in 5 countries. The management response values the findings and considers the recommendations as an opportunity to advance FP. Three of the 6 recommendations are considered to be of *very high priority* (recommendation 1, 2 and 3). Recommendation 4 is considered of *high priority*, and 4 and 5 of *medium priority*. All found their translation into operational actions, and progress will be monitored and reported upon

integrated approaches for family planning; capacity to advocate on sensitive issues; gaps in knowledge management. The country case studies further illustrate UNFPA's work on family planning at the country level, the successes and the challenges. For example, the country case on Ethiopia outlines the difficulty of implementing a human rights based approach, and the fine balance that needs to be found between strong government promotion of family planning and respect for users' freedom of choice (including the choice of not using FP). (See also the case study on GPRHCS).[89] The case study on Ethiopia also showed how strong national leadership can lead to rapid increase in demand and uptake of family planning, and a potential space for UNFPA to broker between government, NGOs and the private sector was identified.[90] In box 5 below a summary of the overall evaluation conclusions and recommendations is presented.

Box 5: UNFPA Family planning evaluation – summary of the conclusions and recommendations

Conclusion 1 on raised profile: UNFPA, through the GPRHCS, raised the profile of family planning.

Conclusion 2 on brokering: UNFPA has played an important role in coordinating action in FP at internal and national levels. However, in some contexts UNFPA found it difficult to fill the gap in brokering between government, NGOs and private sector.

Conclusion 3 on integration: UNFPA has had mixed success in promoting and supporting the integration of family planning with other sexual and reproductive health services. There are upstream successes (commitment to integration at policy level), but less success in integration of SRH services and FP at the service delivery level (downstream).

Conclusion 4 on sustainability: Successes are identified on improving financial sustainability for FP, for example through improved government commitments to FP. Less progress is seen in supporting efforts to sustainably strengthen health systems to deliver quality FP services.

Conclusion 5 on key and marginalised populations: There are mixed results on implementing the HRBA to programming in family planning. At global level advocacy has been successful, but at country level there are differences in understanding of the approach.

Conclusion 6 on evidence and learning: UNFPA is an important source of practical field level experiences in FP, however there is a lack of systematically organising evidence on important aspects of effective programming in family planning.

Conclusion 7 on modes of engagement: UNFPA country offices are well attuned to the needs and priorities of their government partners, however more focus is needed on the demand side and on building longer term, sustainable domestic commitment to family planning delivery in the context of an integrated approach. More support to knowledge management is needed.

Conclusion 8 on contributing to commodity security: UNFPA was effective in supporting national governments on FP (need to invest, supply chain strengthening), in lowering contraceptive prices, and in improving the availability of different contraceptive

[89] Country case studies on Bolivia, Burkina Faso, Cambodia, Ethiopia and Zimbabwe. Available at: http://www.unfpa.org/admin-resource/evaluation-unfpa-support-family-planning-2008-2013

[90] The Ethiopia case study described the 'new' approach of the business model, with the country being in the red quadrant needing all four modes of engagement: service delivery support, capacity building, advocacy and knowledge management. Country case studies on Bolivia, Burkina Faso, Cambodia, Ethiopia and Zimbabwe are available at: http://www.unfpa.org/admin-resource/evaluation-unfpa-support-family-planning-2008-2013

Box 5: UNFPA Family planning evaluation – summary of the conclusions and recommendations
methods, the latter an important element in a human rights-based approach to supporting family planning. **Conclusion 9 on technical support and oversight:** The availability and quality of technical support varies widely across regions and between different divisions or branches; and the overall quality of FP programming at the country level is highly dependent on the technical capacity of country office personnel.
The evaluation formulated 6 recommendations on: **1. Coordination and brokerage:** advocating for a total market approach, building capacity and continued promotion of a human-rights based approach in FP, among others. **2. Integration: avoiding** silod/vertical approaches, and focusing on both demand and supply sides. **3. Learning agenda:** building capacity; improving documention and reporting on results. **4. Human rights-based approach and vulnerable and marginalised groups: need to** continue to take a strong stance, and ensure that 'no one is left behind'. **5. Modes of engagement: need to** spread efforts less thinly at country level, collaborate with others and position FP within the development landscape. **6. Technical support and oversight: need to** clarify roles and responsibilities of different branches at the Technical Divisions, other divisions and offices, especially RO.[91]

Adolescents and young people [92]

At the end of 2016 the Corporate evaluation on adolescents and youth was published.[93] Evaluators conclude that UNFPA is a recognized leader in the area of adolescents and youth sexual and reproductive health, among others to lead on youth development in the context of the SDGs, and as an advocate for investment in adolescents and youth to harness the demographic dividend. Also, UNFPA supported large programmes on the prevention of adolescent pregnancy, child marriage and female genital mutilation – in general through multi-stakeholder partnerships. The evaluation concludes that UNFPA has been at the vanguard of calling for the respect, protection and fulfilment of human rights of adolescents and youth. Strong results are presented on UNFPA's commitment to meeting the needs of marginalised and vulnerable adolescents, in particular on adolescent girls and youth populations at the risk of HIV. However targeting adolescents girls aged 10 to 14 has yet to be taken fully on board. Through long-term investments, UNFPA has made important contributions to increasing the availability and use of youth-friendly health services and sexual and reproductive health education and information, including life-skills programmes, for in- and out-of-school youth. However work on the integration of such services is needed and adequately address sustainability and quality of services when taken over others. UNFPA was also successful in bringing voices of youth to the ICPD review process (all levels). The SP 2014-2017 has sharpened the focus on adolescents and youth, however more clarity is needed on how to align mainstreamed and dedicated adolescent and youth programmes. The increased focus on adolescents and youth is reflected in an increase in expenditure on adolescents and youth (73% between 2008 and 2015).[94]

Some results are presented in the 2016 synthesis of the CPEs which firstly noted the lack of concrete evidence, attributing this mainly to the fact that this criteria was not included in the SP 2008 – 2013.

[91] UNFPA (2016a). *Evaluation of the UNFPA support to family planning 2008 – 2013. Volume I*
[92] Outcome 2 SP 2014 – 2017
[93] UNFPA (2016f). *Evaluation of UNFPA support to adolescents and youth 2008-2015. Volume I*
[94] In 2017 the management response is expected after presentation of the study in the Annual Board session

The 2016 review of CPEs also addressed adolescent programmes and refers to effective programming especially in the area of health education (Including in-school and peer-to-peer education) and youth participation programmes such as Youth Advisory Panels. UNFPA has also supported capacity building and research related to adolescents and young people. Evaluators have particularly noted progress in the introduction of youth-friendly health services in some countries. In Gambia, for example, the provision of these services was considered to have resulted in reductions in sexually transmitted infections (STIs), unwanted pregnancies and baby dumping. However, there are also many examples (in Bosnia and Herzegovina, Jordan, Madagascar, Mongolia and Yemen) where progress on providing youth friendly services was less than expected. In many of the evaluations, A&Y were not highlighted specifically, but were discussed in terms of working with the vulnerable and disadvantaged, including the out-of-school youths, rural young people, unemployed youths and those in inner cites.[95] The 2013 report of the ED report noted progress an increase of the UNFPA support to countries in providing capacity development for the provision of SRH services to young people. Progress was also reported on implementing comprehensive programmes to reach marginalised girls and support to the design and implementation of comprehensive sexuality education programmes.

Gender equality [96]

DER 2016 on gender equality:
"UNFPA's performance with respect to gender equality has been highly effective. A key contributing factor is the fact that UNFPA programmes not only contain specific gender components but also mainstream gender equality into priority programme areas, including in reproductive health and population dynamics. Results achieved in gender equality often took the form of integration of gender equality and women's rights into national policies, frameworks and laws, as well as supporting efforts to respond to gender-based violence."

The UNFPA report on lessons learned from UNFPA Country Programme Evaluations (2016), reports on the wide range of gender equality activities, targeting women and men in general, but also focusing on specific groups of women, including women suffering from gender based violence, women in rural and remote areas, female sex workers and poor women suffering from obstetric fistula. As the synthesis of lessons learned shows, gender programmes are assessed as effective, but they are also generally under-resourced compared to other outcome areas. Positive developments are mentioned in policy development, human rights, combating GBV, and involving men and religious or community leaders in SRH and gender equality. Country programme evaluations were not equally positive, as some see areas where effectiveness was hindered, such as because of restrictions in funding, staffing issues, limited institutional and government capacity. In the period under review two evaluations were conducted on gender programmes, one dealing with Joint Gender Programmes in the United Nations System (2006 – 2013) [97], and the other one addressing a specific programme: the joint UNICEF and UNFPA programme on combating Female Genital Mutilation/Cutting (FGM/C).[98] The evaluation of joint UN programming reports successes of joint programming, like ensuring the integration of gender issues in political, policy and legislative agendas – most notable

[95] UNFPA (2016b). *Lessons learned from UNFPA Country Programme Evaluations*
[96] Outcome 5 SP 2008 – 2013 and outcome 3 SP 2014 – 2017
[97] UN Women (2013). *Joint Evaluation of Joint Programmes on Gender Equality in the United Nations System*; and the 2014 Management Response drafted by the MR Working Group (UN Women, UNDP, UNFPA, UNICEF, MDGF/UNDP)
[98] UNFPA/UNICEF (2013). *Joint Evaluation of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation / Cutting (/C): Accelerating Change (2008 - 2012). Final report*

the results on reduced tolerance for GBV and increases number of GBV cases reported and on strengthening of policy and legislative frameworks for gender. The evaluation of the joint UNICEF/UNFPA programming on combating FGM/C is a largely positive example of joint programming in gender. The programme achieved some tangible results, including the alignment of the programme with national and international commitments for the abandonment of FGM/C, and the strength of the design of the programme – in particular its emphasis on pursuing a holistic and culturally sensitive approach to addressing FGM/C. Although predominantly positive, the evaluators caution that sustainability of results may be threatened by the lack of financial and technical resources among many national and community-level actors, and the influence (which is growing in some countries) from conservative groups advocating for the continuation of FGM/C. Both evaluations substantiate the strength of joint programming as they could be(come) an important modality for funding gender equality and women's empowerment programmes, even more so than the extent to which a single organisation could do this on its own. However not all joint programming lead to increased efficiencies in programme implementation, mainly due to systemic barriers, unclear management arrangements and weak design processes. Also, the evaluation of made clear that joint programmes should not be the default option, and that their effectiveness very much depends on the context.

The 2016 Development Effectiveness Review (DER) of UNFPA – which is based on an assessment of UNFPA evaluations – reports that the level of coverage of the two cross cutting themes (gender and sustainability) contrasted strongly, with a strong coverage for effectively addressing gender equality. This finding is in line with the fact that gender equality is an integral part of the UNFPA mandate. Reported successes were on effective UNFPA support to gender equality, which is mainstreamed in population dynamics, RH, and human rights (mentioned in close to 30% of the evaluations). The evaluation also noted that UNFPA-supported programmes had undertaken specific gender-focused activities to strengthen gender equality and women's rights with evidence of results at output and, sometimes, outcome level. Often this involved the integration of gender equality and women's rights into national policies, frameworks and laws. The evaluation also reported that UNFPA-supported programs have been effective in improving services responding to gender-based violence (GBV). The combination of gender mainstreaming in key thematic program areas with specific, targeted support to gender equality initiatives in areas such as GBV and empowerment of girls and women was the most frequently cited factor contributing to positive evaluation findings for gender equality in UNFPA evaluation reports. Other positive factors were UNFPA's ability to target the right group of decision makers, and to put together coalitions and technical work groups to address gender equality issues. The global thematic evaluations also pointed to similar positive factors for effectively addressing gender equality.[99] The DER 2016 sees overly ambitious goals and vaguely defined results indicators as negative factors actually hindering achievements in gender equality, and notes the absence or limited scope of a gender equality strategy in addition to limited budgets and severe fragmentation, and a lack of qualified staff in terms gender equality expertise.

[99] Mid-Term Evaluation of UNFPA Strategic Plan Organizational Goal 3 – Gender Equality – Phase I Report (2010), and Phase II Report (2011) noted that there was considerable evidence of successfully integrating gender equality dimensions in the areas of population and development and reproductive health. It also highlighted the advocacy work and strategic engagement leading to national policies, development plan and laws better reflecting the rights of women and adolescents, particularly their reproductive rights.

Population dynamics [100]

The Evaluation on Population and Housing 2005 – 2014 (P&H)[101] noted the UNFPA role as a convening partner in the census and its expertise in the material as core assets. The latter is positive, however it may be at risk as staff with census expertise is retiring. The ICPD Beyond 2014 reports also notes such concerns, in particular with regard to the shortage of experts in the 2020 census rounds. The Evaluation also sees partnering, and civil society engagement as key in UNFPA's support in this domain. UNFPA financed and actively encouraged consultations with the public, such as during the Myanmar census where UNFPA was instrumental in overcoming government's initial resistance to consultations with civil society and ethnic groups. The evaluation is critical on the fact that support to census – considered as a flagship area – is rather modestly positioned among UNFPA global strategic priorities. A missed opportunity for UNFPA appears to be proactively promoting the use of census data, and encouraging governments to explore the full potential of combining data sources (census and specific surveys, or administrative sources or big data) and making use of data for development planning. UNFPA could do more when it comes to enhancing the capacity of national stakeholders, and making use of data to inform decision-makers and policy makers. More corporate guidance is called for, especially to assist country offices in understanding the sociopolitical implications of censuses, in particular in fragile contexts and countries affected by conflict. The evaluators have three main recommendations regarding (1) to consolidate UNFPA's position on population and housing censuses; (2) to exploit more fully the potential of census data: and (3) explore new resource mobilization strategies (such as a global-level trust fund exclusively for the dissemination and use of data), and tap into the full potential of South-South cooperation.[102]

Humanitarian action

Humanitarian action is increasingly becoming of importance for development partners. As cited in the UNFPA 2012 *Humanitarian Response Strategy "Second Generation"* fulfilling the ICPD and other human rights commitments includes ensuring that the right to SRH and the right to live free from sexual and other forms of gender-based violence apply to all people at all times, including populations affected by or recovering from emergencies. Therefore, UNFPA's mandate and comparative advantage in humanitarian settings is well defined: "*the provision of emergency SRH services is a key component of essential life saving activities. Gender issues, particularly sexual violence and other forms of gender-based violence often become more acute in humanitarian settings."* (2012 Strategy). As under the SP 2008 – 2013, UNFPA's humanitarian programming is also mainstreamed in the SP 2014 – 2017 appearing under several outcomes. In line with focus on preparedness in the Inter-Agency Standing Committee's transformative agenda and the QCPR, UNFPA works with national authorities in select high-risk countries to ensure that the SRH needs of women, adolescents and youth are adequately addressed in preparedness and contingency plans.

[100] Outcome 1 SP 2008 – 2013 and outcome 7 SP 2014 – 2017

[101] The evaluation had the objectives whether the support provided was relevant, effective, efficient, sustainable and had added value; the use of census-related data; and to identify lessons learned. The independent evaluation took place in 2014/2015 and was conducted by the EO in collaboration with an external team of evaluators, and included: desk study and interviews (global and regional levels); CO survey; country case studies and extended desk review. Of the 8 recommendations 4 were considered of high priority and 4 of medium priority; the management response includes the operational suggestions and plans regarding the actions to be taken. See also: UNFPA (2016a). Evaluation of UNFPA support to population and housing census data to inform decision-making and policy formulation 2005 – 2014 and the management response to the Thematic Evaluation

[102] UNFPA (2016a). *Evaluation of the UNFPA support to family planning 2008 – 2013. Volume I*

Implementing the UNFPA mandate in emergency situations helps to ensure these rights are met, and decreases the risks of maternal and infant mortality and morbidity, HIV infection, unwanted pregnancy, sexual violence and exploitation, and other reproductive health-related conditions. Some of the results UNFPA reports over 2015 include support to 543 maternity tents/homes operational in 23 countries, 751 mobile clinics in 23 countries, 9 million affected population reached with SRH/GBV services in humanitarian settings in 34 countries and 430 safe spaces supported by UNFPA in 33 countries. Though no specific evaluation was found on UNFPA's humanitarian action[103], the 2016 overview of lessons learned of Country Programme Evaluations refers to good practice examples of support to populations affected by humanitarian crises (refugees from the Central African Republic and Chad and to populations affected by outbreaks of cholera in the northern regions), through the provision of SRH products and services (such as dignity and obstetrical kits, contraceptives, etc.).[104]

3.3.2 UNAIDS

The UBRAF guides UNAIDS work, and under this framework (2011 – 2015) UNAIDS has oriented its work to maximise progress towards the achievement of the 10 targets set forth in the 2011 UN General Assembly Political Declaration on HIV and AIDS. Table 5 gives a summarised overview of progress against the outcomes, goals and targets.[105] The annual performance monitoring reports served as primary base for this overview, which report predominantly at output level. Effectiveness of programmes and projects are included whereas presented in the analysis section of these reports. Because of the large number and diversity of the interventions of the UNAIDS secretariat and its co-sponsors the overview is a summary, highlighting main partnerships, multi-year or multi-countries initiatives or innovative approaches in the three areas (three zero's).[106]

Table 5: Progress against outcomes, goals and targets regarding the three pillars of UNAIDS 2011 – 2015 strategy	
ZERO NEW INFECTIONS **<u>Pillar 1</u>: Efforts to revolutionise prevention of HIV transmission** Since 2000, there has been a steady global progress towards reducing the number of people newly infected with HIV. In 2014, 35% fewer people acquired HIV worldwide (1.9 – 2.2 million) compared to 2000. However the progress has been slower than hoped. Between 2010 and 2014, the annual number of young people and adults (aged 15+) newly infected worldwide fell by just 8%, with reductions in sexual transmission of HIV falling significantly short of the 2011 Political Declaration target of 50% reduction by 2015.	
Building an evidence	UNAIDS is the center of strategic information of the epidemic. The most comprehensive on any global epidemic and the evidence base on which PEPFAR and Global Fund resources are

[103] With the exception of a 2011 evaluation of UNFPA's provision of dignity kits, and a quite critical evaluation of the Evaluation of Implementation of 2005 IASC Guidelines for GBV Interventions in Humanitarian Settings in the Syria Crisis response

[104] UNFPA (2016b). *Lessons learned from UNFPA Country Programme Evaluations*

[105] This overview does not detail the work of UNAIDS (Secretariat and the co-sponsors) in humanitarian settings. UNAIDS considers this a cross cutting theme. In 2011 the Security Council adopted Resolution 1983 which broadened the HIV and AIDS agenda in peacekeeping operations to address violence in conflict and non-conflict situations and to draw the attention to the vulnerability of women and girls. Much of the work of UNAIDS Secretariat and the co-sponsors in the period under review was on developing and dissemination guidelines on, among others, the delivery of ART to migrants in crisis affected persons in SSA, on the continuity of a minimum HIV programme in the context of Ebola, and on PMCTC in humanitarian settings. Other actions included advocacy across Inter Agency Working Groups (IAWGs) on the inclusion of HIV activities in other sectors, and the support of national AIDS programmes in countries affected by crisis.

[106] Source: UBRAF Performance Monitoring Reports 2012 – 2013 and 2014-2015; the 2014 Mid-term review of the UBRAF; and the 2016 Synthesis report

Table 5: Progress against outcomes, goals and targets regarding the three pillars of UNAIDS 2011 – 2015 strategy	
base, norm-setting	allocated and programmed. UNAIDS has helped develop and revise guidelines on HIV programming, including for sex workers men who have sex with men and transgender people and adolescents and young people. UNAIDS led analyses and reviews of national responses to integrate new technologies and advocated for evidence-informed combination prevention. In 2013, the UNAIDS cosponsor, WHO, issued conditional recommendation for all pregnant and breastfeeding women with HIV to start lifelong ART, removing eligibility criteria (Option B+).
Strategic focus on key populations and locations	As a result of focused interventions with UNAIDS support, HIV infections among female sex workers declined in the early epidemics of Cambodia, India and Myanmar. In 2013, WHO prequalified the first nonsurgical circumcision device for adults and developed a framework for VMMC for ESA in 2016. The Corridor Economic Empowerment Project in Southern Africa focusing on the vulnerable populations along the transport corridor resulted in 48% and 81% increase in the number of individuals adopting HIV risk reduction strategies in 2014 and 2015.
Eliminating MTCT	Considerable progress was made in eliminating mother-to-child transmission (eMTCT) of HIV through the Global Plan on the Elimination of New Infections in Children by 2015 and Keeping their Mothers Alive. Co-led by UNAIDS and the United States President's Emergency Plan for AIDS Relief (PEPFAR), it resulted in new paediatric infections in low- and middle-income countries decreasing from 550 000 in 2001 to 260 000 in 2012, with more progress in the past three years than in the previous 10. Adopting decentralized approaches resulted in 62% of prevention of mother-to-child transmission (PMTCT) coverage among 21 priority countries, with 19 adopting policies to initiate ART for all pregnant and breastfeeding women. In Botswana, Ghana, Namibia and Zambia, antiretroviral drugs (ARVs) were provided to at least 90% of pregnant women living with HIV. In 2015, Cuba was the first country validated for having eliminated mother to child transmission of HIV and syphilis, while meeting basic human rights considerations. In 2016, Armenia, Belarus, and Thailand were validated for having eliminated vertical transmission of HIV. The validation process includes a human rights, gender equality and community engagement tool. This is the first public health certification process for virtual elimination of a disease to include attention to human rights considerations.[107]
Better treatment options	As cosponsors of UNAIDS, UNICEF and WHO pioneered Option B+, offering HIV-positive pregnant women the triple-combination first-line antiretroviral regimen. With Joint Programme support, Option B+ has been implemented in Namibia, Rwanda, Uganda and the United Republic of Tanzania.
Key populations	UNODC has placed HIV and drug use at the heart of its global agenda and led Joint Programme efforts to increase access to harm reduction services for people who inject drugs (PWID). Legislative guidance and policy analyses contributed to legal reforms for drug-related services in Azerbaijan, Cambodia, Uzbekistan and Vietnam.

[107] Elimination without violation. UNAIDS supports women living with HIV to put human rights, gender equality and meaningful engagement of communities at the centre of validating elimination of mother-to-child transmission of HIV. https://results.unaids.org/sites/default/files/documents/Validation%20Case%20Study.pdf

Table 5: Progress against outcomes, goals and targets regarding the three pillars of UNAIDS 2011 – 2015 strategy	
Young people, HIV prevention	Efforts to advance education for HIV prevention and address broader sexual and reproductive health (SRH) have yielded promising results. UNESCO, UNFPA and UNICEF reviewed curricula and undertook teacher training and peer education for regional and country capacity-building. In December 2013 UNESCO and UNAIDS supported health and education ministers in 20 Eastern and Southern African Member States to develop a regional commitment to comprehensive sexuality education and SRH services for young people. The ESA Commitment has a regional accountability framework and information can be accessed on : http://youngpeopletoday.net/.[108] UNESCO and UNFPA contributed to scale up of CSE in 97 countries and published a joint report on the status of CSE in 48 countries.[109] In 2013 UNAIDS co-created with 25 youth-led organizations the PACT for social transformation to create solidarity and collaborate strategically in the AIDS response. Through the 'All in! Campaign to end adolescent AIDS' the UNAIDS Secretariat, co-sponsors and partners have built a framework to strengthen participation and catalyze policy change. Also specific guidance was prepared to prevent HIV among adolescent girls and young women.[110]
Despite progress, challenges remain like increases in risky sexual behaviour, and the need to ensure linkages between having CSE in place and access to youth-friendly SRH and HIV prevention services as part of a combination prevention package. The comprehensiveness is particularly important to ensure that the structural aspects of prevention are considered. The recently developed UNAIDS 2016-2021 Strategy puts CSE and SRHR centrally in the response. Many countries with the highest HIV burden remain largely dependent on donor support for prevention services, including condom provision and other prevention commodities. Uptake of VMMC is too low, and more evidence is needed on the value and preferences of PrEP for transgender women and sex workers. In the area of vertical transmission, despite considerable advancements, ANC testing and ART coverage are persistently low. Commodity stock-outs in high burden countries and underlying weakness in MNCH and other SRH services prevent women from accessing services. Integrating family planning into EMTCT programming requires more programming attention.	
ZERO AIDS RELATED DEATHS **Pillar 2: Catalyzing the next phase of treatment, care and support** As a result of sustained global commitment to HIV treatment at the global, regional and country level, by 2015 more than 16 million people living with HIV were on ART, surpassing the global target of 15 million by 2015 and achieving 45% treatment coverage. Between 2000 and 2014, HIV treatment prevented and estimated 7.8 million deaths and access to ART continued to increase in all regions – between 2011 and 2014 alone, ART coverage of people living with HIV more than doubled – though there are regional and population variations. The greatest scale-up occurred in sub-Saharan Africa, however, global treatment coverage among children, adolescents, men who have sex with men and other key populations lag behind.	
Treatment	To reach 15 million PLHIV with lifesaving ART by 2015, UNAIDS has provided global leadership and guidance. Access to treatment has been scaled up, with nearly 10 million people on ART at the end of 2012, the African region showing the greatest increase. Consolidated guidelines on ARVs were issued by WHO (and updated in 2014), and Treatment 2015 was launched in 2013 by the UNAIDS Secretariat, WHO, the Global Fund and PEFPAR to

[108] Before the ESA commitment on CSE, Latin America had already secured a much more solid commitment between its Ministers of Health and Education, on the sideline of the 2008 International AIDS Conference. This commitment was almost entirely pushed for by UNAIDS, and has produced outstanding results in CSE coverage (although still with some gaps). For more information on the agreement, please have a look here http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Santiago/pdf/declaration-preventing-education-english.pdf.

[109] UNESCO (2015). *Emerging evidence, lessons and practice in Comprehensive Sexuality Education. A Global Review*

[110] http://www.aidsdatahub.org/sites/default/files/publication/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women_2016.pdf

Table 5: Progress against outcomes, goals and targets regarding the three pillars of UNAIDS 2011 – 2015 strategy	
	accelerate treatment scale-up and intensify financial and technical support to 30 priority countries that account for 90% of the unmet need for treatment. UNDP managed 48 Global Fund grants in 24 countries – through these grants UNDP supported 1.8 million people living with HIV to access ART (one in every 8 people on treatment globally). Since the start of the partnership the Global Fund and UNDP have jointly supported countries in saving 2.2 million lives from AIDS, TB and malaria. This target was one of the few 2015 targets to be achieved before time.
Key populations	UNAIDS guided key populations, including PWID, MSM, transgender people, sex workers, prison populations and adolescents, in accessing treatment. Guidelines were adapted and disseminated in 90 countries. UNAIDS helped countries apply to the Global Fund in pursuit of treatment services for key populations. UN Women and CSOs did a peer led global study mapping key barriers to womens access to treatment.
Commodities	To maintain ARV supplies and affordable prices, global demand forecasts were assessed and UNDP trained officials from Latin America, the Caribbean and Asia to use TRIPS flexibilities for affordable ARVs. As documented by the ILO, expanding employment opportunities for PLHIV can help sustain treatment gains, as PLHIV who are employed are 39% more likely to adhere to regimens than the unemployed.
Norms and standards	Inspired by the success of Option B+ for pregnant and breastfeeding mothers and in line with increased evidence the WHO updated the consolidated ARV guidelines to recommend a policy of Treat All, extending B+ to all people living with HIV. Norms, standards and tools continued to be developed by co-sponsors WHO, UNDP, UNICEF, ILO and UNODC, for example the TB/HIV policy was disseminated to 49 countries via workshops and joint TB and HIV programming was undertaken through Global Fund processes.
Multi-stakeholder collaboration	Collaborations with governments and stakeholders brought progress in having food and nutrition included in HIV and TB strategies. The World Food Programme's HIV and TB-specific operations in 2012 and 2013 reached an estimated 2.9 million beneficiaries, with WFP supporting programmes in 44 countries. Research to better understand the food preferences of malnourished adult PLHIV, inform product development and identify barriers to treatment adherence was undertaken, with guidelines to integrate food and nutrition into the response.
Challenges in progress include the delayed ART initiation and lack of follow-up, calling for better treatment uptake support, adherence and retention in HIV care, as well as addressing gender-related barriers. that prevent it. This also requires adaptation to different context and settings, including those in humanitarian settings. This also involves addressing underlying drivers of HIV infection and non-adherence which includes addressing stigma, discrimination and other human rights barriers to treatment and working with broader development sectors (eg. child and social protection) which require a longer horizon (medium 5 to 10 years) to produce results. More evidence is needed, as the vast majority of evidence on social protection and HIV prevention, treatment, care and support is from programmes in SSA, and on young women and girls.	
ZERO DISCRIMINATION **<u>Pillar 3</u>: Advances in human rights and gender equality** From 2010 to 2014, there was an increase in the number of countries reporting the existence of general anti-discrimination laws and mechanisms applicable to sex workers, migrants, people in prison, women and young people. From 2006 to 2015, the number of countries criminalizing same-sex sexual acts fell from 92 to 75. However, the elimination of punitive laws and counterproductive legal and policy frameworks around HIV is far from being achieved. Overly broad prosecutions for HIV non-disclosure, exposure and transmission have been recorded in all regions, while some 72 countries report legislation that specifically allow for HIV criminalization.	
Advocacy	In 2015 the UNAIDS Secretariat, UNDP and OHCHR led the issuing of a powerful UN Joint

Table 5: Progress against outcomes, goals and targets regarding the three pillars of UNAIDS 2011 – 2015 strategy	
	Statement calling for action on ending violence and discrimination against LGBTI adults, adolescents and children. Under the leadership of UNDP, the Joint Programme worked with governments and civil society to conduct national dialogues on HIV and the law in 62 countries. UNDP developed a tool to undertake Legal Environment Assessments (LEAs) and led the undertaking of LEAs in partnership with co-sponsors and the UNAIDS Secretariat in 52 countries. High-level policy statements, including by the UN Secretary-General and executive heads of the Cosponsors and UNAIDS, were made at global, regional and country levels, calling for elimination of stigma and discrimination against people living with and affected by HIV. Joint action has been undertaken in 84 countries to advance the recommendations of the Global Commission on HIV and the Law. UNAIDS has supported South-South cooperation on advancing human rights, including through the first dialogue between OHCHR, UNAIDS Secretariat, the Inter-American and African Commissions on Human Rights on protection of LGBTI rights, held in Banjul in November 2015. With the Joint Programme support, Regional Declaration and targets for Zero Discrimination in Latin America and the Caribbean were adopted in Brazil in August, 2015, and guided country-level target setting efforts. Support was provided to development of Inter-American Commission on Human Rights Report on Violence affecting LGBTI people in the Americas. In 2016 UNAIDS Secretariat and WHO launched an Agenda for Zero Discrimination in Health Care, convening stakeholders for multisectorial actions aimed at eliminating intersectional discrimination.
Legal reform at country level	At the country level, UNAIDS worked with health and justice ministries, members of parliaments, PLHIV and national AIDS bodies to develop laws and policies that support effective AIDS responses and protect human rights. Dialogues on HIV and the law were held in 49 countries, with UNDP helping 65 countries undertake legal environment assessments and reviews. UNAIDS has helped countries draft legislation, based on public health evidence and human rights principles. In Congo, El Salvador, Guatemala, Mongolia, Nicaragua, Senegal and Togo, UNAIDS inputs have informed HIV-related laws.
Capacity development, tools and guidance materials	UNAIDS and partners developed advocacy and guidance materials to reduce HIV stigma and discrimination and increase access to justice. More than Ffifty countries completed the People Living with HIV Stigma Index, which has informed talks on improving legal and social environments for effective AIDS responses. At the end of 2012, 55% of countries reported HIV-related legal services, up from 45% in 2009; 57% reported training judges and magistrates on HIV and discrimination, up from 46% in 2008. UNAIDS advocated strongly to remove restrictions on entry, stay and residence. Since 2011, 14 countries, territories or areas have removed their restrictions or have officially clarified that they do not apply such HIV-related travel restrictions, leaving 35 countries, territories and areas that still have such restrictions. UNAIDS invested in strengthening the capacity of organizations of key populations to take their place at the centre of policy-making and service provision. The Network of Sex Work Projects and the Men who have Sex with Men Global Forum are examples of community partners strengthened by sustained UNAIDS assistance.
Addressing gender inequality	In 2012–2015, UNAIDS implemented the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV in more than 90 countries. The Agenda is referenced as a key document by leading intellectual and community organizations, while UNAIDS' strategic guidance on gender and HIV has influenced the work of key partners, such as PEPFAR and GFATM. More than 700 civil society organizations implemented the Agenda, and involving men, boys, religious leaders and human rights advocates. Between 2013 and 2016 more than 40 countries implemented the UNAIDS Gender Assessment Tool to strengthen National Strategies to respond to HIV from a gender perspective. UNAIDS and WHO developed a Tool for strengthening gender sensitive Monitoring and Evaluation for Sexual and Reproductive

Table 5: Progress against outcomes, goals and targets regarding the three pillars of UNAIDS 2011 – 2015 strategy	
	Health and HIV, which was piloted in 27 countries 15 of them in Eastern and Southern Africa in 2016. To better systematize information available on links between HIV and VAW, WHO and UNAIDS developed the 16 Programming ideas to address violence against women and HIV. This document has been used to inform a framework for guiding NGOs in how to develop evidence informed programmes to address the links between HIV and VAW that is close to being finalized. UNESCO developed a global strategy to stop school-related GBV and homophobic and transphobic bullying.
Work in humanitarian settings	To address HIV in humanitarian settings, interagency country needs assessments and consolidated response plans have been developed.
Challenges are the lack of or limited use of sex- and age-disaggregated data and evidence linking HIV/STIs and gender equality. Harmful practices and discriminatory laws and policies continue to have a negative impact on women and girls. More political will is required, which should be translated to institutional support, capacity to address GBV, and increased domestic funding.	

As an integral part of the three zero's, UNAIDS is ensuring the AIDS response remains high on the political agenda, in all countries and across ministries, including through mobilization of heads of state and in Africa, a strong mobilization of First Ladies in support of the response and related agenda, such as ending child marriage. UNAIDS also builds the evidence-base for decision-making, including on strategic investment of resources. An example of this is the launch of the UNAIDS and Lancet Commission 'Defeating AIDS – Advancing global health' in 2013, to ensure the effective positing of AIDS in the post-2015 development agenda and to generate high level advocacy for global commitment to end AIDS.[111] UNAIDS remained the source for information on HIV and AIDS used by a wide range of stakeholders. The 2013 mid-term review of the 2015 targets helped more than 100 counties to take stock, diagnose gaps and revise strategies to respond to AIDS; with the help of UNAIDS some 30 countries developed or made plans for HIV investment cases.

UNAIDS and the Global Fund to fight AIDS, TB and Malaria (GFATM) have established a productive collaboration, in which UNAIDS assists countries in conceptualizing their road map to end the AIDS epidemic, and the GFATM assists in resourcing these plans. Since 2002 UNAIDS has assisted more than 100 countries in mobilising and effectively using US$ 16 billion disbursed by the Global Fund for HIV.[112] UNAIDS supported countries in leveraging Global Fund investments, supporting them to develop investment approaches which are underpinned by robust national strategies, and overall placed a focus on prevention. For example in 2014 UNAIDS and its Technical Support Facilities (TSF) supported 21 countries to develop HIV investment cases that became the building blocks of their GF concept notes; and a total of 26 countries reviewed or developed national HIV strategic plans. In 2011 – 2015, workshops in all regions built capacities of key national stakeholders to integrate human rights and gender equality in national HIV strategic plans, Investment Cases and GF concept notes. The investment approach promoted by UNAIDS has enabled countries to prioritize high-impact interventions, with due attention to critical enablers , with at least 30 countries making plans for HIV investment cases. In addition, UNAIDS brokered with countries and development partners to

[111] UNAIDS (2014g). *Update on the aids response in the post-2015 development agenda. UNAIDS-Lancet Commission: Synthesis report of consultations*
[112] UNAIDS (2016d). *Snapshot. UNAIDS and the Global Fund. A life-changing partnership*

make the case away from traditional cooperation relationships to more innovative approaches. For example, the African Union's roadmap for a new response to AIDS, TB and malaria is an example of how African countries and development partners have embraced mutual accountability. Developed with UNAIDS support, the roadmap offers practical, African-owned solutions, structured around health governance, diversified financing and access to medicines. The roadmap also establishes an accountability structure within the New Partnership for Africa's Development (NEPAD) to monitor progress. As a result, UNAIDS developed with NEPAD the first G8 accountability report on AIDS in Africa.[113] In 2014 the Global Fund launched a new funding model, an approach which was promoted by UNAIDS as it provides countries with more flexibility and predictability in funding.[114] In the context of this new model UNAIDS and its TSF trained over 300 technical support providers and national partners (2014).

Gender equality

UNAIDS developed several guiding documents on inclusion of a gender perspective in planning and programming. In 2010 the UNAIDS Agenda for accelerated country action for women, girls, gender equality and HIV 2010–2014 (hereinafter, the Agenda) was launched. The 2012 Mid-Term Review showed the first results of countries results with accelerating action in this domain.[115] Since the global launch, 90 countries undertook a national launch of the Agenda. Progress was reported in 60% of the countries that started with the implementation of the agenda. Just over half the UN accountability targets were achieved, with 67%, 17% and 55% achieved at the global, regional and country level, respectively. Stakeholders identified inadequate funding as the prime barrier to the Agenda's implementation and as the main way to further accelerate action for women and girls. Most notably were the actions in translating political will into scaled-up action. UNAIDS high-impact countries made more progress to strengthen gender equality in the HIV response than others. The review further noted that in countries that have seen significant advancement for women and girls already, the Agenda's usefulness has been limited. The MTR review found that a more systematic approach to data collection is needed for evidence-based planning and budgeting. In response of the Mid-Term Review, UNAIDS developed the Gender Assessment Tool (GAT) that has been implemented in more than 40 countries between it was piloted in 2013 to date. The Gender assessments have informed national Strategic Plans and Global Fund Concept notes.[116] However, political will alone is not enough to move towards gender-transformative HIV responses. According to findings from the End Review, the Agenda had an overall positive effect as a political platform in mobilizing CSOs and governments around issues related to gender equality in the context of an HIV response. It contributed to generating new partnerships and creating spaces for dialogue, leading to increased visibility and awareness of these issues. The End Review also found that it contributed to increased participation of networks of women living with HIV in global fora, which led to them having

[113] UBRAF Performance Monitoring Reports 2012 – 2013

[114] In 2014 GF launched a new funding model providing more flexibility and predictability in funding (with two streams of funding; timeline based on country needs and processes; and ongoing Secretariat engagement and support). See: GFATM (2013). *Fourth Replenishment (2014-2016). The Global Fund's New Funding Model*

[115] UNAIDS (2012). *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV. Mid-Term review - Final report*

[116] The tool has been applied in 40 countries linked to NSP development or Mid-Term reviews of National Strategic Plans on HIV to ensure sustainability. This is close to 50 % of countries with UNAIDS presence in a time period of 2 years. Most Fast Track countries have conducted the assessment. The GAT has been reviewed based on assessment reports in 37 countries and recommendations will be used to inform a review of the tool and its update

greater influence in decision-making processes, as well as increased empowerment of individual women and girls through training and greater inclusion. However, more support is still needed to create an enabling environment for women and girls in the context of HIV.[117]

3.4 Contribution of UNFPA and UNAIDS to the Dutch priorities in SRHR

The 2011 policy document of the Netherlands defines the 4 outcome areas of the SRHR policy (see box 1): (1) Adolescent and youth SRHR; (2) Better access to SRH commodities; (3) SRH as part of an accessible, affordable basic health care system; and (4) More respect for SRH rights of key populations. In all of these areas Dutch funding was geared towards reaching scale, both in terms of information and service provision: not creating a patchwork of proven interventions, but instead working with partners towards replication, scalability and sustainability, with selective, learning-oriented use of pilots.[118] The Ministry therefore entered into partnerships with Dutch and international NGOs to address the issues mentioned above in such a way that they are complementary to bilateral and multilateral programmes, including those of UNFPA and UNAIDS.[119] In annex 7 the results of the support on all indicators are presented. The section below discusses the contributions of UNFPA and UNAIDS to achieving the objectives in the Netherlands SRHR policy areas.

Result area 1: Improved SRHR of adolescents and youth

Indicators results area 1

- Higher number of young people with accurate knowledge on HIV
- Increased number of facilities providing youth-friendly (SRH) services
- Increased number of youth accessing such services
- Decreased number of teenage pregnancies

For both organisations the focus on adolescents has increased in the period under review. **UNFPA**'s work on adolescents is guided by the Framework for Action on Adolescents and Youth and the UNFPA Strategic Plan 2008-2013, and the UNFPA Strategy on Adolescents and Youth (2012-2020) under the current the UNFPA Strategic Plan (2014-2017). Under Outcome 2 of the UNFPA SP 2014 – 2017 priority of adolescents, especially very young adolescent girls is increased, for example UNFPA launched an adolescent girl initiative preventing early marriage aiming to reach at-risk girls with a holistic approach. This is one of the priority areas of the Netherlands in the SRHR policy. **UNAIDS**' work in the area of adolescents is guided by the 2013 Background Note on HIV, adolescents and youth, the 2012-2015 UBRAF – which addresses the needs of young people as a cross-cutting theme – and from 2016 onwards by the new UNAIDS Strategy 2016-2021 and the Political Declaration.

[117] Universalia (2016). End Review of UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV

[118] Annual reports of MFA/DSO

[119] In SRHR support was also provided to the Global Fund (services), UNICEF (with UNFPA for their work on child marriages), and the WHO (to generate and gather knowledge and develop guidance for countries on youth friendly service delivery and norm setting) and for the UN (in collaboration with NGOs) to advocate for inclusion of an indicator in the post 2015 agenda as a basis for accountability

Because of the evidence that age-appropriate sexuality education can help young people to delay sexual debut, practice safer sex and improve their contraceptive use, the Netherlands supports varied actions targeting adolescents and youth including NGOs that implement Comprehensive Sexual Education (CSE) programmes and provide youth friendly services. The underlying assumption is that in order to facilitate ownership and sustainability, sexuality education needs to be aligned with policy and curriculum review cycles. [120] Therefore, UN organisations such as UNFPA, UNAIDS, UNICEF and the WHO were supported for development of technical guidelines and advocacy for the right to information and services. Specific advocacy on the rights of young people to comprehensive SRH services, and safe abortion – where this is legal – was a joint focus of the Netherlands, UN (UNFPA, UNAIDS) and others during the 2012 UN Commission for Population and Development session. Efforts resulted in the adoption of a resolution that for the first time calls upon Governments *"to give full attention to meeting the reproductive health-service, information and education needs of young people, with full respect for their privacy and confidentiality, free of discrimination, and to provide them with evidence-based comprehensive education on human sexuality, sexual and reproductive health, human rights and gender equality to enable them to deal in a positive and responsible way with their sexuality"* (article 26) and *"to strengthen health systems to ensure that they prioritize universal access to sexual and reproductive information and health-care services (….) including quality services for the management of complications arising from abortion, reducing the recourse to abortion through expanded and improved family planning services and, in circumstances where abortion is not against the law, training and equipping health-service providers and other measures to ensure that such abortion is safe and accessible".* (article 27) [121] Guidelines that were developed by UNESCO (as co-sponsor of UNAIDS) in 2010 on sexuality education were adopted in 21 countries in Eastern and Southern Africa in 2012. In that same year UNFPA supported the ministries of education of 38 countries to develop age-appropriate, comprehensive sexuality education, which typically includes information about condom use to prevent HIV, sexually transmitted infections (STIs) and unintended pregnancy. Subsequently, after lengthy negotiations, these guidelines were also the reference point for CSE in the UNAIDS 2016-2021 Strategy adopted by the UNAIDS Board in October 2015. **UNFPA** has increased the priority of adolescents, especially very young adolescent girls, in its programmes, like SRH services for adolescents (68% of programme countries have laws and policies that allow adolescents to access SRH services) and CSE curricula alignment with international standards.

Together with UNICEF, UNFPA, WHO and partners the **UNAIDS** Secretariat developed the All-in! initiative which targeted adolescents in 25 countries, aiming to decrease new HIV infections of young people globally with 75% and lower AIDS-related death among youth with 65%. Another UNAIDS initiative, together with ILO and the South African Development Community was to economically empower young women, which has led to an increased condom use in a number of programme countries. To guide **UNAIDS**' work on HIV and young people recommendations were used from more than 5000 young people from 79 countries participating in CrowdOutAIDS, an innovative youth-led web-based crowdsourcing project. It was the first ever document produced in the history of the UN using a crowd-sourcing strategy, an unprecedented initiative. Also, CrowdOutAIDS is a good example of how the UN can support youth participation to shape the UN's internal policies and programming

[120] MFA (2013a). *Annual report of the Social Development Department (DSO) of the MFA on SRHR*
[121] 45th session of the UN CPD, adoption of Resolution 2012/1 on Adolescents and youth http://www.un.org/esa/population/cpd/cpd2012/Agenda%20item%208/Decisions%20and%20resolution/Resolution%202012_1_Adolescents%20and%20Youth.pdf

exercises, given that young people's inputs were directly used to build the UNAIDS youth programme. In 2012, UNAIDS supported the consolidation of the regional network of young people living with HIV from Latin America and the Hispanic Caribbean, and the strengthening of more than 10 national networks of young people living with HIV in the region, in youth leadership, participation, advocacy and organizing. "UNICEF, UNFPA and the Secretariat organized the first meeting of young people living with HIV.

Result area 2: Improved access to SRH commodities

Indicators results area 2

- Increased number / amount of couples using contraceptives
- Increased number / amount of people with HIV on anti-retroviral drugs
- New, user-friendly products and medicines that prevent maternal mortality and transmission of HIV

People need diverse commodities (contraceptives, medicines and medical devices) that enable them to have safe sex, safe pregnancy and safe delivery, and if women so desire – safe abortions.[122] However many lack the knowledge about and access to essential products and commodities. Access to ARVs, contraceptives and other commodities are required for good sexual and reproductive health. In the period under review the Netherlands resources have contributed to a wide range of results, including the development of new medicine and vaccines, and increasing the availability, affordability and accessibility of all commodities. Whether people use these commodities depends on the quality of the services and demand-side issues such as stigma and taboo towards sexuality and contraception.

In the period under review, the Netherlands was the second largest donor to the **UNFPA** Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS, in 2013 renamed to UNFPA Supplies). The GPRHCS was launched by UNFPA in 2007 to ensure access to a reliable supply of contraceptives, condoms, medicine and equipment for family planning, HIV/STI prevention and maternal health services. Commodities distributed through GPRHCS supported women in 46 countries; this is about 28% of the women using contraceptives in the 69 so-called FP2020 countries.[123] In the programme's first five years, results included higher rates of contraceptive prevalence rates, more service delivery points kept their shelves stocked, and availability and choice of contraceptives and life-saving maternal health medicines increased. Also, family planning is increasingly being prioritized at the highest levels of national policies, plans and programmes. For example in 2013, 25 of the 46 programme countries had national budget allocations for contraceptives and/or maternal health medicines. In 2013 GPRHCS procured contraceptives worth 35 million couple years of protection – an increase with 6 million compared to 2012.[124] In 2014 the programme supported 20 million users of modern methods of FP and helped to avoid an estimated 6,75 million unwanted pregnancies, 21.000 maternal deaths, 120.000 child deaths and 2,4 million

[122] MFA (2014). *Annual report of the Social Development Department (DSO) of the MFA on SRHR*

[123] The FP 2020 initiative pledged additional support to 69 focus countries (poorest countries with a 2010 gross national per capita annual income less than or equal to USD 2,500. www.familyplanning2020.org

[124] The programme provided 35 million couples and individuals with the opportunity to protect themselves from unwanted pregnancy with the contraceptive method of their choice for one year

abortions (of which 2,1 million would have been unsafe). Couple-years of Protection (CYP) levels vary per year, also because of variations in method mix (short acting versus long acting). However, more important is access to choice: 21 countries had 3 modern methods or more available in at least 85% of primary Service Delivery Points in 2014, a large increase from 7 countries in 2013.[125] See box 3 for more on the contours, the results, and the challenges of this programme.

Box 8: UNFPA Supplies [126]

The ***UNFPA Supplies programme*** was launched mid-2007 to support priority countries to speed up their progress towards reproductive health commodity security, an essential step towards universal access to universal health, the ICPD and the MDG5b goal.[127] Phase I covered 2007 – 2012, and phase II runs from 2013 to 2020. ***The goal of the Thematic Fund*** is to make RH commodities and medicines available for family planning, prevention of HIV and other STIs (condoms and HIV test) and for safe pregnancy, delivery and abortion. The programme is being implemented in 46 countries with the highest MMR and the lowest use of contraceptives, all countries among the 69 focus countries of the FP 2020 global partnership to expand access to contraceptives for an additional 120 million women and girls by 2020. The selected countries are lower or lower middle income countries, and include those with both high mortality and high unmet need, but few sources of external support, including in central Africa. Around 60% of the programme's total financing will be expended on commodities, and 40% on other outputs including capacity building, policy dialogue and data generation, and strategic interventions to build demand and access for vulnerable groups. At ***impact level***, UNFPA Supplies contributes to UNFPA's overall aim to achieve universal access to reproductive health. This will be measured through UNFPA's contribution to achieving global SRH goals: reducing MMR, adolescent fertility rate and HIV prevalence among 15-49 year olds. ***Outcome measures*** include contraceptive prevalence, unmet need and demand satisfied for family planning; and progress towards a balanced method mix. ***Supply chain results at outcome level*** include: availability of at least three modern methods of contraception at over 80% of service delivery points; seven life-saving maternal health medicines at over 80% of birthing facilities; and at least 80% of facilities with no stock-out of the five contraceptive methods in the last six months.

The programme ***aligns with result area 2 of the Netherlands MFA***; it supports the efficient purchase of commodities, strengthening of national systems and works on demand creation for contraceptives. ***The Netherlands supports*** the programme since its beginning with on average 24 million Euro annually (varying from 5 to 41 million Euro per year), a support which is being continued for the period 2014 – 2017 (totaling to 100 million Euro for 4 years).[128]

UNFPA Supplies is a large player in the RHCS, in 2013 financing one third of all contraceptives worldwide and in many countries UNFPA Supplies is the only or one of the few external sources procurement support for contraceptives. The scope of UNFPA Supplies grew – expenses and payments in 2014 were the highest since its beginning – and ***in 2014*** contraceptives procured by UNFPA Supplies had the potential ***to reach an estimated 33 million users*** and avert an estimated:

[125] MFA: Annual report of the Social Development Department (DSO) of the MFA on Sexual and Reproductive Health and Rights (2012-2013-2014)

[126] Source: internal memo MFA (November 2014), UNFPA Annual reports GPRHCS/Supplies (2012 – 2014); DFID (2013). *Business Case and Intervention Summary*. London; UNFPA (2016). *Evaluability Assessment of GPRHCS Phase II. Final Report*

[127] Formerly known as the Global Programme Reproductive Health Commodity and the Global Programme to Enhance Reproductive Health Commodity, renamed UNFPA Supplies in 2014

[128] The UK will provide a total of £340 million over seven years (from 2013/14 to 2019/20). Other major donors that contributed to GPRHCS Phase 1 and are likely to contribute to Phase 2 are the EC, Denmark, Australia, France, and earmarked support to commodities from Norway (for underused products such as implants). Source: UK 2013 Business case

Box 8: UNFPA Supplies [126]

- 7.8 million unintended pregnancies;
- 24,000 maternal deaths;
- 138,000 child deaths; and
- 2.8 million abortions (including 2.5 million 'unsafe').

The programme has a good track record for both procuring good value for money and reducing delivery time. Both UNFPA and USAID – the two largest public sector procurers – managed to consistently procure quality products at lower prices than the median benchmarks (DFID Business Case). Besides procurement, the programme invest in strengthening of the supply chain, delivery of services together with the NGOs working on family planning and social marketing (IPPF, PSI and Marie Stopes) and is active involved in FP 2020 and UN processes (*Every Woman Every Child and the UN Commission on Life Saving Commodities for Mothers and Children).*

Despite good results, often hard-fought in countries with very challenging maternal health indicators, the programme needed to take a ***different approach*** for its second phase (2013 – 2020).

- One of the main challenges is to broaden the donor base (currently the UK and the Netherlands are the main donors).[129]
- Other challenges are the articulation of programme objectives reflecting to cover the full breath of components of national family planning prorgammes, and to better align the thematic fund with the UNFPA Family Planning Strategy at national level (clarifying the roles of the FP Strategy and the Supplies programme). Whilst commodity security has been strong, other aspects of the FP agenda need attention including human resources (strengthening the national health human resources), service delivery and demand creation. This requires clearly defining the scope of the programme at national level (and its relation to the UNFPA FP Strategy). The evaluability assessment sees therefore a need to address country leadership and capacity in several of the 46 priority countries (in the context of the new Human Resource Strategy).
- As the Maternal Health Thematic Fund and the Supplies Thematic Fund share the goal on maternal mortality, there is a need to better define linkages and options to integrate, and share their resources to strengthen the health system building blocks (service delivery, health human resources and information). Thematic fund integration has been recommended by senior management (since 2009) however remained a challenge in the context of the organizational structure of the Technical Division.
- A related issue is the need to clarify roles and responsibility between the technical branch and the commodity security branch (within the Technical Division), when it comes to supporting country offices, on a technical and managerial level (programming for results). Regarding programming, it is advised to work with multi-year programmes (which require multi-year funding).
- In order to rapidly scale-up access and coverage, the programme should better align and collaborate with other actors at country level, increase working with in-country partners such as NGOs, strengthen national coordination with governments and other development partners. Other issues that need attention are the effective distribution in recipient countries, in particular through better collaboration with local business communities (pharmacies and local shops), expanding services through advocacy, demand generation and application of a total market approach. The good practice of delivering quality-assured

[129] The budget for the new phase is 200 million USD per year – about one fifth of UNFPA's overall budget in 2013. To reach the FP 2020 goals funding should be doubled to at least USD 500 million per year. The UK contributes USD 830 for 7 years, and the Netherlands USD 125 during the period 2014 – 2017

Box 8: UNFPA Supplies [126]
generic medicines should be continued and expanded. The Netherlands, as one of the main donors, takes seat in Steering Committee of the programme which allows for active participation in deciding on the directions of UNFPA Supplies. The establishment of this committee forms part of the different approach that has been taken for the second phase of UNFPA Supplies.

The Netherlands was the 4th largest donor of **UNAIDS** in 2012 and contributed approximately 10% to all results. In the domain of commodities, most notably is the increased access to antiretroviral therapy (ART) which has averted 7.8 million deaths and 30 million new infections between 2000 and 2014.[130] Even taking into account the broadening criteria for receiving ART, the doubling of the amount of people receiving ART between 2010 and 2015 – from 7.5 million to 15 million – is a big success. Of all people with HIV globally 38% is receiving ART. The percentage of HIV-positive pregnant women who receive ART to prevent HIV transmission to their babies increased from 48% in 2010 to 64% in 2012, and in 2014 this number went up to approximately 73%. In twenty-one high priority countries in Sub-Saharan Africa about 77% of women are reached with services that help prevent mother-to-child transmission of HIV.[131] However according to key informants the inclusion of HIV testing in ANC services remains an area for improvement.

Result area 3: SRHR as part of an accessible and affordable basic health system

Indicators results area 3

- Increased % / number of HIV-positive women treated to prevent mother to child transmission
- Increased number of doctors, nurses and midwives per 1 000 population
- Improved compliance to the 2012 WHO / the latest guidelines on safe abortion and post abortion care

A well-functioning health system is needed to deliver sexual and reproductive health care (including HIV/AIDS services) to all, including young people and disadvantaged groups.[132] Ideally those services are delivered through public and private health services in an integrated manner, i.e. all the SRH services that someone may need in one place, such as antenatal care and STI (incl. HIV) testing combined; or post abortion care combined with counselling on contraceptives. Public and private (for profit and not-for-profit) players all have their roles to play, in quality control, service delivery, staffing, financing. UNFPA and UNAIDs worked on health system strengthening through different programmes. UNFPA supported programmes in maternal health, with particular focus on midwifery (training of midwives, support to the establishment of midwifery associations and advocacy for policies to support midwifery work[133]), emergency obstetric care, fistula repair (training of health

[130] UNAIDS MDG6 report, 2015, p.33
[131] Overview of results based on the data in the annual reports of MFA/DSO 2012, 2013, 2014
[132] MFA/DSO AR 2014
[133] Efforts in international advocacy have been effective in achieving better policies to support midwifery work in 30 countries MFA/DSO AR 2013

workers on fistula repair and supporting treatment and social reintegration services) and task shifting.[134] Evaluations show the effectiveness of such initiatives, however are critical on sustainability and lack of exit strategies. Lessons learned from the first implementation phase are taken further in the 2014 – 2017 phase.[135] One of the new areas of attention are adolescent mothers.[136]

Through the Supplies and Family Planning programmes UNFPA invested in increased access to family planning, also an important component of strengthening health systems. The Supplies Programma is being implemented in 46 countries, most of them countries with limited access to family planning and the highest demand. In many of these countries UNFPA is the only supplier and partner of the government in this domain. Besides procurement of SRH commodities the programme is also instrumental in encouraging governments to invest in this area (generating financial support locally) and in training of health workers.

UNAIDS successfully worked on Prevention Mother To Child Transmission of HIV/PMTCT within the context of the *Global Plan on the Elimination of New Infections in Children by 2015 and Keeping their Mothers Alive*. UNAIDS and President's Emergency Plan for AIDS Relief (PEPFAR) coordinated a plan that resulted in the reduction of infections in children (from 550 000 in 2001 to 260 000 in 2012). In Botswana, Ghana, Namibia en Zambia 90% of HIV positive pregnant women received ARVs. An increasing number of countries strengthened the linkages between HIV/AIDS and SRH services. Close to 80% of the 80 countries that officially launched the **UNAIDS** Agenda for Women and Girls report linking HIV and sexual and reproductive health (2013 data). UNICEF, in cooperation with UNAIDS supported 26 of 38 of the UNAIDS HIC countries to develop national HIV/AIDS strategies that include proven high-impact, evidence-based interventions focused on adolescents. Also, in cooperation with UNAIDS in 19 of 22 HICs non-physician health care providers have been trained to provide antiretroviral treatment in antenatal care settings for HIV-positive pregnant and breastfeeding women. UNICEF furthermore launched the action plan 'Every Newborn' to end preventable death of mothers and children in high-burden countries. The plan focuses on maternal and newborn care around the time of birth. The percentage of HIV-positive pregnant women who receive antiretroviral therapy increased from 48% in 2010 to 64% in 2012. In order to prevent mother-to-child transmission of HIV the WHO treatment guidelines in 2013 recommended providing lifelong treatment to pregnant and breastfeeding women living with HIV.[137]

[134] For example, in 2012, UNFPA facilitated training of more than 1,300 healthcare workers, including surgeons, nurses, midwives and community health workers to repair fistulas. Nearly 7,000 women underwent surgery to repair obstetric fistulas. UNFPA contributed to the establishment of 36 new functioning treatment centres and 25 new facilities offering social reintegration services. In 2013, UNFPA supported 43 countries with comprehensive midwifery programmes and 38 countries with strengthening of EoMNC. UNFPA was also involved in the training programmes and support to midwifery associations. UNFPA reported that so far, 37 countries have launched the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA)

[135] Zie de evaluaties uit 2012: UNFPA/Evaluation Branch/Division for Oversight Services (2012). *UNFPA Support To Maternal Health. Thematic Evaluation /Volume 1 and II*; and UNFPA/Evaluation Branch/Division for Oversight Services (2012a). *Thematic Evaluation. UNFPA support to maternal health 2000-2011.* Final report + VOLUME 2 Annexes

[136] UNFPA (2015). The Maternal Health Thematic Fund. Improving maternal health: Surging towards the 2015 deadline Annual Report 2014

[137] UNAIDS MDG6 report 2015. Cuba became the first country in the world, as validated by the WHO, as having eliminated mother-to-child transmission of HIV and syphilis (WHO news release, June 30th 2015: http://www.who.int/mediacentre/news/releases/2015/mtct-hiv-cuba/en/).

Result area 4: SRH rights of key populations

Indicators results area 4

- Increased conduct of good problem analyses on the sexual health of marginalised groups in policies at country level
- Better national legislation, law enforcement and concrete policies in the area of sexual and reproductive rights (increased marital age for girls, against female genital mutilation, against criminalisation of homosexuality, and liberal legislation around abortion)

In several countries themes such as sexuality and HIV/AIDS are difficult to address because of a lack of an open atmosphere to discuss the more sensitive issues of the ICPD Programme of Action.[138] In many countries sexual and reproductive rights and the right to sexual and reproductive health (care services) are not fully upheld. Girls, women and young people in general are most often denied those rights and the freedom to exercise them; and vulnerable groups such as sexual minorities and indigenous people are often stigmatised or criminalised. The Netherlands is one of the few donors which is prepared to address the health and human rights issues of vulnerable groups such as (poor) women and adolescents/youth and populations that are key for HIV prevention (sex workers, men having sex with men and people who inject drugs).[139] The approach of the Ministry is to support various programmes and partners through a multi-pronged approach: providing concrete support under result areas 1, 2 and 3, working on the international human rights framework (e.g. ICPD and Post-2015) and applying that framework in advocacy for national legislation, policies and accountability through result area 4.[140] Results have been hard to achieve, and in a number of countries the situation worsened, e.g. increased homophobia, sexual and gender based violence and opposition against women's (reproductive) rights. On the positive side, many sensitive issues like child marriage, FGM and comprehensive sexuality education are nowadays subject to (international) debate, which was not the case 10-15 years ago. Specific successes have also been achieved, ranging from closure of detention centres for sex workers in Vietnam, to less restrictive abortion laws in a number of countries and tripartite cooperation agreements between the Netherlands, UNAIDS and Dutch-funded NGOs on HIV and key populations in three countries, improving access for young people living with HIV to services.[141] See the box 9 below for the contours and results of this initiative.

Box 9: NL-UNAIDS Tripartite Cooperation on HIV and Key Populations in Indonesia, Kenya and Ukraine [142]

In collaboration with its partners in Indonesia, Kenya and Ukraine the Netherlands MFA initiated an ***innovative partnership*** with a focus on 'HIV and key populations". Combining the strengths of the different partners was seen as an added value, enhancing the joint work of the Ministry and its diplomatic missions, civil society at international and local level and UNAIDS, both at central and country level. The partnership started with building trust, getting to know each other better and make use of each other's strategic positions, networks and expertise. The approach is quite different as it does not follow traditional

[138] MFA (2013a). Annual report of the Social Development Department (DSO) of the MFA on SRHR
[139] MFA (2014). Annual report of the Social Development Department (DSO) of the MFA on SRHR
[140] Ibid
[141] Ibid
[142] Sources: Programme documents; interviews with key informants; a case study prepared for UNAIDS PCB in 2015

Box 9: NL-UNAIDS Tripartite Cooperation on HIV and Key Populations in Indonesia, Kenya and Ukraine [142]

project-based planning and budgeting; something which stakeholders had to get used to. ***The overall objective*** of the collaboration was jointly decided: key populations, including people living with HIV, are empowered to access (health and legal) services, demand their human rights and enact change. As the cooperation evolved, an additional aim was added: strengthen the link between Community Based Organizations (CBOs) and Country Coordination Mechanism to enhance the opportunities of CBOs to get access to Global Fund support.

Results of the programme include raised awareness on common concerns of key populations like violence, discrimination, and lack of access to (health and legal) services and human rights. This understanding lead to exchange of expertise and knowledge and joint working at country level. Also, representatives of key populations (local CSOs/CBOs) have been introduced and linked with national Country Coordinating Mechanisms (CCM) of the Global Fund. In Indonesia an extra seat was created at the CCM for a representative of key populations. Some of the CBOs got better access to influence national AIDS plans/reviews and/or proposals to be submitted to the Global Fund.

Joint funding by the different stakeholders is the base of this partnership which does not have separate project-funding. Major partners are the Dutch Ministry of Foreign Affairs and embassies, Aids Fonds, Mainline, Aids Foundation East West, GNP+, COC, HIVOS, International HIV/AIDS Alliance (IHAA), UNAIDS (both at central and country level). Local partner organisations of these Dutch NGOs and the Alliance active in the area of HIV and key populations. The partnership is valued because of its horizontal structure. The lead of the partnership is with the NGOs, as they share the responsibility for the development of the country road map (objectives, activities, planning). At global level there is a Steering Group of senior staff of UNAIDS, Dutch and international civil society and the Ministry of Foreign Affairs.

The initiative has ***potential to become a model*** for engagement of key populations, joining forces in advocacy around sensitive issues such as defending the human rights of key populations, and on the role of Ministry in brokering better relationships between CSO/CBO and national governments.

The formation of strategic partnerships is important for achieving results in the area of SRH of key populations. At the international level, progress has been made in facilitating an open atmosphere in which to discuss the agenda agreed at the International Conference on Population and Development (ICPD, Cairo, 1994). In 2013 MFA, together with **UNFPA** and the Office of the High Commissioner on Human Rights (OHCHR), organised the ICPD Beyond 2014 International Conference on Human Rights in the Netherlands. At the UNGA Special Session on ICPD Beyond 2014 all governments agreed to extend the ICPD agenda with a renewed focus on the gaps and new emerging issues. The ICPD Global Review indicated many legal and policy barriers in implementation of ICPD and SRHR, such as discriminatory laws and practices, restrictive abortion laws, lack of respect for human rights and poor accountability. The Netherlands was actively involved in the review and committed to this renewed ICPD agenda, and especially – together with UNFPA – advocated for human rights in ICPD implementation as a neglected but crucial area. At regional level, the UNAIDS Secretariat together

with OHCHR have supported the first dialogue between the Inter-American and African Commissions on Human Rights on protection of LGBTI rights, held in Banjul in November 2015. The report of this Joint Dialogue on sexual orientation and gender identity has been launched at the African Commission session in April 2016 and in Geneva in September 2016 at a session of the regional human rights bodies.

Policy and legal reforms that are in line with internationally agreed human rights and which promote and protect the rights of key populations are most often the results of years of advocacy, and in many cases the efforts of a number of parties. A good example of joint advocacy, and on the leading role of **UNAIDS** is the work on the Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030.[143] Behind the scenes UNAIDS worked hard to include SRH and RR in the document (twice, in paragraph 14 and 61b); thereby advancing from the 2011 Declaration which did not mention any of this. Article 42 specifically refers to key populations, and also – for the first time in a political declaration – provides the key statistical facts on the scale of epidemic among key populations.[144] To ensure that human rights are prominently addressed within the Political Declaration, the UNAIDS Secretariat has worked with a core group of member states at the Human Rights Council led by Brazil to secure the adoption of Resolution 30/8 on Contribution of the Human Rights Council to the high-level meeting on HIV/AIDS in 2016 co-sponsored by over 80 countries and calling for a panel at HRC to mark 20 years of International Guidelines on HIV and Human Rights and provide critical inputs to the Political Declaration. The panel at the 31st session of the Human Rights Council on the progress in and challenges of addressing human rights issues to end the HIV/AIDS epidemic by 2030 showed remarkable consensus from member states and civil society on the prerequisite of addressing stigma and discrimination for ending AIDS, and the summary report of the panel has been submitted by the President of the Human Rights Council to the President of the General Assembly to inform the 2016 Political Declaration.

Other programmes supported by the Netherlands under this result area are the UNFPA programmes targeting young girls to prevent child marriages and early pregnancies (in 12 countries). Also together with UNICEF, **UNFPA i**mplemented a joint programme on abandoning FGM/C. Through this programme close to 9,775 communities across Africa have abandoned FGM/C; in 2012 alone as a result of the initiative, 4000 communities were convinced to eliminate FGM practices, an increase of 400% compared to 2011. To address the problem of early and forced marriage and consequently early childbearing, UNFPA published 'Marrying too young: end child marriage' which summarised data and evidence from 40 countries and identified hot spots with the largest proportions and numbers of girls at highest risk.

UNAIDS introduced the HIV Stigma Index, which is a tool devised by and for people living with HIV to build evidence and measure the level of stigma they experience within their communities. 2012 data show that the tool was rolled out in more than 75 countries, 29 more than in 2010. In 2012, the Global Commission on HIV and the Law, led by UNDP and UNAIDS Secretariat, issued its report and recommendations. In follow-up to the recommendations the UNAIDS Joint Programme in collaboration with governments and civil society, supported action on HIV and the legal environment in 73 countries, including 31 high impact countries. Successes are seen for example in 2012, following

[143] Adopted by the General Assembly on 8 June 2016
[144] Interviews with key informants

continued engagement by UNAIDS, the African Commission on Human and Peoples' Rights adopted its first general comment which clarifies the provisions of Article 14 of the African Women's Rights Protocol, thereby enhancing women's rights to confidentiality and autonomy in the context of HIV. The number of countries with laws against gender-based violence has doubled since 2010. UNAIDS has implemented an information education communication strategy on HIV for the general population that includes messaging to fight violence against women. The percentage of countries where country-specific data on the links between gender-based violence and HIV is collected and available increased from 16% to 27% between 2010 and 2012. UNAIDS continued to strive for the inclusion of populations that are left behind (see the Gap report) and speaking out on human rights violations. The organisation is regarded as an ally for populations that systematically have been criminalised, fighting punitive laws and the criminalisation of LGBTIs, and condemning human rights violations. In 2012 the Executive Director of UNAIDS was the first to come out with a statement on the killings of transgender people in Honduras.[145] Often endurance is asked for; see for example the sustained work on the adoption by the Commission on the Status of Women, and implementation of the resolution 'Women, the girl child and HIV/AIDS' (resolution 58/3). According to a key informant, *"the involvement of the Netherlands MFA in this, and other advocacy processes is highly appreciated especially at these regional and global spaces and given the current difficult environment for SRHR. It has proven very important to establish have such alliances and engagements with countries who are committed to a full engagement of human rights in the promotion of SRHR."*

In 2012 UNFPA released, together with WHO, UNAIDS and the Network of Sex Work Projects, guidelines on Prevention and Treatment of HIV and other STIs for Sex Workers in Low- and Middle-Income Countries. In 2013, the WHO, in partnership with UNFPA, UNAIDS, the World Bank and the Global Network of Sex Work Projects, published a tool kit with practical advice on implementing HIV and STI programmes for and with sex workers. 38 programme countries of UNFPA have at least one community-based sex worker-led organization engaged in designing, implementing and monitoring programmes that address HIV and SRH needs of sex workers. This is one example of the many publications by UNAIDS on human rights and key populations.

3.4 Conclusions

To what extent have UNFPA and UNAIDS achieved the development objectives and expected results (performance regarding organisation-wide and country-wide results; contribution to national goals and priorities, including MDGs, and shaping of the post-2015 agenda)?

UNFPA is rated 'good' on achieving organisation-wide results especially considering their results in family planning, gender equality, and data availability and analysis around population dynamics, SRH and gender equality. The organisation is considered a committed partner and praised for its sustained support to governments in conducting housing and population surveys and censuses. UNFPA could be more proactively involved in promoting the use of data, and work with governments on combining and applying data sources for improved national planning in SRHR. The organisation demonstrated its leadership in promoting access to family planning (global level), and through its Global Programme for RHCS for increasing access at national levels. UNFPA is in a good position to

[145] Interviews with key informants

broker with government, civil society and private partners, however could take up this role more actively. Also, the implementation of a human rights based approach needs more attention at the national level. As regards UNFPA's performance in the area of maternal health, another key area for the organisation, it is concluded that UNFPA demonstrated its strength in partnering around improving maternal health (global, regional and national level). Also UNFPA was instrumental in creating demand (at community level), and underlining the important role of the midwife in improving maternal health, besides other health system necessities as emergency obstetric and neonatal care. More attention could be given to ensuring the accessibility of services for marginalized / hard to reach populations.

UNAIDS is considered a strong partner in advocating for combating HIV/AIDS and positioning sensitive issues on the global agenda (rights of key populations, discrimination) – good examples of such is the work on the Political Declarations. Increasingly focus is placed on adolescents and youth in prevention efforts. UNAIDS is an expert organisation on data collection and is a reference base for information and quality data on the epidemic (trends, country and global level data). UNAIDS is particularly commended for its role in establishing partnerships, in particular with key populations and bringing stakeholders together at national level. A good example of such an approach is the tripartite partnership on key populations in three countries.

UNFPA and UNAIDS align their work to national priorities (and national planning and programming processes), and both have contributed to the achievement of the MDGs – in particular regarding MDG 3 (gender equality), MDG 5 (maternal health), and MDG 6 (combating HIV/AIDS). The ICPD beyond 2015 review specifically intended to inform and influence the SDG agenda, a process that took place under guidance and support of UNFPA.

To what extent did UNFPA and UNAIDS supported activities effectively address the cross-cutting issue of gender equality?

UNFPA is commended for achieving tangible results in achieving gender equality, in particular the successful integration of gender equality and women's rights into national frameworks. In particular the work on combating Female Genital Mutiliation/Cutting is considered as successful, however sustainability is a concern. UNAIDS has developed guiding documents on inclusion of a gender perspective in planning and programming, such as the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010–2014. In terms of effectiveness, the Agenda had an overall positive effect as a political platform in mobilizing CSOs and governments around issues related to gender equality in the context of an HIV response. It contributed to generating new partnerships and creating spaces for dialogue, leading to increased visibility and awareness of these issues. The End Review also found that it contributed to increased participation of networks of women living with HIV in global fora, which led to them having greater influence in decision-making processes, as well as increased empowerment of individual women and girls through training and greater inclusion. However, more support is still needed to create an enabling environment for women and girls in the context of HIV, as stakeholders identified inadequate funding as the prime barrier to the Agenda's implementation, hence to accelerate action for women and girls.

To what extent are UNFPA's and UNAIDS's programmes sustainable?

Sustainability appeared to pose a serious challenge for UNFPA's development effectiveness. Evaluations note sustainability as a key challenge for the organisation which is addressed through focusing on capacity development of implementing partners, and its sustained attention to policy development in SRHR and in advocacy: working strategically at the national level on policy and legislative frameworks, while at the same time building capacity at all levels. However, much of the work in SRHR still suffers from excessive donor dependence, and much still needs to be done on integration of programme costs into national budgets. Global thematic evaluations note that a major threat to the sustainability was the lack of funding after UNFPA support ceases. In the case of UNAIDS, much depends on the strengths of the national frameworks, which in turn the organization also influences significantly, as it is frequently the closest partner of the government when these are developed. A particular challenge is to keep the fight against HIV/AIDS on the political and development agenda, but one where UNAIDS has been particularly successful. The number of Heads of State and Governments, First Ladies and Ministers that are mobilised for the UN General Assembly High Level Meetings remain a solid indicator of this.

To what extent were UNFPA and UNAIDS able to meet the expectations of the Netherlands considering the priority areas of the Netherlands in SRHR? What conclusions can be drawn on the effectiveness of UNFPA and UNAIDS for achieving development objectives in SRHR?

UNFPA and UNAIDS both increased their focus on SRHR of adolescents and youth (result area 1). The MFA's approach of supporting various channels and actively promoting the coordination and collaboration between various actors is considered essential to achieve tangible results, seen in the work on comprehensive sexuality education for example. UNFPA – with other UN organisations – has proven its worth in promoting the inclusion of CSE in national curricula among governments, something with in interplay with NGOs has helped to position adolescents' needs and concerns more prominently on national development agendas. Another priority area of the Netherlands MFA which successfully has been taken up by UNFPA is early marriage. UNAIDS has successfully worked on increasing access to HIV testing and counselling, and on establishing youth networks around HIV/AIDS.

The UNFPA Supplies programme has boosted access to SRH commodities (result area 2), despite the many challenges on the ground. The Netherlands MFA committed its support to increasing access to family planning, and the support to UNFPA must be seen in this context. UNFPA and UNAIDS both contribute to improved access to other SRH commodities, with positive results on increasing access to antiretroviral drugs (ARVs) – with the support of UNAIDS in collaboration with the GFATM – and in the prevention of mother to child transmission of HIV. As with other result areas it is not possible to attribute results directly to the work of the two organisations. What is possible however is to illustrate the work of the organisations (at output and outcome levels) which contribute to results, and the successes they themselves report in their results frameworks, most notably on access to FP, ART, counselling, and PMTCT services.

The extent to which expectations of the Netherlands regarding SRHR as part of an accessible and affordable basic health system (result area 3) are met, is not clear-cut as health system strengthening goes beyond the specific area of SRHR and requires commitment and major inputs from country governments. Specific results of strengthening the health system (in particular of midwives) are noted, in particular those reported under the UNFPA Supplies programme (supply chain

strengthening). Strengthening of midwifery services (under the maternal health programmes) is also part of system strengthening, however, as commented earlier the sustainability of these efforts are challenged. Health system changes require multi-year and multi-partner investments, hence, attribution problems also are noted. Commended is the work and the successes of UNFPA in maternal health (especially) at the community level, knowledge and lessons learned which need to be disseminated more widely. UNAIDS shows successes in systems strengthening, in particular in the area of PMTCT.

In terms of advocating for the SRH rights of key populations (result area 4) UNAIDS showcased how partnering at the national level (in Kenya, Indonesia and the Ukraine) around key populations can successfully influence the debate and the national agenda. Successes are hard to achieve, and many discriminatory laws and practices still exist – as the UNFPA lead ICPD beyond 2014 review process showed. Promising initiatives are the HIV Stigma Index – introduced by UNAIDS – as well as information and education campaigns and the work of both UNFPA and UNAIDS on increasing prevention and treatment of STIs among sex workers.

IV. Efficiency of UNFPA's and UNAIDS' programmes

Guiding questions to be answered in this chapter:

- To what extent were UNFPA and UNAIDS able to meet the expectations of the Netherlands considering their organisational performance (efficiency)?
- What conclusions can be drawn on the efficiency of UNFPA and UNAIDS for achieving the development priorities in SRHR?

4.1 Introduction

According to the Organisation for Economic Co-operation and Development (OECD), *"efficiency measures the outputs (qualitative and quantitative) in relation to the inputs".*[146] It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results. In this chapter efficiency issues of UNFPA and UNAIDS regarding result based management, partnerships, efficiency of the governance structure, human resources and financial management are dealt with them (4.2). The chapter closes with conclusions.

4.2 Organisational performance of UNFPA and UNAIDS

Strategic focus

Both organisations have sharpened their focus on their mandates. In the context of the development of the Strategic Plan 2014 – 2017 (SP), **UNFPA** developed the "bull's eye" concept[147], adopted a new integrated results framework and developed outcome theories of change.[148] The new strategic plan is considered an advance, as with a lower number of strategic priorities the organisation can better concentrate on the core priorities.[149] Reviews and interviews rate UNFPA strong for the clarity of its mandate, and alignment of the strategic plan to the priorities of the quadrennial comprehensive policy reviews (QCPR).[150] The organisation is also rated strong on its focus on the crosscutting priorities of gender equality, HIV/AIDS, and human rights based approaches.[151] UNFPA considers the QCPR was an important influence on the development of the new strategy.[152] The article in the QCPR on sustainable development (paragraph 14) encourages organisations *"to further enhance the*

[146] For UNFPA efficiency is defined as: *"Efficiency is defined as the extent to which CPAP (Country Programme Action Plan) outputs and outcomes have been achieved with the appropriate amount of resources. In other words, to be efficient, a programme should have the appropriate management of resources to achieve its goal".* IN: UNFPA (2016) Lessons learned from Country Programme Evaluations

[147] The MTR of the 2008-2013 strategic plan resulted in a significant refocusing of UNFPA, with SRH and Reproductive Rights placed squarely at the centre of the work of the organisation. The 'bull's eye' is the goal of UNFPA: the achievement of universal access to SRH; the realisation of RR; the reduction in maternal mortality

[148] The SGR on QCPR in article 246 mentions progress of UNFPA among others, in improving the results frameworks in strategic plans through the adoption of a 'theory of change' or similar methodologies to improve the identification and formulation of results

[149] For example according interviews with key informants questioned the added value of working on thematic issues like ageing

[150] MOPAN UNFPA 2014, DER 2016, interviews with key informants

[151] MOPAN UNFPA 2014

[152] 2013, annex 5 to the Strategic Plan

mainstreaming of sustainable development into their respective mandates, programmes, strategies and decision-making processes" which for UNFPA translated into *"recognising that improving maternal health has a number of broader developmental impacts for all the other MDGs, since ensuring universal access to family planning is an important component of a path toward sustainable development."*[153] Sustainable development is also explicitly included in Outcome 4 (of the SP): "*strengthened national policies and international development agendas through the integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality*".[154]

UNAIDS has a clear mandate which is reflected in its Strategic Plan 2011 – 2015: Getting to Zero. The reforms in the period under review are inspired and guided by the recommendations as formulated in the Second Independent Evaluation (SIE) 2009, MOPAN 2012, in DFID's Multilateral Aid Review (MAR) 2013, and the QCPR. The 2009 SIE noted the complexity of the structure and unclear delineation of responsibilities within the organisation, and UNAIDS needed to become *"more focused, more strategic, more flexible and responsive, more accountable and more efficient."*[155] In the years thereafter UNAIDS invested in making the organisation more focused, among others through the introduction of the Outcome Framework which forced countries (Joint UN Teams on AIDS) to prioritise. The 2011 – 2015 Strategy helped the organisation to become more strategic and more responsive with an increased focus on prevention, and on 'game changers' such as PMTCT. In terms of being more responsive and flexible, UNAIDS updated its Technical Support Strategy increasingly focusing on building local capacities, and improved South-South collaboration. In terms of getting more efficient, the new strategy presents more clearly defined division of labour between the Secretariat and the co-sponsors, has a transparent budgeting framework, and places an emphasis on the critical role of country ownership and shared responsibility. Furthermore, in the lead up to the development of Agenda 2030, ECOSOC highlighted UNAIDS and the joint programme as a model for the UN for the SDG era. In particular the inclusive governance model was highlighted. In the period under review the new strategy was developed, for the period 2016 – 2021. It builds on the 2011 – 2015 Strategy maintaining the 3 zeros and the 3 strategic directions, including its rights-based and people-centered approach. It builds on key publications such as the Fast-Track, Cities and GAP reports – the latter identifying people left behind. The strategy puts a strong emphasis on the role of women, especially young women and girls, in the response and takes a clear position on empowering and engaging young people – who are, in so many contexts, both at the centre of the epidemic and the response. It is also the first UN strategy to be explicitly embedded in the 2030 Agenda for Sustainable Development - which offers a platform to forge new alliances to address a wide range of determinants of HIV – many of which are directly linked to accelerators for achieving the SDGs such as women's empowerment and leveraging private sector engagement. Overall, the new strategy succeeded in bringing people together behind a common vision, and it includes SRHR, CSE, and removal of punitive laws that block access to health and HIV services.[156]

Because of the nature and the structure of the organisation, **UNAIDS** strives to align its work to national structures. The new strategy is more results-oriented than its predecessor, and more clearly

[153] Focus on reduction of maternal deaths is reflected in the fact that the majority of core resources are spent on this actions in this area
[154] Annex 5. Alignment of the Strategic Plan with the QCPR
[155] http://www.imaxi.org/delivering-results-michel-sidibe-ed-unaids/
[156] Interviews with key informants

describes the work relation between UNAIDS and co-sponsors at country and worldwide levels.[157] The updated MAR on UNAIDS (2013) reports progress and reconfirms that UNAIDS significantly contributes to facilitating progress on HIV/AIDS at the global level, including meeting the MDGs which are relevant to HIV/AIDS. In 2014 UNAIDS introduced the Fast-Track Initiative, acknowledging that time-bound targets drive progress, promote accountability and unite stakeholders in pushing towards common goals.[158] The global consensus is to aim for 90% of people living with HIV knowing their HIV status, 90% of people who know their status receiving treatment and 90% of people on HIV treatment having a suppressed viral load so their immune system remains strong and they are no longer infectious. The renewed focus (Fast Track) is outlined in the UNAIDS 2016 – 2021 Strategic Plan (SP) and UBRAF. Compared to the 2012 – 2015 UBRAF, the 2016-2021 framework among others has a clearer and simpler structure, a stronger link between resources and results, fewer outputs (20 compared to the 64 previously) and a theory of change linking the UBRAF outputs to higher level results and the SDGs. The number of indicators has vastly reduced, shifting from process indicators to monitoring changes at country levels which will help to better demonstrate progress and results.[159]

Results based management

The 2014 – 2017 Integrated Results Framework is seen as progress, as it allows **UNFPA** to better link resources (core, and non-core) and results. The implementation of the framework at country level is also an improvement, as the framework includes baselines and targets more clearly. In concordance with the SP and the new business model the transparent Resource Allocation System (RAS) is instrumental in fine-tuning the financial allocations to countries, following the ICPD priorities – taking into consideration the countries that are lagging behind on this agenda. Reporting on results according to the SP 2014 – 2017 was first carried out in 2015 (see also chapter 3 for results). This is seen as an improvement, considering the critical assessment of result based management (RBM) in the MOPAN 214 and in the 2016 Development Effectiveness Report: *"While findings on evaluation systems and processes as well as the use of evaluations to improve development effectiveness were positive, those for monitoring and result-based management systems were predominantly negative"*.[160]

Since MOPAN 2012 **UNAIDS** has improved its results based monitoring (RBM), thanks to the introduction of the Unified Budget Results and Accountability Framework (UBRAF), covering 2011 – 2015. This instrument helps to track and trace the results at different levels. The scorecard 2015 reports that planning based on results has improved, as well as coordination between co-sponsors and the secretariat. This minimalized overlap, though synergy at national level between programmes of the co-sponsors and the secretariat still needs improvement, as does the synergy between activities of UNAIDS across the levels. In 2012 UNAIDS developed the Joint Programme Monitoring System, which according to the mid term review of the UBRAF: *"contributed to better planning and clarity on results at country and regional levels"*. UNAIDS is transparent in the allocation of financial resources, and disperses funds based on results of co-sponsors, their capacity to fundraise, and the priority of a region, or a country.

Partnerships

[157] Scorecard 2013, interviews with key informants
[158] UNAIDS (2014j). *Fast Track Initiative. Ending the AIDS Epidemic by 2030*
[159] UNAIDS (2016). 2016 – 2021 UBRAF. Presented at the June 2016 session of the PCB
[160] DER 2016

UNFPA partners in several relevant networks, like the H4+ network in which UNFPA, World Bank, UNICEF, UNAIDS and UNWomen align their work on maternal and newborn health in 25 selected countries. The role of UNFPA in this partnership is to harmonise the work at country level on maternal health in the programme countries. UNFPA participates and is a member of the governing board of the WHO Human Reproduction Programme (HRP) – the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. The organisation is also a member of the board of the Partnership for Maternal, Newborn and Child Health (PMNCH). Reviews and interviews with key informants show the importance of involvement in partnership, as it enhances the quality of the work – through evidence-based research like HRP – and avoids overlap. In addition to increased collaboration within the UN, working with the private sector increasingly has become important to UNFPA. In 2013 a special branch for working with the private sector was established, which was a strategic approach to involve others besides governments.[161] In 2014 UNFPA worked with more than 40 companies, worldwide; and they have some 75 ongoing partnerships with For example, in the context of the SG Global Strategy for Women's and Children's Health, FP2020 and the UN Commission for Life Saving Commodities UNFPA developed partnerships to promote the female condom. Collaboration with the private sector is also stimulated and facilitated by the Netherlands MFA; for example in the PMNCH the involvement of private partners is encouraged.

UNAIDS is *the* living example of a partnership, an element which is considered a strong point of the organisation. Partnering is core to the mission of UNAIDS, and a central element in the 2011-2015 Strategy. In some cases, the role of UNAIDS is that of a broker, as in the context of the Tripartite programme which strives for better treatment and rights of girls, women, LGBTIs, sex workers and drug users (see the case study in chapter 3). The Global Fund to fight AIDS, Tuberculosis and Malaria values UNAIDS as an effective partner in their partnership which covers many areas.[162] UNAIDS is valued for its partnerships with non-governmental organisations (NGOs). For example in the context of delivering services for mobile populations in Africa, UNAIDS partners with more than 70 partners including the Dutch NGOs North Star Alliance and AIDS Fonds.

Efficiency of the governance structure

UNFPA is governed by the Executive Board (EB) which provides intergovernmental support and supervision for the activities of UNDP, UNFPA, and UNOPS in accordance with the policy guidance of the General Assembly, the Economic and Social Council, and the United Nations Charter. The Executive Board ensures that UNFPA remains responsive to the evolving needs of programme countries, and supports the work of UNFPA. The EB consists of representatives from 36 countries serving on a rotating basis (24 from programme countries and 12 donors). Reviews and interviews with key informants value the functioning of the board and its ability to guide the work of the organisation. A concern is that, due to the joint executive board arrangements with UNDP and UNOPS, there is a danger that UNFPA's Executive Board may become more politicised and less effective.[163]

[161] Strategic Partnership Branch under the Division of Communications and Strategic Partnerships
[162] Scorecard 2015
[163] AusAid (2013). *Australian Multilateral Assessment UNFPA 2013*

For UNFPA, MOPAN 2010 was a turning point which led to a large scale reform process aiming to increase the implementation capacity and efficiency of the organisation – in particular at the country level.[164] It resulted in a clearer division of tasks, roles and responsibilities, with headquarters being responsible for guidance; country offices for the implementation of programmes; and the (sub)regional offices for providing support to the country offices and monitoring of quality of the country programmes.

The Programme Coordinating Board (PCB) is **UNAIDS**' governing body, and is generally considered effective in overseeing strategic direction and holding management to account for performance. Key informants value the open and transparent structure of the board, the participation of NGOs and the relative ease of interaction with senior staff to propose issues for discussion, among others through the Friends of UNAIDS platform. The 2009 Second Independent Evaluation (SIE) was quite critical of the functioning of UNAIDS at country levels. Though UNAIDS is considered a global leader in the HIV/AIDS debate and response, the Netherlands is critical of the passive role of UNAIDS in some countries. This may be related to how the AIDS response is organised. In 84 countries (at the time of this report), there is a UNAIDS Country Director (UCD) or a local recruited UNAIDS Country Officer (UCO), who leads the Joint UN Teams on AIDS which implements the Joint UN Programme of Support on HIV which covers the scope of the activities of the co-sponsors working in-country. The UBRAF is the guiding framework for dividing tasks by policy area as well as the UNAIDS division of labour which was most recently updated in 2014. The document outlines the role of the UNAIDS Secretariat in the ensuring functioning and accountability across all areas of the Division of Labour among the co-sponsors. Several sources are critical of the motivation, involvement or technical expertise of co-sponsors pointing to the lack of leadership at country level which can be a threat to the achievement of national goals, in cases where the mandate of UN agencies prevails over the common agenda. On the other hand, the 2013 case studies on country progress are good examples of efficiency gains and improved sustainability of HIV responses at country level:

(a) Efficiency gains in cases where countries have re-allocated resources to more cost-effective interventions ('allocative efficiency' in Cambodia and Myanmar).
(b) Efficiency gains in countries where HIV programmes were made more efficient ('technical efficiency' in South Africa and Swaziland).
(c) The case studies on Kenya, Namibia, Malawi and Kazakhstan illustrate how sustainable financing can be achieved, as these countries have taken active steps to increase domestic resources for the HIV response.[165]

Human resources

Several sources highlight how **UNFPA** has worked to improve its human resource capacity; among other area through implementation of the Human Resource Transformation Agenda as outlined in the HR Strategy 2014 – 2017.[166, 167] The SP 2014 – 2017 has provided guidance on the right skills mix

[164] Key informants value the role of the Executive Director in leading the reform process
[165] UNAIDS (2013). *Efficient and sustainable HIV responses: case studies on country progress*
[166] MOPAN 2014, *Kaderinstructie* UNFPA 2015, interview with key informants
[167] UNFPA HUMAN RESOURCES STRATEGY 2014–2017. The strategy is based on three pillars: agility, performance and shared responsibility for results. The HR strategy outlines how UNFPA respond to changing needs, particularly at the country level – with a focus on reshaping organizational skills mix, culture, design, and collective performance. The HR Strategy provides the overall direction for HR transformation at UNFPA, and is aligned with, and contributes to, organizational effectiveness and efficiency as reflected in the Strategic Plan

(at all levels) and on identification of the competences needed to achieve the targets. For this active support is given to capacity development of staff, and internal and external mobility of staff.[168] Challenges remain, as in 2010 close to half of the international staff was older than 50 years of age, while at the same time the organisation needs to retain knowledge. Recruitment of youth and talented experts are actively promoted, and since 2013 UNFPA has been developing a leadership pool, to identify and attract talented professionals who are potential leaders.

Following the recommendations of the SIE (2009), **UNAIDS** worked on simplifying its administrative systems – among others with the merger of dual administrative systems[169] - and on implementing a new human resource strategy. The **UNAIDS** 2011-2015 Human Resource Strategy proposes a reduction of staff between 2011 and 2013, and a cost reduction at the Secretariat level. Also, a Competency Framework was integrated into all human resource systems to better monitor and improve staff performance. The organisation revised its mobility policy in 2011, and some improvements are noted in 2013 with 70% staff working at country level and 30% at headquarters. This is a slight improvement compared to 65% staff working at country level and 35% at headquarters in previous years.

Financial management

Following the recommendations in the QCPR **UNFPA** worked with UNDP, UNWomen and UNICEF to develop a new cost recovery policy. In its report on the alignment of the SP with the QCPR UNFPA expresses its plans to harmonise cost clarifications and cost recovery rates, *"which will improve the transparency and consistency of development costing, thereby addressing the long standing concern that the core resources unduly subsidize non-core activities."*[170, 171] To prevent the use of core funds to subsidize non-core activities, UNFPA indicated it would stringently implement the cost-recovery policy.[172] Other issues regarding financial management and efficiencies in operational management include the 2016 updated Harmonised Approach to Cash Transfers (HACT), the risk-based approach to manage financial and operational activities with its implementing partners (IPs). The harmonised approach, together with UNDP and UNICEF allows for achieving economies of scale while improving quality in areas such as contracting, joint in-country workshops, joint micro-assessments and audits of IPs.

In 2014 UNFPA launched a business improvement initiative which addresses flows in finance, human resources and procurement. It is too early to document the effects on how these initiatives have affected the efficiency of processes, but it is expected that these and other initiatives such as the harmonization with the UNDP travel policy, the use of UNDP services (payroll and treasury), and the pilot on carpooling (with UNDP and UNICEF in 5 countries) will have tangible results in the years to come. Reviews commend UNFPA for the work on improving its instruments (HACT and the Implementing Partner Capacity Assessment Tool), however the instruments are not widely used, and need some improvements to increase their use and implementation.[173]

[168] Scorecard 2015
[169] In 2011 UNAIDS started using WHO administrative systems
[170] See QCPR paragraphs 53, 54 and 56 on Cost Effectiveness and Cost Recovery, and annex 5 to the UNFPA SP 2014 – 2017 on the UNFPA proposal to address this issue
[171] The Integrated Budget reflects the new harmonised methodology and rate for calculating non-core cost recovery
[172] Memo DMM July 2016 (on the annual report of the ED, and mid-term review of programme)
[173] Scorecard 2015 + *Beoordelingsmemorandum* 2014-2015

DER 2016 on UNFPA's efficiency:
"The results for efficiency of UNFPA programming were mixed. The negative results for the cost efficiency of programs and timeliness of programme implementation was due, in part, to the absence of appropriate and timely cost data gathered by programs to allow reasonable efficiency calculations or
monitoring. Cost/resource efficiency was also hindered by programme fragmentation across too many sub-activities or geographic locations and failure to realize opportunities for synergy. The timeliness of implementation was affected by administrative processes or delays in the release of funds. However, the results indicated that systems and procedures for programme implementation and follow-up were adequate."

Several sources conclude that **UNAIDS** made considerable efficiency improvements, referring to a new division of work for the co-sponsors for the period 2011-2015, the introduction of a clear division of labour at country level, financial reporting and overview of results.[174] In terms of reporting, co-sponsors are accountable for annual reporting to the PCB against all of the UBRAF outputs, and financially accountable for reporting to the PCB against all UBRAF outputs that receive core UBRAF funds. The grey area is that co-sponsors are not obliged to financially report to the PCB against UBRAF outputs that are UBRAF non-core/other AIDS funds – however, they do report in the annual PMR against non-core funds at goal level. Third parties noted improvements in cost reduction, financial management and reporting on results. Based on these improvements MAR 2013 rated the 'value of money' component of UNAIDS as good. However, according to the same source, UNAIDS need to improve reporting on results further. According to the 2013 Mid-term review of the UBRAF, "*UNAIDS has led the way on joint and coordinated programming in the UN system, adapting to a changing environment to ensure the best use of resources. The UBRAF has been instrumental in enhancing results-based planning and coordination among Cosponsors and the Secretariat."* The organisation has aligned the budget cycles of Cosponsors and the Secretariat; and the strategic planning cycles of UN Funds and Programmes. The review commends the improved planning and coordination which have minimized duplication, but signals the synergies between Cosponsor programmes and the Secretariat as areas for improvement. Similar concerns (MAR 2013) are expressed regarding the need to improve synergies between global, regional and country-level efforts of the Joint Programme, however it was responded to through the development of the 2012 – 2015 UBRAF and the Joint Programme Monitoring System. The Global Fund's new funding model may offer opportunities for synergies with and between members of the Joint Programme.

The SG report on the QCPR activities of the various UN organisations sees an increased focus on integrated strategic plans and results framework as positive steps towards ensuring cost-recovery, as this increased transparency and enhanced the ability to attribute costs to the different programme and operational activities.[175, 176] Both UNFPA and UNAIDS have invested in developing such frameworks. Also, the need is stressed among the UN to avoid using core/regular resources to subsidize non-core/extra budgetary financed activities, reaffirming that the guiding principle

[174] B*eoordelingsmemorandum* 2014-2015
[175] UNSG (2015). *Implementation of General Assembly Resolution 67/226 on the quadrennial comprehensive policy review of operational activities for development of the United Nations system. Advanced unedited version*
[176] UNSG 2015, see articles 65, 66, 67, 70 on ensuring cost recovery

governing the financing of all non-programme costs should be full cost recovery, proportionally, from core and non-core funding sources. UNFPA is among the organisations that approved and implemented in 2014 a new harmonized methodology for determining cost recovery rates, with a new cost recovery rate of 8%.[177]

The review also considered the predictability and quality of resources of a number of UN organisations (including UNFPA).[178, 179] In general, there was a relatively smooth and stable movement in total core and non-core resources to these entities. However more detailed review showed that the volatility in contributions from top donors was much more pronounced than the changes in total core and non-core contributions would suggest. Foreign exchange rate movements also lead to fluctuations. The report referred also to the role of trust- or thematic funds as funding sources (both modalities in which UNFPA participates) whereas Multi-donor trust funds (MDTFs) are generally considered more flexible and representing a higher quality form of non-core contributions. The other form of pooled funding, the e*ntity-specific thematic funds* (widely used in UNFPA) generally offer long-term planning and flexibility, and are considered an effective way to attract large-scale non-core resources through internally pooled donor funds, which in turn saves on transaction costs.

The review also comments on an increase of local resources amounting to some USD 1.33 billion in 2014 or some 6% of total non-core resources to the United Nations development system (UNDS). These are most commonly used in Latin America and the Caribbean.[180] Local resources represent a substantial source of funding LAC for many UN entities on the ground, including UNFPA.[181] Such resources can also be viewed as a step towards self-reliance, as host governments provide their own resources to complement funding from other sources.

Overall, the number of entities reporting joint global and regional activities has increased.[182] UNAIDS, UNFPA, and UN Women reported that over 60% of global and regional activities were carried out jointly, with UNAIDS reported over 80% of its activities were carried out jointly at both levels.

4.3 Conclusions

To what extent were UNFPA and UNAIDS able to meet the expectations of the Netherlands considering their organisational performance (efficiency)? What conclusions can be drawn on the efficiency of UNFPA and UNAIDS for achieving the development priorities in SRHR?

Both organisations show improvements in terms of strategic management, as both developed and / or implemented new strategic frameworks which also were accompanied by robust integrated results frameworks. UNFPA included in its new SP the approach of what is known as the 'bulls eye' implying an increased focus on working on the core business, rather than aiming to 'do everything'.

[177] Jointly with UNDP, UNICEF, UNFPA and UN Women
[178] UNSG 2015, see articles 73, 74, 80, 83, 84 on improving the predictability and quality of resources
[179] UNDP, UNICEF, UNFPA, FAO, ILO, UNESCO and WHO, which together account for more than 80% of total development-related activities
[180] UNSG 2015, see articles 89, 90 on local resources
[181] Next to UNDP, UNODC, WFP, FAO and UN-Habitat
[182] UNSG 2015, see article 128 on joint global and regional activities

UNAIDS embarked also with a new framework (2011-2015) which is seen as more results oriented than its predecessor, and more clearly describing the work relations between the Secretariat and the co-sponsors of the organisation.

In terms of operational management UNFPA and UNAIDS have shown increased efforts in making the systems more transparent, and less burdensome. More attention is being placed on efforts to harmonise and align procedures. Human resources are seen as an area of concern, for both organisations especially in the context of the decentralisation processes. For UNFPA there are additional issues to be dealt with including how to deal with a relatively large contingent of staff aged 55 and older, and the need to retain expensive and knowledge within the organisation. Decentralisation processes have asked for renewed attention to clarifications of roles and responsibilities of staff at country, regional and global levels. UNAIDS also worked successfully on re-allocation of resources at country and HQ levels.

Both organisations have improved on their results measuring and accountability frameworks, and in developing and introducing tools to facilitate programme management and result tracking systems. UNFPA placed considerable efforts on aligning their strategic plan with the QCPR resolution.

Building on lessons learned from the 2008 – 2013 strategic plan, UNFPA, in its new strategic plan which commenced in 2014, vastly reduced its number of priorities, and enhanced its focus on the core mandate (reducing from 7 to 4 outcome areas), this is foreseen to enhance efficiency. UNAIDS also developed a concrete plan (focusing on the three zeros), considering the recommendations from the comprehensive evaluation from 2009. UNFPA and UNAIDS showed their capacity in establishing partnerships at country and global levels. In part this can be seen as result of a strengthened focus on the core business, on the other hand it is also a demonstration of their ambitions to increase efficiency, especially regarding joint UN procedures and processes.

V. The quality of the evaluation function of UNFPA and UNAIDS

Guiding questions to be answered in this chapter:

- What is the quality of the evaluation function of UNFPA and UNAIDS, considering the standard components for the evaluation function of the UN?
- What conclusions can be drawn on the quality of the evaluation function of UNFPA and UNAIDS?

5.1 Introduction

In this chapter the quality of the evaluation function of UNFPA and UNAIDS is assessed. The criteria are based on the five components as presented in the 2013 evaluation of the Joint Inspection Unit (JIU):[183]

- Component 1: Enabling environment, corporate independent evaluation function
- Component 2: Consistent independent evaluation of results
- Component 3: Quality assurance of evaluations
- Component 4: Utility and uptake of lessons and best practices from evaluation
- Component 5: Relevance and readiness to support the UN and system-wide reforms and to address emerging changes and challenges

The JIU judged the value or worth of the UN evaluation system, and assessed whether the UN organisations included in the review are doing the right things, achieve results, and whether the evaluation function of the organisation is contributing to impact and sustainability of their work. In addition to JIU's assessment of UNFPA and UNAIDS regarding these components, this chapter also takes into account other sources such as the scorecards and other assessment documents developed by the Ministry, external reviews of the evaluation function of the organisations, and interviews with key informants.

5.2 Assessment of the evaluation function of UNFPA and UNAIDS

a) Component 1: Enabling environment, corporate independent evaluation function

UNFPA has a stand-alone evaluation function, with a separate Evaluation Office at Headquarters which reports directly to the UNFPA Executive Board. The Evaluation Office was split off as a separate entity from the former Division for Oversight Services (DOS) in 2013. In that same year UNFPA presented its updated evaluation policy which was developed taking into account guidance from other UN organization, recommendations from the QCPR, norms and standards of the United Nations Evaluation Group (UNEG), and international best practices. The evaluation office is governed by the UNFPA Evaluation Policy (EP), and the Executive Board is custodian of the policy.[184] The EP emphasises strategic planning and quality, and guarantees an impartial, independent Evaluation

[183] JIU (2014). The evaluation function in the United Nations System
[184] Documentation provided by UNFPA's EO (July 2016)

Unit. According to donors, including the Netherlands, the Revised Evaluation Policy constitutes a *timely* achievement. In their Joint Statement 2013 on evaluations they commend the Executive Director for his commitment to evaluations, and for the actions taken to improve the evaluation capacity within the organization. To them, these efforts set the cornerstone for the implementation of the QCPR, which stipulates many expectations in the field of evaluation and system-wide evaluation.[185] The donors welcome the improvements made to tracking funds allocated to the evaluation function.

UNFPA is among the few UN organisations which have defined a norm for budget allocation to evaluation (according to the JIU report these are: UN Women, UNFPA, UNICEF and the WHO). The targeted 3% level of budget allocated to evaluations has not been reached, the figure being 0.56% in 2016 – an increase from 0.37% in 2015. UNFPA is taking steps to strengthen the capacity and professionalization of the evaluation function, however it still faces limited availability of skilled evaluators.[186]

Since 2012 **UNAIDS** has a department (Evaluation Team) responsible for evaluation which forms part of the programme direction. The Executive Director commissions corporate evaluations, and the Board approves evaluations. A Taskforce or independent commission oversees the implementation of evaluations, which are generally conducted by the secretariat and co-sponsors as joint evaluations. UNAIDS has a reference group that advises on evaluation at global and country levels. The three streams of evaluation work in UNAIDS are: (1) independent external evaluations mandated by the PCB; (2) evaluation of the UBRAF; (3) support to evaluations at global level and country led evaluations through a global monitoring and evaluation reference group and UNAIDS country presence. The latter lies with the UNAIDS Evaluation Team located in the Economics and Evaluation division.[187]

The JIU scored the evaluation function of **UNAIDS** as well defined: *"key measures and mechanisms of the various components are in place and the operation is no longer ad hoc but has become routinized with some level of stability".*[188] According to the JIU report, the focus of the function is on enhancing the integration, quality and institutionalization of the elements, mostly internally oriented to improving its function. Until 2015, there was no separate evaluation policy, though the 2012 – 2015 UBRAF was being applied as an evaluation framework. A separate evaluation policy is now in place and a 2016-2017 prioritized and a costed evaluation plan is being implemented and will first be reported on in 2017. The expectation is that UNAIDS evaluation function will evolve and become stronger in the foreseeable future.

b) Component 2: Consistent independent evaluation of results

[185] 2013 Joint statement by Switzerland on behalf of Australia, Belgium, Canada, Finland, France, Germany, Greece, Ireland, Israel, Italy, Japan, New Zealand, Netherlands, Norway, Sweden, United Kingdom and the United States

[186] In 2014 the Human Resources profile of the EO is: Director of Evaluation Office: Female; 5 Evaluators (3 females, 2 males); 3 evaluation advisers (2 male, 1 female); 1 evaluation specialist (female), 1 evaluation analyst (female); and 2 Support staff (1 female, 1 male). All regional M&E advisors are male, and of the 121 M&E Officers or focal points in Country Offices, 57 are female and 64 are male

[187] In 2014 Human Resources profile of the Evaluation Unit is 1 head (male), and 2 evaluators (1 male and one female); and 1 female support staff. Some 56 Monitoring and Evaluation Advisors (46 male and 20 female) conducting decentralized evaluations in country offices and reporting to the Evaluation Unit

[188] JIU (2014). The evaluation function in the United Nations System

Independence of the evaluation function helps ensure the impartiality and objectivity of evaluation and thus enhances credibility. The report of the Joint Inspection Unit (2014) sees this as the *most developed component among all the components of the function*. But there is room for improvements according to the standards applied by the JIU study.[189]

UNFPA's Evaluation Office reports directly to the Executive Board, and is considered independent from the operational, management and decision-making functions in the organisation. It is considered impartial, objective and free from undue influence, as it has the authority to determine the scope of, design, conduct and commission evaluations, and to submit reports directly to the appropriate decision makers, including the Executive Board. Programme-level evaluations are independent from programme management since the Evaluation Office approves the final design and selection of consultants, even though management may participate in the design and commissioning of such evaluations. The management can't impose restrictions on the content and recommendations of evaluation reports. UNFPA's EO undertakes corporate evaluations on issues that are strategically significant to the organisation. Programme level evaluations (Country Programme Evaluations, CPEs) are conducted by external evaluators, and commissioned by relevant business units.

The **UNAIDS** evaluation function is not independent from the management, as the Chief of the Evaluation Unit doesn't have the authority to sign off on or distribute evaluation reports without prior clearance. The Evaluation Team directly reports to the Director of strategic information and evaluation. Thematic evaluations are conducted by co-sponsors, and the organisation conducts country studies on a regular basis according to Programme Planning & Performance Management.[190]

Component 3: Quality assurance of evaluations

The JIU report concludes that UN Organizations have sought to ensure validity and rigour in the evaluation function through a range of measures, including internal unit quality assurance, the use of external experts, the use of a reference group of key stakeholders and enhanced staff competencies. These measures are considered *internal* quality assurance mechanisms, while there are only few *external* assessments (of evaluation functions, and of the quality of central evaluation reports) available. The JIU analysed the quality of evaluations based on existing external assessments and concluded that of the 13 organisations that were included in the review, 7 have reached a high level of quality of evaluation reports meeting professional standards; UNFPA and UNAIDS were not included among these seven.

UNFPA employs several quality assurance mechanisms such as tools and manuals.[191] Furthermore, the Evaluation Office approves all terms of reference for evaluations, and is part of the selection process of the evaluators. In addition, the Evaluation Office conducts a quality assessment of all

[189] Ibid
[190] For example: Efficient and sustainable HIV responses: case studies on country progress (2013)
[191] Such as the 2011 introduced Evaluation Quality Assessment (EQA) Grid, and the 2013 published Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA. Revised and updated edition

evaluations and evaluation processes. In their 2016 statement regarding the evaluation function of UNFPA, the donors appreciate the quality improvements of the Country Programme Evaluations. The quality and the use of the evaluation reports has been an area of concern over the past years, as noted in several reviews.[192]The MOPAN 2014 reports: *"The quality of existing CPEs remains an area of concern, despite slight improvements between 2010 and 2011. UNFPA evaluation quality assessments noted that 81% of CPEs carried out in 2012-2013 were rated as poor or unsatisfactory. This has implications for the quality of the evidence base on UNFPA's contributions to outputs and outcomes at a country level."*

An area of concern is the fact that the new UNFPA evaluation policy reduces the coverage of the CPE from once every programme cycle to once every two programme cycles. The MOPAN 2014 report, donors in their Statement on evaluation donors (2016), and key informants are skeptical of this proposal, and question whether this would be enough given the importance of evaluative information for development of new country programmes.

In the case of **UNAIDS,** the quality of evaluation reports is systematically reviewed against a set of quality rules, which cover evidence-based evaluation reports, findings and actionable recommendations, methodology and limitations, research design, sample selection method, data analysis, local participation / ownership of evaluation findings, and data use strategy.[193] A majority of external assessments are critical regarding the coverage, quality and access to evaluations.[194, 195] On the other hand, these reviews refer mostly to the period before the evaluation policy came into place and before the organisation took steps to strengthen its evaluation function which features significantly in the 2016 – 2021 UBRAF. In addition, UNAIDS now no longer depends on the evaluation policy and practice of the individual co-sponsors.

c) Component 4: Utility and uptake of lessons and best practices from evaluation

This component refers to findings and evidence to design new interventions, and uptake of lessons and best practices from the evaluation. The JIU report assessed the organisations on their capacity to enhance the outcome and impact of the evaluation function, including tools to enhance its use (newletters, briefs), quality reports and stakeholders involved and systems in place to assess the impact of the use of evaluations. Overall the JIU assessment concluded that this is the weakest of all components among all organisations. UNFPA and UNAIDS score below average, indicating that the systematic use of evidence from evaluations for decision-making is low. However, the report also indicates that tracking the use of the evaluations is difficult, as only 40% of the UN organisations included in the study have well-established tracking systems with good reporting on the use of the evaluation; **UNFPA** and **UNAIDS** are not among these 40%.

[192] MOPAN 2010 and 2014, the 2013 IOB evaluation on SRHR, and DER 2016
[193] http://www.uneval.org/about/memberagencies/detail/35
[194] DANIDA (2014). *Danish Organisation Strategy for UNAIDS 2014-2016*
[195] UNAIDS (2014a). *Key findings from external reviews and assessments of UNAIDS 2012- 2013. Overview and summary*

In their 2016 Statement on evaluations[196], donors to **UNFPA** underline the importance of this component, ensuring that lessons learned from past and on-going modes of engagement are reflected in future programming and institutional adjustments. The group of donors sees the Management Response Tracking System (MRTS) as a key instrument which needs to be further strengthened to better monitor the extent to which evaluation results feed into programming or decision-making processes. However, as mentioned in the 2014 Annual Report: *"the MTRS is not subject to external validation, making it more difficult to ascertain to extent to which evaluation results are effectively utilised to support organisation decision-making".*[197] In addition, progress on the use of this system has been slower than expected, as the planned start of the management response tracking system (MRTS) improvement project was postponed due to resource constraints in 2015.[198] The group of donors welcomes initiatives of the EO to increase the dissemination of evaluation results, such as stakeholder workshops at country level, dissemination events at corporate levels (workshops, webinars, information briefs and abstract available on the evaluation web page, newsletters, etc). Twice a year IMPACT is published, the newsletter of the Independent EO.[199] The Evaluation Office also manages the UNFPA repository of evaluation reports (which includes both independent and decentralized evaluation reports). The database is available on the public UNFPA website.

Since 2011, UNFPA has been working to improve the quality, credibility and use of CPEs. A report on lessons learned from the CPE conclude that there has been a slow, but steady, improvement over time.[200] The synthesis brings together findings from a sample of 30 UNFPA CPE reports, conducted and quality-assessed between 2010 and 2013. There was a wide variety in the quality of reports during this period: relatively few reports were assessed as 'good quality'. However, a larger number were considered to have positive features and were thought to contain useful elements that could contribute to organisational learning. This is a considerable improvement as compared to the findings of a quality assessment of CPEs, conducted by UNFPA.[201] Of the 34 (decentralised) evaluations included in the assessment, a vast majority (23 evaluation, 67%) were rated poor, and another 8 evaluations (24%) as unsatisfactory. None of the evaluations was rated very good.

In the case of **UNAIDS** evaluation results are disseminated widely within and outside the organisation. Lessons are systematically extracted and communicated through information briefs, abstracts, press releases, workshops, meetings with senior management, meetings with operations management and annual evaluation reports. Evaluation reports, including the Second Independent Evaluation of UNAIDS, are available online.[202]

d) Component 5: Relevance and readiness to support the UN and system-wide reforms and to address emerging changes and challenges

[196] Executive Board of UNDP/UNFPA/UNOPS Annual Session (June 2016). Item 12: UNFPA Annual Report on Evaluation. Statement by Switzerland on behalf of Australia, Belgium, Canada, Denmark, Germany, Finland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Sweden, UK, USA and Switzerland
[197] UNFPA (2015b). *UNFPA Annual report on evaluation. Report of the Director, Evaluation Office*
[198] UNFPA (2016d). *UNFPA Management Report. Report of the Director, Evaluation Office 2015.* (DP/FPA/2016/5) Agenda Item 12: Evaluation
[199] http://www.unfpa.org/admin-resource/newsletters
[200] UNFPA (2016b). *Lessons learned from UNFPA Country Programme Evaluations*
[201] UNFPA/Evaluation Branch/Division for Oversight Services (2012b). *Quality assessment of UNFPA decentralised Country Programme Evaluations*
[202] http://www.uneval.org/about/memberagencies/detail/35

The Joint Inspection Unit assessed this component by looking at the relevance and efficiency via joint evaluations, and the capacity and strategic positioning of the evaluation function in helping the United Nations system to address changes, challenges and emerging agendas for transformative change and sustainable development, both within organizations and at a system-wide level. The JIU evaluation found that about half of the UN organisations are not involved in joint evaluations. It was not considered a priority, as they focused on improving the evaluation function of their own organisation first. Also, perceived difficulties of joint or inter-agency work limited their motivation to carry out joint evaluations. Increasingly UN Organisations are involved in joint programming for cross-cutting issues, such as gender. The JIU and others consider this may stimulate the conduct of joint evaluations. The 2016 Statement of the donors on evaluations "*strongly encourage the Evaluation Office in its efforts to integrate the United Nations System-wide Action Plan for Gender Equality and the Empowerment of Women evaluation indicator reporting tools into its existing quality assessment system."*[203] In addition, the donors call for reflection within the United Nations Evaluation Group (UNEG) and partners to see how best joint approaches, such as joint rosters of qualified staff, joint evaluations and/or joint funding, could increase the efficiency and effectiveness of evaluation capacities at regional and national levels. The group of donors recognises the leadership role of the Director of the Evaluation Office of UNFPA within UNEG and therefore specifically encourages her to continue her engagement for a stronger evaluation function in the UN System.

Both **UNFPA** and **UNAIDS** are among the organisations that conduct joint evaluations. In the period under review two evaluations of large scale joint programmes were conducted: the **UNFPA**-UNICEF evaluation of the joint programme on female genital mutilation/cutting (date and footnote reference); and the Joint evaluation of gender joint programmes in the UN system (with UNWOMEN, UNICEF, UNDP, the Spanish MDG Fund and other bilateral agencies). The joint evaluations on FGM/C note that monitoring and evaluation is an area for improvement. For **UNAIDS** the conduct of joint evaluations is central to the nature of the organisation. Since 2006 the UN Joint Programme has allocated substantially greater effort to programme evaluations of the overall response to AIDS in selected areas of work.[204] To them the purpose of the joint evaluations are to yield evidence-based recommendations to help UNAIDS Co-sponsors and the Secretariat refine targets, adjust working methods and alter strategies to better support countries. The joint evaluations complement the evaluations conducted individually by UNAIDS Co-sponsors and the Secretariat addressing specific global, regional, and selected country UNAIDS initiatives implemented in the framework of the UBRAF.[205]

The refocusing of the UNAIDS Monitoring and Evaluation Reference Group (MERG)[206] in 2012 – first established in 1998 to harmonize HIV/AIDS monitoring and evaluation approaches at all levels – is

[203] Executive Board of UNDP/UNFPA/UNOPS Annual Session (June 2016). Item 12: UNFPA Annual Report on Evaluation. Statement by Switzerland on behalf of Australia, Belgium, Canada, Denmark, Germany, Finland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Sweden, UK, USA and Switzerland

[204] Ibid

[205] Ibid

[206] A high level global agenda-setting body with membership from donor agencies, civil society, government, cosponsors, and academics. MERG advises UNAIDS on promotion of evaluation and strategies for internalisation and incorporation of evaluation into programme development and strategic planning. http://www.uneval.org/about/memberagencies/detail/35

considered conducive to the strengthening of the evaluation function and to better address emerging challenges. The 2012 evaluation of MERG revealed some of these challenges. The structure of MERG was considered sub-optimal for addressing challenges such as an emerge of new stakeholders and shrinking resources, and a relative weak evaluation function as compared to M&E, including the need for impact evaluations. Also the MERG structure was considered too abstract and not practical, making it difficult to support policy making and decision making.[207] The role for the new MERG is broadened from a purely technical body to a more rigorous and empowered mechanism with strategic advisory and decision-making capacity, next to a pool of experts for M&E harmonization and coordination.

5.3 Conclusions

What is the quality of the evaluation function of UNFPA and UNAIDS, considering the standard components for the evaluation function of the UN? What conclusions can be drawn on the quality of the evaluation function of UNFPA and UNAIDS?

Both organisations are assessed against five components of evaluations. With regard to an enabling environment (component 1) and level of independence (component 2) UNFPA scores relatively well, with an independent functioning evaluation office, and a defined norm for budget allocation to evaluation (of 3%). UNFPA is commended for its quality improvements in the period under review, the separate evaluation unit established in 2013, a revised evaluation policy (also in 2013), and strong and qualified leadership at head quarters level. Weaknesses are the reporting at outcomes levels, and capacity concerns within the organisation. Though a budget allocation was set, in 2015 only 0.56% of the total organizational budget was spent on evaluations, which is far below the proposed 3%. UNFPA also is improving on the quality of the evaluation function, gauged by improved quality of externally conducted evaluations and (slowly) improving quality of country programme evaluations. However, overall reporting on levels beyond output levels is poor which in turn impacts on the quality of country programme, or corporate/thematic evaluations.

With regard to the uptake of lessons learned (UNFPA), there is room for improvement. Translating lessons learned, or disseminating innovative approaches is an area which has received more attention in the period under review (UNFPA). An increased use of management responses is a demonstration of such practice, however there is an underutilisation of potential. UNFPA values corporate evaluations, given its investments in conducting large scale thematic evaluations in the period under review. It is important to monitor how the insights, lessons and recommendations from these evaluations are translated into programmatic choices in the future. An area of concern is the proposed reduction in conducting country programme evaluations cycle (from 4 to 8 years), as this could turn out a missed opportunity to align the programme to a particular national context, and in any case reduces the availability of data on SRHR at country level.

In the case of UNAIDS, the structure of the organisation creates some complexity in the joint planning and roll out of evaluations of its co-sponsors. However, the organisation is commended for its efforts in evaluating and disseminating country experiences. Improvements are noted, as since 2015 there is an evaluation policy, a costed evaluation plan which will be first reported on in 2017.

[207] UNAIDS/PCB(31)12.22. Agenda item 6 at the PCB thirty-first meeting 2012

The UBRAF is the framework to monitor progress; the new UBRAF is an improvement as it has a clearer and simpler structure, stronger link between resources and results, fewer outputs, and a theory of change linking UBRAF outputs to higher-level results and the SDGs, and explaining how to Joint Programme contributes to outcomes and impact.

VI. Comparative advantages of UNFPA and UNAIDS

Guiding questions to be answered in this chapter:

- What are the comparative advantages of UNFPA and UNAIDS regarding:
  - Economies of scales;
  - Knowledge management and norm setting;
  - Contributing to the policy dialogue and agenda setting;
  - Alignment to national strategies and building effective partnerships with government and other actors at the national level;
  - Their role and involvement in 'One UN' and 'Delivering as One' processes.
- What conclusions can be drawn on whether, and how UNFPA and UNAIDS have used their comparative advantages to further priorities in SRHR?

6.1 Introduction

In its statement to the Executive Board of UNFPA, in June 2016, the Netherlands reconfirmed its commitment to UNFPA, to the UN as a whole, and to the Agenda 2030. The role of the UN in global governance is recognised, however in order to play that role *"the UN must continue to invest in effectiveness and efficiency. Agenda 2030 offers a perfect opportunity to agree on reforms and we ask the UN to show leadership. (…) Improved cooperation and coordination amongst agencies and actors, support the capacity of local actors and integrate development and humanitarian needs assessment, planning and implementation."* While asking the UN to increase cooperation, the Netherlands committed to provide multi-year contributions, reduced earmarking and harmonized reporting requirements.[208]

This chapter addresses the how UNFPA and UNAIDS deliver on the expectations of the Netherlands regarding their comparative advantages: (1) economy of scale; (2) knowledge management and norm setting; (3) contributing to the policy dialogue and agenda setting by UNFPA and UNAIDS; (4) alignment to national strategies, and building effective partnerships with government and other actors at the national level. The last section (5) deals with UNFPA's and UNAIDS' role and involvement in One UN and Delivering as One processes. Conclusions are described in 6.3.

6.2 Assessment of the comparative advantages of UNFPA and UNAIDS

(1) Economies of scale

[208] Paper of the Netherlands presented to UNFPA Executive Board at the Annual Board Meeting in June 2016

Both organisations have a global reach. **UNFPA** works in more than 150 countries and territories through its network of 129 country and 10 (sub)regional offices. In some countries there is increased programmatic attention to areas that require accelerated actions, through the flagship programmes on maternal health (through the thematic programme on maternal health), and on family planning (focusing on 48 countries through the Supplies programme). **UNAIDS** has a global reach through its network of 84 country offices and 7 regional offices. In the context of the 2012 – 2015 UBRAF UNAIDS has prioritized its work in 30+ so-called High Impact Countries (HIC). Across these 30+ HIC (38 countries) **UNAIDS** has taken steps to intensify assistance, enhance the coherence and coordination of joints efforts, and strengthen the mobilization of financial and technical resources to expedite progress towards national AIDS goals. High Impact Countries also align with the priorities of key funders and global initiatives.

Both **UNFPA** and **UNAIDS** have a presence in the partner countries of the Netherlands. UNFPA has country offices in all partner countries, and UNAIDS is present, either with an UNAIDS Country Director (UCD) or a local recruited UNAIDS Country Officer (UCO), in all cases UNAIDS coordinates the activities of the co-sponsors through the / Joint UN Teams on AIDS.[209] Table 6 provides an overview of thematic programmes being implemented in the partner countries by UNFPA and UNAIDS.

Table 6: UNFPA's and UNAIDS' thematic programmes in the partner countries of the Netherlands

Partner countries of Netherlands[210]	***UNFPA***	***UNAIDS***
Afghanistan		
Bangladesh*		
Benin*	GPRHCS / Supplies	
Burundi		
Ethiopia*	GPRHCS / Supplies	HIC
Ghana*	GPRHCS / Supplies	
Indonesia		HIC
Kenya	GPRHCS / Supplies	HIC
Mali	GPRHCS / Supplies	HIC
Mozambique	GPRHCS / Supplies	HIC
Palestinian Territories		
Rwanda	GPRHCS / Supplies	
South Sudan	GPRHCS / Supplies	HIC
Uganda	GPRHCS / Supplies	HIC
Yemen	GPRHCS / Supplies	

(2) Knowledge management and norm setting

MOPAN, DER, scorecards and interviews with key informants point to the role of UNFPA and UNAIDS in the area of knowledge management and norm setting. According to MOPAN 2014 UNFPA *"has scaled up its efforts to systematically capture feedback on performance and share that information throughout the organisation in the form of lessons learned or good practice".* Also, the new evaluation policy stresses the organisation's commitment to public accountability and sharing

[209] UNAIDS is present, either with an UCD / UCC or a local recruited UCO, in all cases UNAIDS coordinates the activities of the co-sponsors through the Joint UN Teams on AIDS

[210] Countries with * are so-called transition countries

knowledge. The ambitions of the 2013 established Evaluation Office are in line with this new agenda. The number of good practices and lessons learned in the database has increased from 33 in 2011 to 185 in 2013, and includes lessons on for example lessons learned on work in humanitarian settings, on the integration of gender and human rights in programming and the role of midwives in maternal health. UNFPA also reports increased use of Fusion (a knowledge sharing platform that provides tools for collaboration and knowledge creation) and of webinars to share lessons learned (the number of participants doubled between 2009 and 2013). At the country level, UNFPA has established mechanisms for peer-to-peer support as well as training activities to strengthen knowledge sharing (e.g. learning afternoons, webinars, and courses/e-learning). (MOPAN 2014) The 2016 FP evaluation however identified the need *"elaborate a proactive learning agenda to contribute to the evidence base on family planning, and enhance its role in synthesizing, translating and disseminating evidence at regional and international level."* Current indicators of MOPAN are not well-suited to specifically address UNFPA's norm setting work at the global and regional level, including its role as a global convener and knowledge broker for policy and technical issues and the support provided to governments to integrate internationally recognized norms and standards into national legislation, policies and development plans. Evidence on these issues however in other parts of this review show that UNFPA increasingly has taken this role at country and global levels.

According to Australian Multilateral Assessment of **UNAIDS** the organisation contributes to the development of normative frameworks and guidelines – with many of them developed in close collaboration with the WHO – across a range of areas, including ARVs, HIV and tuberculosis and infant feeding.[211] However, according to the same review, the organisation could do more to ensure that guidance is relevant to concentrated and low-level epidemics. Key informants consider UNAIDS a 'creative' organisation and a leader in developing and disseminating technical guidelines and policy briefs on a wide range of topics.[212] According to MFA, UNAIDS is a reference base, and since its establishment UNAIDS continuously invested in data collection, analysis and dissemination of information. This function of the organisation is valued and rated strong in all reviews consulted and confirmed in the interviews with key informants.

(3) Contributing to the policy dialogue and agenda setting by UNFPA and UNAIDS.

In its Strategic Plan 2014 – 2017 **UNFPA** outlined how the organisation would increase its upstream work (advocacy and policy dialogue/advice), depending the country context. This recognition of the importance of upstream work follows the key concepts from the Mid-term Review, such as "*not trying to do everything everywhere, and addressing better the changing needs of the Fund's clients. It also responds to the calls in a number of settings – including in the QCPR – for the entire United Nations system to shift away from "delivering things" to "delivering thinking", or move more upstream to focus on advocacy and policy dialogue/advice rather than service delivery."* [213] Overall, several reviews and interviews with key informants value UNFPA's role in this upstream work, in policy dialogue at global and country levels, both for its content and respect for the views of others

[211] AusAid (2012). *Joint United Nations Programme on HIV/AIDS – UNAIDS*

[212] For example, in the period under review UNAIDS published on a wide range of topics: Know your epidemic, know your response (2008); Guidance Note on HIV and Sex Work (2009); HIV, adolescents and youth (2013); Technical guide on HIV prevention treatment and care for injecting drug users (with the WHO and UNODC, 2009); Technical Guidance Note for GF HIV Proposals (with WHO, 2011); Strategic and Technical Guidelines on a wide range of issues in HIV/AIDS prevention, treatment and care

[213] UNFPA Strategic Plan 2014 - 2017

(MOPAN 2014). Concrete examples of such are UNFPA's work *"to improve data availability around population dynamics, SRH (including family planning) and gender equality, and its efforts to ensure the integration of empirical/evidence based data on these issues into national development and poverty reduction plans and international development frameworks."* (MOPAN 2014)

Other examples of UNFPA's upstream work are, at country level, involvement in demonstrating the linkages between population and reproductive health issues and the achievement of the MDGs, and how investments in gender equality and reproductive health pay off. A good example of UNFPA's engagement at the global level is the involvement in the policy dialogue related to the ICPD Beyond 2014 and the post-2015 and SDG agenda. According to key informants UNFPA played an essential role in moving the agenda forward, and advocating for the inclusion of tangible targets on SRHR in the SDG framework. In the context of the FP 2020 commitments, UNFPA contributed to policy dialogue on family planning, at global and country levels; also, through the GPRHCS, UNFPA contributed to reducing the cost of contraceptives at global level and achieving commodity security in some countries. UNFPA also worked on the Pledge Guarantee for Health system.[214] Some informants were critical on the rather withdrawn position of UNFPA when it came to debating sensitive issues like abortion.

One of the major strengths of **UNAIDS** is its leadership role and global advocacy on the AIDS response. MOPAN 2012 and other reviews conclude that UNAIDS committed itself to organizational renewal, in order to overcome its complex structure and be able to better respond to the needs on the ground. Meanwhile the organisation has demonstrably taken this frontrunner role, and shown its capability to take on a leadership role in voicing concerns regarding stigma, discrimination towards PLWHA, and promoting a human rights agenda.

UNAIDS engaged actively on several fronts during the Sustainable Development Summit, and also in the events or processes leading up to or following the Summit. During the Summit, UNAIDS engaged a broad array of stakeholders, such as the private sector and faith-based and youth organisations. To facilitate civil society engagement in the post-2015 debate UNAIDS collaborated closely with global coalitions, such as the Global Coalition on Women and AIDS and the International Community of Women with HIV/AIDS.[215] During the Summit UNAIDS organised side-events on *Young people leading change: how the SDG targets to end the AIDS epidemic and ensure universal access to sexual and reproductive health services will be met; Financing Health and Education: Girls driving development; Ending the AIDS epidemic by 2030 – Shaping new models and means of implementation;* and *The role of communities in sustaining human development and the HIV response.*[216] Overall, the organisation proved a strong advocate for the recognition that HIV and AIDS constitute a global emergency, and for the inclusion of 'ending the AIDS epidemic' under the health goal (SDG 3), thereby securing the fight against AIDS as one of the goals in the 2030 agenda. The 'UN GA Political Declaration on the On the Fast-Track to End AIDS in the age of Sustainable Development' (2016) underlines this recognition of emergency, and the need to end AIDS, *"as HIV is often the cause*

[214] Plegde Guarantee for Health (PGH) system is an innovative financing partnership designed to increase the availability and predictability of funding from international donors for health commodities. PGH is able to leverage $100 million in credit from commercial banking partners which, in turn, extend short-term credit to traditional donor aid recipients
[215] UNAIDS (2015a). *Update on the aids response in the post-2015 development agenda. UNAIDS-Lancet Commission: Synthesis report of consultations*
[216] Ibid

of poverty and inequality and therefore critical to the achievement of many Sustainable Development Goals (SDGs) including to "End poverty in all its form everywhere" as well as to reduce inequality and secure social justice". [217] In the 2016 Political Declaration the UNAIDS Secretariat and its co-sponsors are recognised for their leadership on AIDS policy, strategic information and coordination and for the support they provide to countries through the Joint Programme. UNAIDS and the Netherlands MFA and other partners will work closely in the organisation of the AIDS2018 in Amsterdam which is considered an shared opportunity, as in the words of the SRHR and HIV/AIDS ambassador at the Netherlands MFA: *"The conference is a platform and an instrument. It cements our political commitment to women and girls in southern Africa, who are especially vulnerable to HIV. The same applies to the status of key populations, such as sexual minorities, who primarily live in middle-income countries.* [218]

(4) Alignment to national strategies, and building and maintaining partnerships at the national level

Both organisations under review play a convening role at the country level. **UNFPA** recognises and emphasises the importance of working with national governments, UN and others. (MOPAN 2014) In all programme countries UNFPA enters into an agreement with its Implementing Partners (IPs), either government or an NGO/Academic institution. Increasingly UNFPA partners with private sector companies. MOPAN 2014 notes that UNFPA performs strongly in demonstrating the alignment of its country programmes to government priorities in programme countries. It appears that the organisation also makes appropriate use of country systems and contributes to mutual assessments of progress. Both MOPANs (2010, 2014) recognise its valuable contribution to policy dialogue at country and global levels – illustrating the importance of its normative and upstream work in general. The Evaluation of Family Planning also values UNFPA's work in this area. [219] Responding to changing environments – demonstrating flexibility and capacity to adjust procedure – is rated as adequate in the MOPAN 2014 review, though concerns are about administrative delays. The reform processes and the roll-out of the new business model is expected to address such issues adequately.

It closeness to the government places **UNFPA** in a favourable position to influence decision makers and policy makers. Its role in promoting and furthering the agenda on family planning is an example of how UNFPA has implemented this 'brokering' role. Key at the Family Planning summit in 2012 (FP2020) was the ground-breaking commitment of countries to increase access to family planning. Given its prominent role in FP2020 partnership, its convening role at country level and its closeness to government, UNFPA was in an ideal position to sensitize governments on the need to invest in SR commodity security and assist countries in delivering on their promises. The Family Planning Evaluation 2008 – 2013 acknowledges the role of UNFPA in brokering *"commitments to family planning by national governments, yet, particularly at the country level, it does not always use its strategic advantage to the fullest, such as to broker partnerships on sensitive issues or between government and civil society."* [220]

[217] UN General Assembly 2016 Political Declaration on the On the Fast-Track to End AIDS in the age of Sustainable Development (2016). Zero Draft
[218] http://www.diplomatmagazine.nl/2015/06/07/looking-forward-to-aids-2018-a-shared-opportunity/
[219] UNFPA (2016a). Evaluation of the UNFPA support to family planning 2008 – 2013. Volume I
[220] Ibid

UNAIDS is mandated to play the role of a 'broker' and convener between the different parties (local and national government, the UN, NGOs, and the private sector) and around the common goal of the fight against HIV/AIDS. Therefore, core to the work of the organisation is to establish or maintain effective partnerships in the fight of the epidemic. As such, partnerships play an important role in work of UNAIDS; this is reflected in the 2012 – 2015 UBRAF. For the Global Fund, UNAIDS is an important interlocutor with governments in addressing HIV and AIDS. Also, UNAIDs leverages its relationships and partnerships to assist countries in securing Global Fund resources, implementing grant programmes and overcoming bottlenecks.[221] Overall, UNAIDS is highly valued by its direct partners and the co-sponsors[222], and for its support to strengthening civil society organisations through involvement at the PCB and at country level among others.

UNAIDS responded to recommendations from the UNAIDS Second Independent Evaluation (2009) regarding the Paris Declaration on aid effectiveness. The organisation took steps to improve alignment to the principles, for example through its active membership of the International Health Partnership (IHP+): an attempt to align donor countries and organisations with a single country-led national health strategy.[223]

One of the reviews as compiled in the Australian Aid review of UNAIDS commended **UNAIDS** for its openness and willingness to provide a voice for stakeholders, for example NGOs and people living with HIV are represented on the Governing Board of UNAIDS, and it brings together a wide range of stakeholders from community, government and donors.[224] In particular the organisation was praised for its capacity to maintain effective partnerships with community organisations and NGOs, alongside with its relations to governments and donors.

With regard to the work with co-sponsors, the 2014 Division of Labour Guidance note clearly outlines the division of labour between **UNAIDS** and its co-sponsors, thereby better defining areas of responsibility.[225] The Division of Labour Guidance is a response to the outcome of the Second Independent Evaluation of UNAIDS (2009) recommending UNAIDS to be more focused, strategic, flexible and responsive, efficient and accountable. The evaluation noted inadequate coordination between the UN agencies; fragmented programmes, structures and support to countries; and a lack of lack of adequate accountability mechanisms (monitoring, reporting and evaluation).[226] In 2016 this strategy was updated taking into consideration the Sustainable Development Goals, the UNAIDS fast-track Strategy, the 2016-2021 UBRAF, and the outcome of the High Level Meeting of the UN General Assembly on Ending AIDS provide a clear path for the work of the UNAIDS Secretariat in the coming years. The updated and extended strategy supports these goals and targets through four pillars, and the Secretariat foresees to strengthen its workforce, and to deploy staff strategically in accordance with evolving organisational priorities.[227]

(5) 'Delivering as One', UN Standardisation and coordinating

[221] UNAIDS (2016d). Snapshot. UNAIDS and the Global Fund. A life-changing partnership
[222] MOPAN UNAIDS 2012
[223] AusAid (2012). *Joint United Nations Programme on HIV/AIDS – UNAIDS*
[224] Ibid
[225] UNAIDS (2010). *Division of labour. Consolidated guidance note*
[226] UNAIDS/ITAD/HLSP (2009). *UNAIDS Second Independent Evaluation 2002 – 2008. Final report*
[227] UNAIDS (2016f). *Update on strategic human resources management issues*

In terms of operational Activities for Development of the United Nations System (as outlined in the QCPR), **UNFPA** reports progress in particular on advancing the second generation of 'Delivering as One' and the cost-sharing of Resident Coordinator (RC) System. Progress was also noted on the improvement of the UNDAF programming process, the simplification and harmonization of business practices and the promotion of South-South and triangular cooperation. [228] In addition, the Strategic Plan (SP 2014-2017) is in alignment with QCPR and with those of UNDP, UNOPS, UNICEF and UN Women. The Integrated Results Frameworks of UNFPA, UNDP, UNICEF, UN Women and WFP include common indicators. [229] Currently there are 50+ "Delivering as One" (DaO) countries, and increasing numbers of UN Country Teams (UNCTs) are choosing to work jointly in a more integrated way by implementing the UNDG Standard Operating Procedures (SOPs). UNFPA was involved in the preparation of the SOPs, and proactively engaged in UNCTs (the third most represented member in UNCTs, and with UNICEF and UNDP having most chair posts in inter-agency groups). [230]

UNFPA has taken an active role in other system-wide initiatives such as IATI, definition of common data-sharing standards, and optimising selected common services, and promoting organisational effectiveness in the areas of finance, human resources, information technologies and procurement. UNFPA has developed a resource mobilization strategy, and further broadened its donor base to include new countries, and programme country governments. In recognition of national ownership of the SDGs, and adopting a differentiated country approach, UNFPA has successfully leveraged domestic/national resources for country programmes. As such, co-financing agreements have been secured in a number of middle-income countries. [231] UNFPA actively promotes South-South and Triangular Cooperation, such as around the ICPD agenda.

The scorecards refer to **UNAIDS** as *the* example of 'Delivering as One'. [232] The organisation embodies the principles of UN coordination, shared responsibility, and mutual accountability. [233] Against the back-drop of the global financial crisis and austere measures by major donors, the UNAIDS model of working and delivering as one is regarded as value for money, but also as providing an unique opportunity to build consensus around a shared responsibility: country responsibility (domestic investments alongside with participation); responsibility of the international community (long-term and predictable aligned funding); and shared responsibility for innovative financing and partnership mechanisms (support emerging countries and new development partners and enhanced mutual accountability). [234]

6.3 Conclusions

What are the comparative advantages of UNFPA and UNAIDS? What conclusions can be drawn on whether, and how UNFPA and UNAIDS have used their comparative advantages to further priorities in SRHR?

[228] UNFPA: ANNEX 8 Implementation of Quadrennial Comprehensive Policy Review (QCPR) General Assembly resolution 67/226 on Operational Activities for Development of the United Nations System
[229] Ibid
[230] Ibid
[231] Ibid
[232] Scorecards and *Kaderbrieven*
[233] Besada H and Kindornay S, Eds. (2013). Multilateral development Cooperation in a Changing Global Order
[234] Ibid

Economies of scale. UNFPA and UNAIDS both have a global reach, through their network of country and (sub-)regional offices. Partnering with others, such as other UN organisations, national and international NGOs, the private sector, and research institutes further complements their work in key areas. Both UNFPA and UNAIDS have a presence in the partner countries of the Netherlands. In all, except for Afghanistan, Bangladesh and the Palestinian Territories the organisations also work on a thematic focus (UNFPA Supplies or in the context of the UNAIDS HICs).

Knowledge management and norm setting. Given their specific position within the UN – both with a mandate strongly tied to the SRHR and HIV/AIDS agenda – their potential to increase knowledge and set norms is considerable, however not always fully exploited. UNFPA, in many cases in collaboration with the WHO produces manuals and guidelines on topical / key issues in SRHR which are widely disseminated. More information is needed on the use of these guidelines by stakeholders. UNAIDS is considered the reference base for information and update on trends; also in collaboration with the WHO the UNAIDS secretariat produces materials that guide key players in the field.

Contribution to the policy dialogue and agenda setting. Both organisations have demonstrated their strength in contributing to the policy dialogue and agenda setting. For UNFPA this is most noticeable in their work on improved data availability around population dynamics, SRH (including family planning) and gender equality, and its efforts to ensure the integration of empirical/evidence based data on these issues into national development and poverty reduction plans and international development frameworks. Important in the period under review was UNFPA's leading role in the ICPD beyond review process and the shaping of the post-2015 agenda. UNAIDS has shown its leadership role in voicing concerns regarding stigma and discrimination and overall in promoting a human rights agenda. UNAIDS has played a strategic role in fundraising for HIV prevention, and also, showed its capacity to engage a wide range of stakeholders around the SDGs.

Alignment to national strategies and building and maintaining effective partnerships at the national level. Both organisations have demonstrated their capacity to partner with government and other actors at the national level. This is a core asset of the work of UNAIDS, and proved very instrumental in the work of UNFPA. This is positive, however UNFPA could make more use of its brokering position with the government, by making linkages with NGOs or civil society, or on the other hand, make more use of its strategic closeness to the government and push more proactively for key issues in SRHR. In practice however the organisation is cautious in speaking out publicly on issues such as sexual health (of adolescents), access to safe abortion, sexual preferences, comprehensive sexuality education, to often safeguard their position with country governments or with the member states.

Delivering as One, UN standardization and coordinating. UNFPA reports progress on advancing the second generation of 'Delivering as One' and the cost-sharing of Resident Coordinator (RC) System, and other system-wide initiatives including the work on the Standard Operating Procedures, proactively engaged in UNCTs, and other initiatives such as IATI, the definition of common data-sharing standards, optimising selected common services, and promoting organisational effectiveness in the areas of finance, human resources, information technologies and procurement, among others.

UNAIDS is considered *the* example of 'Delivering as One', and as such *the model* for UN reform at country level. The level to which the organisation was able to function as such depended vastly on the country circumstances, and must be seen against the back-drop of the global financial crisis and

austere measures by major donors. The model is still regarded as value for money, and as providing an unique opportunity to build consensus around a shared responsibility.

VII. Assessment of policy influence and conclusions

Guiding questions

- Policy influence of the Netherlands and collaboration
- What were the specific contributions of UNFPA and UNAIDS in the achievement of the development objectives in SRHR?
- What is the assessment of the organisational performance (efficiency) of UNFPA and UNAIDS regarding the achievement of the development priorities of the Netherlands in SRHR?
- Which were the comparative advantages of UNFPA and UNAIDS in achieving the development objectives of the Netherlands MFA in SRHR?

The chapter starts with an overview of the policy influence of the Netherlands and collaboration with UNFPA and UNAIDS (7.1); followed by overall conclusions (7.2).

7.1 Influence of the Netherlands and collaboration with UN

The Dutch input to UNFPA and UNAIDS is visible in thematic areas, as well as efforts of the organisations to enhance effectiveness and efficiency of the organisations.

Influence of the Netherlands on the thematic areas:

- The Netherlands participates in the Steering Committee of UNFPA Supplies. This allows for strategic dialogue and discussions on directions and models for improvement.[235]

- The tripartite programme 'NL-UNAIDS Cooperation on key populations in selected countries' – a joined project which started in 2012 – is a good example of an innovative form of collaboration in an area within SRHR that is important for the Netherland (human rights, discrimination of key population). The project is valued because it shows how the parties complement each other; at the same time it strengthens the collaboration between the Ministry, the Embassies, civil society and UNAIDS.

- Lessons learned and experiences from the country level are being used to feed the debate at international level. One of such examples is the discussion based on the work with the *Commission on Narcotic Drugs* in 2015. The Ministry considered this experience as illustrative, which offers valuable lessons learned.[236]

[235] Internal memo on the support to UNFPA GPRHCS (November 2014). The document outlines areas for improvement: better collaboration with other donors in this domain; effective distribution in recipient countries; more emphasis on qualitative good generic products. The Netherlands is the second largest donor of this Programme (after the UK)
[236] The Netherlands is also a member of the Steering Committee. See case study for the PCB (37nd meeting in 2015: Country best practices on Shared Responsibility and Global Solidarity for an effective, equitable and sustainable HIV response for the post-2015 agenda

- In 2013 the Ministry in collaboration with the Office of the High Commissioner on Human Rights and UNFPA organised the ICPD Beyond Conference on Human Rights.[237] The Netherlands and UNFPA actively worked together in the preparations of the conference and in the dissemination of results and insights. The Netherlands considered the Conference as important, in particular for the opportunity to schedule human rights on the agenda, to discuss the findings of the ICPD review and the embedding of SRHR in the post-2015 agenda.

- Given the context of increased opposition against a progressive SRHR agenda – including safe abortion and access to sexuality education for young people – the Netherlands is working together with many parties, including the UN. Of particular importance is the influence of member states through diplomacy. The Netherlands links working the UN on these issues with civil society, in particular Dutch based organisations that are active on these themes. In addition to this, the Netherlands has appointed a Special Ambassador for SRHR and Human Rights for setting the agenda and discussing (sensitive) issues in SRHR.

- The Netherlands collaborates with UNFPA and other UN agencies in the area of preventing child-marriages, an important area for the Netherlands. The Netherlands co-lead the tabling of resolutions at the UN General Assembly in 2013 and the Human Right Council in 2014, both calling for halting the practice of child marriages and for developing policies in this domain.[238] Other areas of collaboration between the Netherlands and the UN in the period 2012 – 2015 was the combat of gender based violence (reduce sexual violence against women), and human rights of sex workers (area of work for both UNFPA and UNAIDS).

Influence of the Netherlands on the organisation and performance of UNFPA and UNAIDS:

- The Netherlands made use of various channels and ways to influence UNFPA and UNAIDS in the period under review. Most often it was a combination of input in meetings, thematic sessions and formal representations in the Board[239] from: MFA experts and staff; thematic experts from the Embassies (in countries where SRHR is a thematic priority); and the Permanent Mission in New York and Geneva. In addition, the Netherlands invested in strategically positioning experts from the Ministry within both organisations.

- The Netherlands is considered a solid partner of UNFPA and UNAIDS, not only in financial terms but also because of the Dutch consistency in prioritising SRHR, its policy commitments, and experienced and dedicated staff. UNFPA and UNAIDS see the Netherlands as a reliable and knowledgeable partner in planning and implementation of the policy of both organisations. Staff of the Ministry regularly organises sessions during meetings of the Board (UNAIDS).

- The Nederlands is committed to the Busan agreements on aid transparency within the aids effectiveness arena, improving countries' access to and use of aid information. In 2015 the

[237] July 7-10 2013 in Noordwijk, the Netherlands. Under tagline "All Different. All Human. All Equal", the conference provided a platform for dialogue amongst the diverse range of participants to address human rights commitments and identify opportunities to strengthen the operational links between human rights and implementation of the PoA, with particular emphasis on SRHR and their intersection with gender equality (see: http://www.unfpa.org/events/icpd-beyond-2014-international-conference-human-rights)

[238] Adopted despite opposition during the negotiations from the side of the Vatican, Saudi Arabia, Iran and Russia

[239] Formal representation in the Board (seat or represented) and in the UNAIDS Friends of the Board

Netherlands, as chair of the *International Aid Transparancy Initiative* (IATI), made use of this position to further fine-tune the standards and enhance its worldwide use. During two consecutive meetings of the UNFPA Annual Board, the Netherlands – jointly with other donors – emphasized the need to improve evaluations, in particular data collection and presentation of results on outcome levels, as well as the M&E capacity within UNFPA.

7.2 Overall conclusions

What were the specific contributions of UNFPA and UNAIDS in the achievement of the development objectives in SRHR?

- UNFPA is commended for its sustained support to governments in the conduct of population and housing censuses, an important source of data for understanding population dynamics. It is a critical area which will grow in importance, considering the importance of data for national planning and strategy development, for example regarding the demographic dividend and the need to develop policies to respond adequate to this development.

- The UNFPA Supplies programme has boosted access to SRH commodities, despite the many challenges on the ground. This flagship programme continued to place FP high on the agenda, and improved access in many disadvantaged areas. However, as the FP evaluation concludes, it is an area where UNFPA should enhance its brokering role at the national level, and improve its capacity to apply a human rights based approach to FP at the national level. UNAIDS' support was instrumental in increasing access to ARVs, in particular increasing access to commodities and in the prevention of mother to child transmission of HIV.

- UNAIDS has proven to be a strong partner in advocating for combating HIV/AIDS, in positioning sensitive issues on the global agenda (rights of key populations, discrimination) and in focusing attention on adolescents and youth in prevention efforts. UNAIDS has a strong profile on data collection and continues to serve as a reference base for information and quality data on the epidemic (trends, country and global level data). The success of its coordination role at country level depends for a great deal on the extent to which UNAIDS is able to play a leadership role.

- In terms of advocating for the SRH rights of key populations – one of the key priorities of the Netherlands in SRHR – UNAIDS showcased how partnering at the national level (in Kenya, Indonesia and the Ukraine) around key populations can successfully influence the debate and the national agenda, as well as join forces in implementing programmes. Promising initiatives are the Gender Assessment Tool and the HIV Stigma Index – introduced by UNAIDS – and the work of both UNFPA and UNAIDS on increasing prevention and treatment of STIs among sex workers.

- Both organisations align their work to national priorities and have contributed to the achievement of the MDGs – in particular regarding MDG 3 (gender equality), MDG 5 (maternal health), and MDG 6 (combating HIV/AIDS). The ICPD beyond 2015 review specifically intended to inform and influence the SDG agenda, a process that took place under guidance and support of UNFPA.

What is the assessment of the organisational performance (efficiency) of UNFPA and UNAIDS regarding the achievement of the development priorities of the Netherlands in SRHR?

- In the period under review, both organisations showed improvements in terms of strategic management. UNFPA and UNAIDS both developed and implemented new strategic frameworks, which improved their efficiency. UNFPA and UNAIDS reduced their number of priorities and sharpened their focus. UNFPA and UNAIDS established partnerships at country and global levels, around key areas, such as reducing maternal mortality, combatting gender-based violence, and preventing child marriages. This joint work on thematic areas in turn has influenced the organisations to address joint procedures and processes.

- UNFPA's new framework and business plan reflect the wish to better fine-tune the organisation's work 'not wanting to do everything', and increasing its focus on the core business. The new framework of UNAIDS improved in terms of being more results orientated, and clarifying the task division between the Secretariat and the co-sponsors of the organisation. UNFPA and UNAIDS have increased efforts in making the systems more transparent, and less burdensome. More attention is being placed on efforts to harmonise and align procedures. For both, human resources are seen as an area of concern especially in the context of decentralisation processes. UNFPA and UNAIDS have improved on their results measuring and accountability frameworks, and introduced new tools/systems to facilitate programme management and results tracking.

- No definite conclusions can be drawn on cost-effectiveness; few evaluations have reported on the efficiency of programmes, as most have not related input and results. Both organisations have addressed these weaknesses by investing in systems which allow for linking investments and outputs. Exemptions are the programmes on commodities; these have proved to be cost-effective. In addition, the Supplies Programme is considered essential, as it fills vital gaps in meeting unmet need in disadvantaged areas.

- For the Netherlands, in terms of human resource capacity, channelling funds through UNFPA and UNAIDS has proved to be a cost-efficient way, in particular in comparison to working with a number of smaller ngos.[240]

Which were the comparative advantages of UNFPA and UNAIDS in achieving the development objectives of the Netherlands MFA in SRHR?

- Expectations of the Netherlands regarding comparative advantages of UNFPA and UNAIDS are met. In terms of *economies of scale and outreach*: both have a worldwide presence which offer the Netherlands to have an influence – through the presence of the UN – even in the non-focus countries. The UNFPA Supplies Programme demonstrated economy of scale, as with relative small investments considerable progress is made. Because of their independency and impartiality, both UNFPA and UNAIDS were in a favourable position to complement the work of the Netherlands in addressing sensitive issues in SRHR at the international fora.
- Both organisations have proven to be in a *strategic position to partner with governments* on key issues in SRHR and broker with other actors in SRHR. Both organisations have been able to use

[240] Interviews with key informants, no cost-effectiveness analysis is conducted

this position, albeit to a different extent – depending the country context. For example, UNFPA was instrumental in the promotion of the vital role of midwives in maternal and neonatal care and in the reduction of maternal mortality at international and national levels. UNAIDS has taken a leadership role in promoting the rights of key populations, a good example of how they exploited their position as lead agency in combating HIV/AIDS.

- *Normsetting:* Both organisations have played a vital role in the development and dissemination of international norms, standards and guidelines in SRHR, for a large part in close collaboration with the WHO. Both organisations are key in producing reference materials, and guidelines in important issues in SRHR. UNAIDS is considered the reference base for information and update on trends; also in collaboration with the WHO the UNAIDS secretariat produces materials that guide key players in the field.

- *Policy dialogue and agenda setting*: UNFPA and UNAIDS have demonstrated their ability to perform a leadership role, in the case of UNFPA most manifest in the work in the ICPD beyond 2015 review process. UNAIDS has shown its leadership role in voicing concerns regarding stigma and discrimination and overall in promoting a human rights agenda. UNFPA played an important role in participating / organising international conferences and review processes (ICPD beyond 2014; post-2015 agenda, CSW and CPD). The Netherlands finds in UNFPA and UNAIDS collaborative partners in continuously asking attention for the Cairo Agenda, and sensitive issues in SRHR. In light of the growing conservative forces it is pivotal not only to advance the agenda, but also to secure the progress that has been made. The climate increasingly is becoming more hostile, in some cases to the level where "even gender is being considered a sensitive issue". In addition, the Netherlands has always been on the forefront of addressing the more sensitive topics like access to safe abortion and post-abortion care, adolescent SRHR, and SRH of key populations. The Netherlands has found a partner in both organisations in the promotion of a progressive SRHR agenda.[241]

- Both UNFPA and UNAIDS played a significant role in the development of the SDGs. Over the past years the opposition against SRHR has increased. UNFPA and UNAIDS have demonstrated that they are important allies in counteracting these voices and joining forces at all levels, at country and regional levels with partners, as well as at the level of the Executive Board through the Member States.

[241] Except for abortion rights which remains a sensitive issue within UNFPA

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Annexes